

SECTION B PROVIDER RESPONSIBILITIES

Phoenix Health Plan (PHP) has no policies which prevent a provider from advising or advocating on behalf of the member who is his/her patient.

AHCCCS IDENTIFICATION NUMBER

Every provider must be registered as an AHCCCS provider, have an assigned provider registration number, and remain active with AHCCCS. Any provider who provides coverage for a PHP contracted provider must be registered and active with AHCCCS and must have a registered National Provider ID (NPI) number.

THE PRIMARY CARE PROVIDER (PCP) AS GATEKEEPER

Primary Care Physicians (PCPs) are the "gatekeepers" of health care services and are responsible for rendering quality care effectively and efficiently. Each PCP is responsible and accountable for the coordination, supervision, delivery and documentation of medical services to assigned members. The use of PCPs as gatekeepers results in greater continuity of care for the member.

Please refer to *Section M* for information on coordination of Behavioral Health services.

PCP Assignment and Panel Status

Members are assigned to PCPs based upon member choice. However, if a member does not exercise his/her right to choose a PCP, he/she will be assigned to a PCP based on closest geographical proximity to his/her home address.

PHP may, at its sole discretion, limit the number of members assigned to a PCP. The recommended standard number of AHCCCS members assigned to a PCP is 1800. The recommended standard number of AHCCCS members who are age 12 and younger assigned to a PCP is 1200. PHP also may reassign or transfer members that are assigned to a PCP if the PCP has exceeded the maximum number of member assignments, has a high number of member complaints or is unable to comply with the AHCCCS mandated appointment availability and wait time standards.

Members assigned to a panel at the time of panel closure are considered an established patient whether or not the patient has been seen in the office and must be offered an appointment regardless of panel status.

SPECIALTY CARE PROVIDER ROLE

Specialists are qualified and licensed to provide comprehensive medical services in a designated specialty. Specialists will accept referrals from PCPs for the purpose of providing medically necessary covered services to PHP members in the provider's designated specialty.

SECTION B PROVIDER RESPONSIBILITIES

ELIGIBILITY VERIFICATION

Providers are responsible for verifying member eligibility prior to providing medical services. It is the Provider's responsibility to verify the eligibility status of all members prior to providing Covered Services on the date of service. Failure to do so may result in denied payment of service rendered.

There are several options available to providers to verify eligibility:

PHP Eligibility	Website: http://www.phoenixhealthplan.com/log_in.aspx	<ul style="list-style-type: none"> • If you are registered, click on link to log in • If you are not registered, click on link to request a User ID and password
	Automated Voice Response System (AVRS) (602) 824-3700 Option 3, option 1 <u>or</u> (800) 747-7997 Option 3, option 1	<ul style="list-style-type: none"> • AHCCCS ID number required for access • Search by either member ID or member name and DOB
	Member Services Representative (602) 824-3700 Option 3, option 7 <u>or</u> (800) 747-7997 Option 3, option 7	<ul style="list-style-type: none"> • You will need your AHCCCS provider ID or NPI number • Member Name, DOB, AHCCCS ID
AHCCCS Eligibility	Website: https://azweb.statemedicaid.us/Home.asp	<ul style="list-style-type: none"> • If you are a new user, click on link to create a new account
	Interactive Voice Response System (IVR) (602) 417-7200 (800) 331-5090	
	On-line Eligibility Verification System (EVS) For more information on EVS, contact: Web MD (800) 366-5716 MediFAX EDI (900) 444-4336	<ul style="list-style-type: none"> • EVS allows providers to use a PC to access eligibility and enrollment information
	AHCCCS Verification Unit (602) 417-7000 (800) 962-6690	<ul style="list-style-type: none"> • You will need your AHCCCS provider ID or NPI number • Member Name, DOB, AHCCCS ID • Date of Service

SECTION B PROVIDER RESPONSIBILITIES

APPOINTMENT AVAILABILITY AND WAIT TIME STANDARDS

Appointments for office visits must be available within the AHCCCS standards. PHP routinely monitors providers to ensure compliance. Appointment accessibility is measured for both “New” and “Established” patients for Primary Care, Specialty and Dental provider types for each appointment standard. The following list details PHP’s appointment availability standards.

Definitions

New Patient: A Member that has not received any professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years.

Established Patient: A Member that has received professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years.

"Urgent" is defined as an acute, but not necessarily life-threatening condition which, if not attended to could endanger the member's health.

PCP Appointments

Emergency appointments	same day of request
Urgent care appointments	within 2 days of request
Routine care appointments	within 21 days of request

Specialty Referrals

Emergency appointments	within 24 hours of referral
Urgent care appointments	within 3 days of referral
Routine care appointments	within 45 days of referral

Dental Appointments

Emergency appointments	within 24 hours of request
Urgent care appointments	within 3 days of request
Routine care appointments	within 45 days of request

Maternity Care

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 plan or maternity care provider, or immediately if an emergency exists

Appointment Wait Time

A new or established member should wait no more than 45 minutes for a scheduled appointment with a physician. Exceptions to this rule include 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.

SECTION B PROVIDER RESPONSIBILITIES

PATIENT CARE RESPONSIBILITIES

Canceled or 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.

Providers are encouraged to fax in a Member No Show Log after two “no-show” appointments within a six month period. The form can be found at:

➤ <http://www.phoenixhealthplan.com/pdf/Member%20No%20Show%20Log.pdf>

The Maternal Child Health (MCH) unit is also available to assist providers with members who have missed an EPSDT visit, dental or obstetric appointment.

After Hours Coverage

Network providers must have coverage 24 hours per day, 7 days per week. It is not acceptable to use the emergency department as coverage. The emergency department should only be utilized for members that require emergency services.

Acceptable Practice Coverage:

- An answering service used after business hours. The service must be able to contact the physician or covering physician.
- An answering machine which directs the caller to the physician or to the covering physician at another number.
- Call forwarding services that automatically send the caller to another number that will reach the physician or covering physician.

Unacceptable Practice Coverage:

- An answering machine that directs the caller to leave a message.
- An answering machine that directs the caller to go the emergency room and offers no other option for contacting the physician or covering physician.
- No answering machine or service.

PHP will not reimburse physicians who provide capitated services while covering for a capitated PCP. However, these services must be reported on a HCFA 1500 claim form in order to submit the required encounter data to AHCCCS. A contracted provider should be used for practice coverage.

Nurse Line

PHP subcontracts with a nurse call center to provide a 24 hour a day, 7 day a week nurse line that is staffed by bilingual registered nurses to answer questions and assist members. After hours urgent/emergent member calls are triaged according to national protocols and directed to the appropriate level of after hour care. A member will always be instructed to contact their PCP for non-emergent issues. All providers are encouraged to inform members to call the nurse line after hours prior to seeking

SECTION B PROVIDER RESPONSIBILITIES

medical services from anyone other than their PCP in order to obtain answers to their medical questions.

Care Coordination and Referrals to Other Agencies

Other state and community agencies may provide services to members that are not otherwise covered. These agencies may include the following:

- ALTCS (Arizona Long Term Care System)
- AzEIP (Arizona Early Intervention Program)
- CRS (Children's Rehabilitative Services)
- DDD (Division of Developmentally Disabled)
- RBHA (Regional Behavioral Health Authority)

The PCP is responsible for coordinating medical care for members who may be receiving services from other agencies.

EPSDT Services

PCPs are required to render EPSDT services as mandated for all AHCCCS eligible members from birth to members' age 20 years and younger.

Please refer to *Section E and G* for more information on EPSDT services.

Family Planning Services

PCPs are responsible for ensuring that members have information about and access to, all family planning covered services.

Please refer to *Section G* for more information on family planning services.

Immunizations

PCPs are responsible for following the Centers for Disease Control (CDC) recommended childhood immunization schedule. Please refer to *Section G* for more information on Immunizations.

Vaccines for Children (VFC) Program

All providers in the metro area are required to register with Arizona Department of Health Services (ADHS) as a "VFC Provider" if assigned children age 18 and younger. Providers in outlying and/or rural areas may opt out of VFC providing there is a Community Health Center to provide immunizations. Through the VFC program the federal government purchases and makes available to the states free of charge, vaccines for children age 19 and younger who are Title XIX eligible, Native American, or Alaskan Native, not insured, or whose insurance does not cover immunizations.

Patient Education

- PCPs are required to provide education to their members regarding disease management and the importance of regular health maintenance visits.
- PCPs also should instruct their members on appropriate use of the emergency room.

SECTION B PROVIDER RESPONSIBILITIES

- If a contracted physician employs physician assistant(s) (PA) and/or nurse practitioner(s) (NP), members need to be informed when scheduling appointments that they may be seen by a PA or NP. Members have the right to see their assigned provider.

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 for additional information)
- Use of code 96110 with EP modifier used when submitting claims
- Submission of PEDS score and interpretation form to the PHP Quality Department along with the yellow copy of the EPSDT form.

PHP sends a monthly list of all children assigned to you 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 or www.forepath.org.

Preventive Care

PCPs are responsible for providing appropriate preventive care to all members; including, but not limited to, age appropriate immunizations, disease risk assessment, well child visits and well woman visits to members age 20 and younger. Assessment and screening services for members age 20 and younger are based on the AHCCCS EPSDT periodicity schedule.

Physical examinations not related to covered health care services or performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

- Qualification for insurance
- Pre-employment physical examination
- Qualifications for sports or physical exercise activities
- Pilots examinations (Federal Aviation Administration)
- Disability certification for the purpose of establishing any kind of periodic payments
- Evaluation for establishing third party liability, or
- Preventative examinations in the absence of any known disease or symptom for members age 21 and older.

Health risk assessment and screenings for members age 21 and older should include, but are not limited to, screening for hypertension, elevated cholesterol, cervical cancer, colon cancer, sexually-transmitted diseases, tuberculosis, HIV/AIDS, mammography, prostate screenings, and diagnostic work-ups.

Physical examinations not related to covered health care services or performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

SECTION B PROVIDER RESPONSIBILITIES

- Preventative examinations in the absence of any known disease or symptom for members age 21 and older.
- Qualification for insurance
- Pre-employment physical examination
- Qualifications for sports or physical exercise activities
- Pilots examinations (Federal Aviation Administration)
- Disability certification for the purpose of establishing any kind of periodic payments or
- Evaluation for establishing third party liability

Please refer to *Section E* for additional information on Covered Services.

Referrals and Prior Authorizations

PCPs are responsible for initiating and coordinating referrals for their assigned members to Specialty Care Providers (SCP) when medically necessary. The PCP should obtain authorization for certain specialist visits (refer to the most current prior authorization guideline). It is critical that PCPs maintain good communication with specialists who are treating their members.

Please refer to *Section F* of this manual for additional information on the referral and prior authorization process.

EMERGENCY DEPARTMENT UTILIZATION

It is the role of the PCP to assist in reducing unnecessary use of emergency department services. Members receive information about the nurse line in their member handbook as alternative resource when seeking hours of non emergency care.

Daytime Emergency Department Usage

Members are educated to call 911 in a life-threatening emergency. In non-emergent situations they should contact their PCP before going to the emergency department. If a PCP is unable to see a member who requires urgent care, the member may be directed to seek assistance from a contracted urgent care facility or member services may become involved to facilitate a referral to another PCP.

The test for appropriateness of a life-threatening emergency service is if a prudent layperson, similarly situated, would request such services. Prudent layperson is defined as a person who possesses an average knowledge of health and medicine. The phrase does not apply to a person's ability to reason but rather the prudence with which he or she acts under a given set of circumstances.

In-Patient Admissions through the Emergency Department

If the member requires admission, the emergency department must contact the member's PCP or designated hospitalist. A reference number must be obtained from the health plan if the member is admitted to the hospital by faxing the admission face sheet to PHP.

PHP conducts random retrospective review of all emergency department claims for appropriateness of services rendered.

SECTION B PROVIDER RESPONSIBILITIES

ADMINISTRATIVE RESPONSIBILITIES

Claims and Encounter Reporting

All episodes of patient care, including services that are capitated, must be reported to the health plan. In order to determine the accuracy of encounter data, AHCCCS Administration annually conducts data validation studies of members' medical records in order to compare recorded utilization information to submitted encounter data. Physicians must cooperate with PHP and AHCCCS when copies of medical records are requested for these studies.

Please refer to *Section I* for additional information regarding billing and claims.

Confidentiality

The Health Insurance Portability and Accountability Act (HIPAA) requires covered entities, which includes, but is not limited to, health plans and providers, to safeguard protected health information (PHI) and use and/or disclosure it only as permitted under federal and state law.

For example, the law permits PHP to ask a provider office for a member's PHI without his/her authorization for health plan payment and operations activities. In turn, a provider is permitted to release PHI to PHP for these activities without authorization from members. Providers may also release patient PHI for treatment purposes under certain circumstances.

In addition, HIPAA provides individuals with certain privacy rights, such as to obtain a copy of their records. Any PHP member is entitled to receive one copy of his or her records from the doctor's office free of charge on an annual basis.

To learn more about HIPAA, visit the government Web site, <http://www.hhs.gov/ocr/hipaa>.

Co-Payments

Certain AHCCCS members may have a co-payment. However, services may not be denied to a member who is unable or unwilling to pay a co-payment, unless their co-payment is mandatory. Capitated providers may not bill members for unpaid co-payments; including Medicare co-payments or deductibles.

Please refer to *Section D* for additional information regarding co-payment, co-insurance, deductible and benefit changes. You can also go to the AHCCCS website at:

➤ <http://www.azahcccs.gov/commercial/providerbilling/copayments.aspx>

Documentation

Providers are required to maintain records and information including, but not limited to, information relating to the provision of covered services to members, billed charges, and payments received. PCPs are required to keep a complete medical record for each assigned member, documenting all office visits, referrals and contact with the member. All information should be accurate, timely, and complete. Providers are responsible for ensuring that a medical record is established when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file in lieu of actually establishing a medical record, but must be associated with the member's medical record as soon as the medical record is established.

SECTION B PROVIDER RESPONSIBILITIES

Advance directives, patient education and family planning information should be noted in the member's medical record. Copies of EPSDT forms and a record of the member's immunization status should also be included. Providers should ensure that they have documented information required by PHP disease management guidelines. PHP conducts periodic audits of medical records to ensure compliance.

TRANSPORTATION

PHP provides medically necessary transportation for members who have exhausted all resources for providing their own transportation. Members are responsible for contacting member services to arrange for medically necessary transportation. Once an appointment is made, a member services representative may confirm the appointment with the provider. Routine appointments require a 3 day advance notice.

Member services also will arrange appropriate transportation for members with special needs and will coordinate with the provider to ensure appropriate access to care is available.

CREDENTIALING AND RE-CREDENTIALING

The credentialing program is designed to reflect PHP standards, as well as State and National regulatory requirements.

In order to establish consistent standards for participation, and to meet regulatory requirements, PHP has developed participation criteria. PHP will verify the credentials of physicians and other health care practitioners and incorporate ongoing assessments of the quality of care services provided by those physicians and health care practitioners as they participate in the network.

Credentialing Application

The Credentialing application is used to identify and gather specific information for practitioners and organizational providers that wish to participate with PHP. The credentialing program determines whether physicians, organizational providers or other health care practitioners are qualified to perform their services and meet the minimum standards as defined by AHCCCS and other national standards. Primary source verification of all required credentials is a mandated component of the program.

Applications will be considered complete under the following circumstances:

- The application is filled out in its entirety;
- The attestation page is signed and dated;
- The following documentation is enclosed with the application:

For Physicians and Health Care Practitioners:

1. Explanations to any questions regarding additional information
2. Copy of AZ State license
3. Copy of current DEA, if applicable
4. Copy of Board Certification or proof of board eligibility and exam date, if applicable
5. Copy of current malpractice liability
6. Copy of AZ State Conscious Sedation Certificate, if applicable

For Facility/Ancillary Providers

1. Copy of Clinical Laboratory Information Act (CLIA), if applicable

SECTION B PROVIDER RESPONSIBILITIES

2. Copy of current DEA, if applicable
3. Copy of liability insurance
4. Copy of state license, if applicable
5. Copy of all accreditation certificates
6. Copy of most recent State and/or Medicare Survey/Audit (NONACCREDITED FACILITIES)

Credentialing Policies

PHP has policies and procedures in place for both the initial and recredentialing process. These policies are subject to change and should be used as a guideline only. Final determination of credentialing status is the decision of the PHP Credentialing and Peer Review Committee (CPRC).

Providers that are not credentialed should not provide covered services to PHP members in an office or outpatient setting until the credentialing and contracting process has been completed without obtaining prior authorization.

Certain provider types require a site visit and chart content audit prior to completion of the credentialing process.

1. Practitioner Credentialing Process

The following information is required and/or will be primary source verified:

- Absence of Medicare/Medicaid sanctions
- Board certification or proof of board eligibility and exam date
- Evidence of graduation from medical school or appropriate professional school (verification of highest level of education or board certification if applicable)
- Clinical privileges in good standing, if applicable
- Current malpractice insurance
- Current, valid DEA or Controlled Dangerous Substances (CDS) certification
- Current, valid, unrestricted license
- Disciplinary status with regulatory board, or agency
- National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) report or minimum five year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of practitioner
- Work history for five years
- NPDB information, along with licensure, clinical privileges and work history will be no more than 180 days old when presented to the Credentialing Committee.

2. Recredentialing Process

Practitioners will be recredentialed at a minimum of every three years. The recredentialing application must be received and completed prior to the recredentialing due date. If recredentialing is not completed by the due date, the provider's contract may be terminated and, if applicable, members will be reassigned. The recredentialing will be processed with the inclusion of the following:

- All primary source verification must be current within 180 days when presented to the CPRC
- Board Certification re-verified

SECTION B PROVIDER RESPONSIBILITIES

- Absence of Medicare/Medicaid sanctions
- Clinical privileges in good standing, if applicable
- Current malpractice insurance
- Current, valid DEA or Controlled Dangerous Substances (CDS) certification as applicable
- Current, valid, unrestricted license
- Disciplinary status with regulatory board, or agency
- National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) report or minimum of three year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of practitioner

In addition, the following information, if applicable, will be presented to the CPRC for consideration during the decision-making process:

- Member concerns including grievances (complaints) and appeals

COMPLAINTS

Providers may file a complaint with PHP by submitting a letter or other documentation to network management or member services at the following address:

7878 N. 16th St. #105
Phoenix, AZ 85020

All provider complaints are researched and resolved by the appropriate department.

COMPLIANCE PROGRAM

PHP is committed to conducting health plan management administrative services in a manner that is consistent with recognized compliance standards.

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>

PHP has documented these standards as part of its compliance program resources, which includes policies, procedures and training materials that provide guidance on federal and state laws, such as the Deficit Reduction Act (DRA) and False Claims Act (FCA) policy. This policy details the following provisions:

- The FCA requirements;
- The administrative remedies for false claims and statements;
- Any state laws relating to civil or criminal penalties for false claims and statements; and
- The whistle blower protection under such laws.

Please refer to the end of this section for more information about the DRA/FCA, which requires health plans and providers to train their personnel on the above listed provisions. Please note that PHP makes

SECTION B PROVIDER RESPONSIBILITIES

information about its compliance resources, including DRA/FCA training materials, available online at the health plan website, <http://www.phoenixhealthplan.com> and upon request.

Compliance program violations and suspected fraud, waste and/or abuse

As part of PHP's compliance program, PHP also encourages health professionals and members to detect, report and prevent any suspected violations of federal and/or state laws as well potential fraud, waste and abuse. Fraud and abuse are defined as follows:

- ❑ **FRAUD** - means an intentional deception or misrepresentation made by a person with the knowledge that the deception may result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. [42 CFR § 455.2]
- ❑ **ABUSE** - means provider practices that are inconsistent with sound fiscal, business, or medical practice, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. [42 CFR § 455.2]
- ❑ **ABUSE OF MEMBER** - means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault. [ARS § 46-451:13-3623]

Examples of Fraud, Waste and/or Abuse

The following list provides examples of fraud, waste and abuse. The list is intended for informational purposes and does not purport to represent the universe of actions which may be construed as fraud, waste and/or abuse.

Falsifying Claims/Encounters

Alteration of a Claim
Up-coding
Incorrect Coding
Double Billing
Unbundling
Billing for Services/Supplies Not Provided
Misrepresentation of Services/Supplies
Substitution of Services
Submission of Any False Documents

Administrative / Financial

Kickbacks/Stark Violations
Fraudulent Credentials
Fraudulent Enrollment Practices
Fraudulent Recoupment Practices
Embezzlement

Abuse of a Member

Physical Abuse
Neglect
Mental Abuse
Emotional Abuse
Sexual Abuse
Discrimination
Providing Substandard Care
Financial Exploitation

Member Fraud

Eligibility Determination Issues:
Resource Misrepresentation (Transfer/Hiding)
Residency / Citizenship Status
Household Composition
Income
Misrepresentation of Medical Condition

SECTION B

PROVIDER RESPONSIBILITIES

Delivery of Services

Denying and/or Limiting Access to Services/Benefits
Failure to Refer to a Needed Specialist
Under and/or Over Utilization

Fraud and Abuse Involving Members

□ If you have information about potential fraud, waste and/or abuse that is committed by a member or someone claiming to be a member, please notify either the PHP compliance officer or the Arizona Health Care Cost Containment System (AHCCCS) Administration using the contact information listed below.

Whenever a member presents for non-emergent or non-urgent services and you have any concerns as to whether he/she is enrolled with PHP, please take the following important steps:

1. Ask for two forms of identification, preferably one with a photograph;
2. Use MediFAX or visit the PHP website to confirm enrollment; or
3. Contact member services for verification of eligibility.

Fraud and Abuse Involving Health Professionals

□ If you have information about potential fraud, waste and/or abuse that is committed by another health professional or his/her staff, such as inappropriate billing or delivery of services, please notify either the PHP compliance officer or AHCCCS Administration using the contact information listed below.

Reporting Fraud and Abuse

To report member and provider fraud, waste and/or abuse, please contact the PHP compliance officer at 602-824-3700 or 1-800-747-7997. You may also forward information about suspected fraud and abuse to:

Phoenix Health Plan
Attn: Compliance Officer
7878 North 16th Street, Suite 105
Phoenix, Arizona 85020

Report any incidents involving non-PHP members to the AHCCCS Administration at 602-417-4193 or 1-888-ITS NOT OK (1-888-487-6686). Please report member abuse to: AHCCCS/DHCM-CQM, 701 East Jefferson, MD-6500, Phoenix, AZ 85034

You may also use the Fraud and Abuse Referral Form in the back of this section or you may use the AHCCCS Reporting form that can be found at:

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

All information provided to PHP regarding a potential fraud and abuse occurrence is maintained in the strictest confidence and in accordance with the terms and conditions of PHP compliance program policies and procedures and applicable law. Any information developed, obtained or shared among participants in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose and no other.

SECTION B
PROVIDER RESPONSIBILITIES

Please direct any questions or concerns regarding confidentiality to the attention of the PHP compliance officer.

Deficit Reduction Act (DRA)
Public Law 109-171
Eliminating Fraud, Waste and Abuse in Medicaid

The Deficit Reduction Act (DRA) applies to any entity that receives or makes annual Medicaid payments, under the state plan of at least \$5 million.

FCA Requirements for Organizations

An entity is required to establish written information, including but not limited to policies, procedures and training materials (collectively "written information") that are distributed to its employees, management, contractors and agents regarding the False Claims Act (FCA). The written information that is provided shall include:

- a) A reference to the United States Code Title 31 § 3729-3733;
- b) A statement that the FCA, also known as the "Lincoln Law," dates back to the Civil War and that the original law included "qui tam" provisions which allowed private persons to sue those who defrauded the Government and receive a percentage of any recovery from the defendant.
- c) A list of activities to which the FCA applies* (see below):
 - (i) Knowingly presenting (or causing to be presented) to the Federal Government a false or fraudulent claim for payment;
 - (ii) Knowingly using (or causing to be used) a false record or statement to get a claim paid by the Federal Government;
 - (iii) Conspiring with others to get a false or fraudulent claim paid by the Federal Government; and
 - (iv) Knowingly using (or causing to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the Federal Government.
- d) Policies and procedures for detecting fraud, waste and abuse;
- e) The rights of employees to be protected as whistle-blowers; and
- f) Mechanism for detecting fraud, waste and abuse.

*In general, the FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud.

Liability for violating the FCA

- Three times the dollar amount that the Government is defrauded (i.e., treble damages) and civil penalties of \$5,500 to \$11,000 for each false claim

How and When an Individual Can Receive an Award for Blowing the Whistle under the FCA

- Any individual must file a *qui tam* lawsuit. Merely informing the Government about the FCA violation is not enough.
- The whistleblower that files an FCA suit receives an award only *if, and after*, the Government recovers money from the defendant as a result of the lawsuit.

How Much Money Can An Individual Receive for Filing a Qui Tam Lawsuit?

- Generally, the court may award between 15 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement.
- The amount of the award depends, in part, upon (i) if the government participates in the suit and (ii) the extent to which the person substantially contributed to the prosecution of the action

Is A Whistle Blower Protected Under the FCA?

- Under Section 3730(h) of the FCA, any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the FCA is entitled to any relief necessary to make the employee whole.

Arizona laws relating to civil or criminal penalties for false claims and statements

- Arizona Revised Statutes (ARS) 13-1802 (Theft), 13-2002 (Forgery), 13-2310 (Fraudulent schemes and artifices), 13-2311 (Fraudulent schemes and practices; willful concealment) and 36-2918 (Prohibited acts).

Access to Additional Information

- www.azleg.state.az.us/ArizonaRevisedStatutes.asp (Arizona Revised Statutes)
- www.gpoaccess.gov/plaws/index.html (Deficit Reduction Act – Public Law 109-171 - insert public law 109-171 in the quick search box)

Fraud and/or Abuse Reporting Form

PHP is committed to a policy that encourages timely disclosure of such concerns and prohibits any action directed against an employee, manager, or staff member for making a good faith report of a concern. PHP's supervisors, managers or employees are not permitted to engage in retaliation, retribution or any form of harassment directed against an individual who reports a Compliance concern.

Deliver Completed Forms to Myrna Chaydez; mchaydez@abrazohealth.com

Name of Individual Referring: _____

PHP Department (if applicable): _____

Date of Referral: _____ **Phone Number:** _____

Please indicate whether this issue involves suspected fraud or abuse: _____

Please indicate if the alleged wrongdoing is being committed by a member, a provider, or the health plan: _____

If the alleged wrongdoing concerns a provider, please provide the NPI number, the provider's address, and phone number: _____

If the alleged wrongdoing concerns a member, please provide the member's AHCCCS or Medicare number, date of birth, address, and phone number: _____

If the alleged wrongdoing concerns the health plan, please provide the name of the department and specific employee (if known): _____

NARRATIVE DESCRIPTION OF ISSUE: *(Please include the Who, What, Where, and When of the issue).*

*** Please write your narrative so that someone who knows nothing about your area or job can understand the issue***

Narrative may be continued by attaching a separate sheet.)

You should include documentation to support your allegations whenever possible (i.e. copies of claims or medical records).

DEFINITIONS OF FRAUD AND ABUSE

Abuse by a provider -- provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS.

Abuse of a member - as defined by Arizona means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault

Fraud by a member or provider -- an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

EXAMPLES OF FRAUD AND ABUSE

Falsifying Claims/Encounters

Alteration of a Claim
Upcoding
Incorrect Coding
Double Billing
Unbundling
Billing for Services/Supplies Not Provided
Misrepresentation of Services/Supplies
Substitution of Services
Submission of Any False Documents

Administrative / Financial

Kickbacks/Stark Violations
Fraudulent Credentials
Fraudulent Enrollment Practices
Fraudulent Recoupment Practices
Embezzlement

Delivery of Services

Denying Access to Services/Benefits
Limiting Access to Services/Benefits
Failure to Refer to a Needed Specialist
Underutilization
Overutilization

Abuse of a Member

Physical Abuse
Neglect
Mental Abuse
Emotional Abuse
Sexual Abuse
Discrimination
Providing Substandard Care
Financial Exploitation

Member Fraud

Eligibility Determination Issues:
Resource Misrepresentation (Transfer/Hiding)
Residency
Household Composition
Income
Citizenship Status
Misrepresentation of Medical Condition