

REFERENCE GUIDE

Now proudly serving the following counties:

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Gila
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Yavapai**

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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

Claims Customer Service
Prior Authorization
Pharmacy Prior Authorization
Medical Services
➤ Case Management
➤ Medical Services Administration
➤ Inpatient Concurrent Review
➤ Behavioral Health
Network Management
Member Services
Quality Department
➤ MCH/EPSDT/Immunizations

Provider Fax Menu

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

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WEBSITE

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
- Prior Authorization On-Line Submissions (Coming Soon)

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APPOINTMENT AVAILABILITY & WAIT TIME STANDARDS

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 MATERNITY CARE

Effective 10/1/2008, AHCCCS will regulate that health plans must track the appointment availability for both *New* and *Established* patients by provider type.

Below are AHCCCS' standards:

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.

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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 date of service.
PHP claims should be mailed to:

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

CLAIMS FORMS

Centers for Medicare and Medicaid Services (CMS) now requires providers submitting paper claims on the most current versions of the claim forms. The claims forms have been revised to incorporate the required NPI fields. The new forms are as follow:

- Physicians – CMS-1500 (08/05)
- Facilities – UB-04
- Dental – J4000 (2006 Version)

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) 296-3736 or go to the website www.emdeon.com for more information.
- For Dental claims, please contact Tesia at (800) 724-7240 or go to the website www.tesia.com for more information.

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

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.

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.

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CLAIMS & REIMBURSEMENT

NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

PHP is requiring all providers to submit their NPI number on every claim. EDI and paper claims received without an NPI will be rejected or denied.

- To apply for your Type 1 and/or Type 2 NPI online, go to www.nppes.cms.hhs.gov or call (800) 465-3203 to request a paper application.
- Practice and physician NPI numbers must be on every claim in the appropriate fields (see table below).
- NPI numbers must be registered with AHCCCS
- Group NPI numbers must also be registered with AHCCCS
- To register the NPI or group NPI with AHCCCS send the confirmation via email to NationalProviderID@azahccs.gov or fax to 602-256-1474 and include your AHCCCS ID#
- The servicing provider’s NPI numbers must be included in the locations listed below for accurate matching within the scanning and claim system:

Claim Form	NPI (Type I)	NPI (Type II)
CMS-1500 (08/05)	Box 24j	Box 33a
UB-04		Box 56
ADA J400 (2006)	Box 54	Box 49

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)

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CLAIMS & REIMBURSEMENT

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.

MODIFIERS

Modifier 25 – Separate Identifiable EM Service

- Modifier 25 is only valid on EM services 99201 - 99499. In addition, local modifiers are no longer allowed under HIPAA guidelines.

Modifier 59 – Distinct Procedural Service

At times a physician may need to indicate that a distinct or independent procedure is separate from another procedure done on the same day. The plan follows NCCI edits when processing claims.

- Modifier 59 is used to report services not normally reported together and to identify the following: a different session or patient encounter, procedure or surgery, a different site or organ system or separate incision/excision, lesion or injury not ordinarily encountered or performed on the same day, by the same doctor.
- Modifier 59 may only be used if there is no other modifier that best describes the circumstances under which the physician performed the service.
- In some situations, modifier 59 may be used in conjunction with other modifiers. It should not be used if the procedure is performed on the same area. The services and/or the procedure must be separate and distinct in nature and be noted as such in the medical record.
- It is not appropriate to use this modifier with codes 77421-77427 nor may it be used with E&M services 99201- 99499. Claims submitted with modifier 59 are subject to medical review. Notes/operative reports should be included with your claim submission.

VACCINES FOR CHILDREN (VFC) PROGRAM

PCPs seeing children ages 0-18 must participate in the VFC program. Certain codes have associated age limits (i.e. 90715 has an age limit of seven years or older, 90655 and 90657 are for children 6-35 months of age, 90658 is for age 3 years and older, etc.). 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. 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 claim dispute form OR a letter detailing the factual and legal basis for the dispute.
(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.
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 business 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 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. 16th Street, Ste. 105, Phoenix, AZ 85020

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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

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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 16th St. # 105
Phoenix AZ 85020

To report directly to the AHCCCS Office of Program Integrity, contact AHCCCS at (800) 654-8713 ext 7-4045. You may also forward information in writing to:

AHCCCS-OPI
Attention: Director
801 E Jefferson, Mail Drop 4500
Phoenix AZ 85034

Please report member abuse to:

AHCCCS/DHCM-CQM
701 East Jefferson, MD-6500
Phoenix, AZ 85034

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:

www.ahcccs.state.az.us/Site/fraudreferralPDF.pdf

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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). PHP is responsible for providing emergency inpatient behavioral health services up to three (3) days per episode not to exceed twelve (12) days per contract year for Title XIX and Title XXI members not yet enrolled with 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
- Emergency transportation
- Evaluation and screening
- Group therapy and counseling
- 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)
- Therapeutic foster care services

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BEHAVIORAL HEALTH SERVICES

Identification and Referral

PCPs may treat 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. PHP requests that providers review and follow the Practice Guidelines for behavioral health when treating adult, adolescent/childhood ADHD. These guidelines can be found on the PHP website under the Provider tab.

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 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.
- 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 enrolled 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 RHBA 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 RHBA 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. **Note: Native American members may utilize their Tribal RBHA.**

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MEDICAL SERVICES

ARIZONA EARLY INTERVENTION PROGRAM (AzEIP)

If a PCP evaluation(s) indicates concerns about a child's development, the PCP must 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.

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 (888) 439-5609. Or visit their website at www.azdes.gov/AzEIP/default.asp. Or email: allazeip@azdes.gov.

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.

Contact Information:

- For Technical Support, paper forms, or free ASIIS web-based application; contact (877) 491-5741
- Other methods of electronic data transfer; contact (602) 364-3619
- For additional information, go to ASIIS website at: www.azdhs.gov/phs/asiis

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:

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

Please contact Case Management at (602) 824-3700 or (800) 747-7997 for additional information and assistance.

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MEDICAL SERVICES

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:

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

Please call our disease management team at (602) 824-3700 or (800) 747-7997 for more information and assistance.

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. 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. 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 which were revised in 2007. Outdate forms will be rejected by AHCCCS.

New Patient	Code	Established Patient	Code
< 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.

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MEDICAL SERVICES

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. 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.

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 according to the ADHS Advisory Committee on Immunization Practices Recommended Schedule located at www.azahcccs.gov/Regulations/OSPPolicy/Chap400/EX430_2.pdf. Adult immunizations are covered when medically necessary or in accordance to the Recommended Adult Immunization schedule. Both Immunization schedules can be located at the ADHS website, www.azdhs.gov or www.phoenixhealthplan.com. Please contact Medical Services at (602) 824-3700 or (800) 747-7997 for any additional information or clarification on covered vaccines.

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 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.

Network Management

7878 North 16th Street, #105, Phoenix, AZ 85020
Phone: (602) 824-3700 or (800) 747-7997
Fax: (602) 674-6670

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

WELL WOMAN EXAM

To ensure prompt payment, please bill with the appropriate preventive care codes. Women may self-refer to any contracted OB/GYN or be directly referred by their PCP.

HIGH RISK PRENATAL HOME CARE INFUSION SERVICES

Matria (800) 950-3963

BABY ARIZONA

Baby Arizona is a quick and easy way for qualified pregnant women to get prenatal care. The program is for pregnant women who have little or no income, live in Arizona and are US Citizens or qualified non-citizens. Pregnant women can call 1-800-833-4642 for a list of participating Baby Arizona providers. Participating providers will schedule a prenatal visit and assist the pregnant woman with completing the AHCCCS application. If the prospective member does not qualify for AHCCCS then the provider will work with the woman to come up with an affordable payment plan to continue care. For more information and a training video for providers offices that wish to participate visit www.babyarizona.gov.

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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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.

DENTAL PERIODICITY SCHEDULE RECOMMENDATIONS

AHCCCS recently adapted the periodicity schedule in accordance with the American Academy of Pediatric Dentistry guidelines. Diagnostic services include comprehensive and periodic examinations for members through 20 years of age. These recommendations for preventative pediatric oral healthcare should be followed by both general dentists and pedodontists.

- For preventative services, PHP allows two oral examinations and two oral prophylaxis fluoride treatments per member per year (i.e., one every six months) for members ages 12 months through 20 years of age.

DENTAL GUIDELINES/PRIOR AUTHORIZATION REQUIREMENTS

- Prior authorization is not required based on dollar amount.
- The dental matrix provides detailed information on those codes that require prior authorization. Please contact network management for the most current version of the matrix.
- Prior authorizations for a consultation are to be submitted on the dental prior authorization/referral form. For a referral to a specialist, such as; an oral surgeon, endodontist, or periodontist submit the Dental Prior Authorization/Referral Request Form to the Dental Prior Authorization Unit. State the reason for the need to refer to a specialist on the form.
- Submit a pre-treatment estimate by mail on an ADA form along with the Dental Prior Authorization Request Form to our Dental Prior Authorization unit. Include necessary supporting documentation of diagnostic quality (x-rays, narrative, charting).

If a treatment plan changes or if during the course of treatment an immediate procedure which is a covered service is required, do not interrupt a patient's care in order to obtain authorization. After the treatment, submit any changes to the original authorization that are needed, along with relevant documentation, and PHP will respond to the change request.

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DENTAL SERVICES

SERVICES FOR MEMBERS UNDER 21 YEARS OF AGE:

General Dentists

All services provided by general dentists to members less than 4 years of age require prior authorization. For members 4 years of age and older, those codes as designated on the dental matrix require prior authorization for members up to age 21.

Pedodontists

Consultation with a pedodontist does not need a referral and no prior authorization is required.

Specialist Referrals

- Consultation with an oral surgeon, endodontist, or periodontist requires a referral from the general dentist or pedodontist AND prior authorization from PHP.
- When submitting the request, include mounted or digital X-rays and documentation supporting the rationale for referral.

Dental Prior Authorization Matrix

- Services designated as requiring prior authorization on the dental matrix require prior authorization. There are no specialty exclusions. If one service on a treatment plan requires prior authorization (i.e. sedation), the entire treatment plan should be submitted with X-rays for review.
- Members may schedule their own appointments with contracted general dentists or pedodontists.
- **Effective 10/1/2009, AHCCCS will no longer cover the behavioral management code (D9920).**
- The dental matrix delineates the prior authorization requirements for all dental codes. The dental matrix is based on benefits by age group. There are limited benefits for members twenty-one (21) years of age and older. Be sure to verify the member's age and eligibility on every date of service, because prior authorization does not guarantee that the member will be eligible at the time of service.
- **Requests for services that require prior authorization must be submitted with mounted or digital X-rays to:**

Phoenix Health Plan
Attention: Dental Prior Authorizations
7878 N. 16th St., #105
Phoenix, AZ 85020

Network Management

7878 North 16th Street, #105, Phoenix, AZ 85020
Phone: (602) 824-3700 or (800) 747-7997
Fax: (602) 674-6670

DENTAL SERVICES

- Upon receipt of the dental prior authorization/specialist referral form the dental advisor will evaluate the request and make a determination.
- Denials will be faxed to the dental provider within twenty-four (24) hours of the decision.
- Prior authorizations are good for 120 days.
- To help educate members regarding the importance of keeping or canceling appointments in advance, report member “no-shows” on the “No-Show Log” and fax to the dental department at (602) 674-6677.
- PHP reserves the right to do post treatment audits of dental records.

Helpful Hint

- For emergency walk-ins for ages 20 and under the provider office must call dental prior auth department at (602)824-3878 for a verbal authorization.
- Treatment plan changes must be submitted for retro review to PHP fiscal address of 7878 N. 16th St. Ste#105 Phoenix, AZ 85020 attention Dental Prior Authorization Department.

SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER:

- **Effective 10/1/2009, AHCCCS no longer covers medically necessary dentures or panoramic films.**
- Pre-transplant services—require prior authorization. Requests are submitted and coordinated with the transplant coordinator.
- Emergency services are covered for members 21 years of age or older. AHCCCS does not cover routine tooth extractions but does cover medically necessary emergent tooth extractions. This emergent care consists of the extraction of a symptomatic abscessed tooth that is associated with pain, swelling, and/or when it immediately threatens the general medical health of the member.

No prior-authorization is required for emergent dental care, including emergent dental extractions. Please submit the periapical films and clinical notes for the treated tooth (or teeth) for emergent dental care with the claim to:

**Phoenix Health Plan
Attn: Dental Coordinator
7878 North 16th Street, Suite 105
Phoenix Arizona, 85020**

Emergency conditions must be documented in the member’s chart notes in detail

Network Management

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

Documentation and X-rays must be submitted with the claim indicating the emergent nature of the service. If the emergency service(s) cover more than 1 day, submit one ADA claim with the dates of service provided.

Dental codes that are payable for 21 or older under emergency conditions are listed on the following page:

All Dental Providers (Generalists, Oral Surgeons, etc):

D0140	Limited Oral Evaluation – problem focused
D0220	Intraoral X-ray, periapical first film limited to symptomatic teeth
D0230	Intraoral X-ray, periapical each additional film
D0240	Intraoral X-ray, occlusal film
D0270	Bitewing X-ray, single film
D0272	Bitewing X-rays, two films
D2910	Recement inlay, onlay, or partial coverage restoration
D2915	Recement cast or prefabricated post and core
D2920	Recement crown
D3220	Therapeutic pulpotomy (excluding final restoration)
D3310	Anterior root canal (excluding final restoration)
D3410	Apicoectomy/periradicular surgery – anterior
D7111	Extraction coronal remnants, deciduous tooth
D7140	Extraction, erupted teeth or exposed root
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth, soft tissue
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7510	Incision and drainage of abscess, intraoral
D7511	Incision and drainage of abscess, complicated
D7610 –D7640	Treatment of fractures, simple
D9110	Palliative (emergency) treatment of dental pain, minor procedure
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9241	IV conscious sedation
D9242	IV conscious sedation, additional 15 min
D9248	Non-IV conscious sedation (oral conscious sedation)

The following codes also are payable for 21 years old and over but must be submitted with documentation showing the date of tooth fracture and will only be paid if the service is provided within 60 days of fracture:

D2335	Resin based composite involving incisal angle (anterior)
D2931	Prefabricated stainless steel crown –permanent tooth
D2932	Prefabricated resin crown

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DENTAL SERVICES

A complete listing of covered AHCCCS emergency dental services is below:

AHCCCS does not cover routine dental care for adults (21 years, or older). No authorization is required to provide covered emergency dental services, which are explained, below.

1. Emergency oral diagnostic examination (limited oral examination – problem focused)
2. Radiographs and laboratory services, limited to the symptomatic teeth
3. Composite resin involving incisal angle due to recent tooth fracture
4. Prefabricated crowns, to eliminate pain due to recent tooth fracture only
5. Recementation of clinically sound inlays, crowns and fixed bridges
6. Pulp cap, direct plus protective filling.
7. Apicoectomy performed as a separate procedure on anterior teeth, for treatment of acute infection or to eliminate pain, with favorable prognosis
8. Immediate and palliative procedures, including extractions if medically necessary, for relief of severe pain associated with an oral or maxillofacial condition
9. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis
10. Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment)
11. Initial treatment for acute infection, including, but not limited to, perapical and periodontal infections and abscesses by appropriate methods.
12. Vital pulpotomies performed on six (6) maxillary teeth and six (6) mandibular anterior teeth only
13. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone or soft tissue, and
14. Preoperative procedures and anesthesia appropriate for optimal patient management.

Important limitations in coverage include the following.

1. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible
2. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma
3. Routine restorative procedures and routine root canal therapy are not emergency services
4. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection
5. Root canals are limited to six (6) maxillary anterior teeth and six (6) mandibular teeth, and only when indicated as treatment for acute infection or to eliminate pain.

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PHARMACY SERVICES**FORMULARY**

All offices should be prescribing medications listed on the current formularies, which are available on line at www.phoenixhealthplan.com. Please consider all formulary alternatives before submitting a prior authorization request for non-formulary medication. Prior authorization requests 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, AWP less 15%. 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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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. 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.

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.

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PRIOR AUTHORIZATION

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.

Helpful Hints:

PHP uses an electronic fax system. All incoming requests are received electronically, so please be sure to follow the following hints to help ensure that your request will be received and processed.

- Be sure to first fax the Prior Authorization Request Form through and then attach any necessary documentation as needed. If you forget to attach documentation, you should refax the entire request as the initial request will be delayed for lack of documentation.
- Do not bundle multiple Prior Authorization Requests into one fax. Each request must be faxed separately.

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HOME CARE SUPPLIES & SERVICES

DME & MEDICAL SUPPLIES

(i.e., colostomy/ostomy, wound care, catheters, etc.)

Preferred Homecare Phone: (800) 636-2123

Animas Diabetes Care (Insulin Pumps) Phone: (877) 937-7867

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 Therapy)

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

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ADDITIONAL SERVICES

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.

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 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.

OUTPATIENT THERAPY SERVICES

- Physical and Occupational Therapy for an acute episode may be referred for an initial evaluation without prior authorization. The therapy provider is responsible for prior authorizing the treatment plan after the initial consultation.
- Speech Therapy 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.

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

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ADDITIONAL SERVICES

TRANSPORTATION SERVICES

- Members are responsible for contacting 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.

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

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

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.

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

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OTHER REMINDERS

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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