

## **SECTION B PROVIDER RESPONSIBILITIES**

### **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. Phoenix Health Plan (PHP) has no policies that prevent the PCP from advocating on behalf of the member.

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

#### **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 12 years of age or 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.

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

### **PATIENT CARE RESPONSIBILITIES**

#### **Appointment Availability**

Appointments for office visits must be available within the standards listed later in this section. Appointment availability and wait time standards are mandated by AHCCCS. Both are monitored on an ongoing basis.

#### **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

## **SECTION B PROVIDER RESPONSIBILITIES**

will assist with this process through member education. Providers are encouraged to contact member services after two "no-show" appointments within a six month period.

The maternal child health unit (MCH) also is available to assist providers with members who have missed an EPSDT, dental or obstetric appointment.

### **After Hours Coverage**

Network providers must have 24 hours per day, 7 days per week coverage. 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 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)  
CRS (Children's Rehabilitative Services)  
DDD (Division of Developmentally Disabled)  
RBHA (Regional Behavioral Health Authority)

## **SECTION B PROVIDER RESPONSIBILITIES**

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 through twenty (20) years of age.

Please refer to *Section 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 who are assigned children 18 years of age and under are required to register with Arizona Department of Health Services (ADHS) as a "VFC Provider". Through the VFC program the federal government purchases, and makes available to the states free of charge, vaccines for children under age 19 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.
- 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.

### **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.

Health risk assessment and screenings for members twenty-one (21) years of age and older should include, but are not limited to, screening for hypertension, elevated cholesterol, colon cancer, sexually-transmitted diseases, tuberculosis, HIV/AIDS, mammography, prostate screenings, physical examinations and diagnostic work-ups. Assessment and screening services for members under age twenty-one (21) are based on the AHCCCS EPSDT periodicity schedule.

## **SECTION B PROVIDER RESPONSIBILITIES**

### **Referrals and Prior Authorizations**

PCPs are responsible for initiating and coordinating referrals for their assigned members to SCPs 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.

### **ADMINISTRATIVE RESPONSIBILITIES**

#### **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.

## **SECTION B PROVIDER 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. Providers may not bill members for unpaid co-payments; including Medicare co-payments or deductibles for capitated providers.

Please refer to *Section D* for additional information.

### **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.

### **Eligibility Verification**

Providers are responsible for verifying member eligibility prior to providing medical services. Providers can access [www.phoenixhealthplan.com](http://www.phoenixhealthplan.com) or call member services to verify eligibility. Providers can not be reimbursed by the health plan for services rendered to members not eligible with PHP on the date of service.

- To verify eligibility online, you must be registered for secured access to login.

### **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.

## SECTION B PROVIDER RESPONSIBILITIES

### APPOINTMENT AVAILABILITY AND WAIT TIME STANDARDS

The following list details PHP's appointment availability standards. PHP routinely monitors providers to ensure compliance with AHCCCS standards. Appointment accessibility is measured for both "New" and "Established" patients for Primary Care, Specialty and Dental provider types for each appointment standard.

#### **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 Waiting 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**

### **CREDENTIALING AND RE-CREDENTIALING PROCESS**

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 an essential 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
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)

## **SECTION B**

### **PROVIDER RESPONSIBILITIES**

#### **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).

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
- 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

## **SECTION B PROVIDER RESPONSIBILITIES**

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. 16<sup>th</sup> St. #105  
Phoenix, AZ 85020

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

### **COMPLIANCE PROGRAM**

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

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 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

## SECTION B PROVIDER RESPONSIBILITIES

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

#### Abuse of a Member

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

#### Administrative / Financial

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

#### Member Fraud

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

#### 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 some one 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.

## **SECTION B PROVIDER RESPONSIBILITIES**

### **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 16<sup>th</sup> 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 AHCCCS referral form on the next page and/or visit the AHCCCS website for this purpose (<http://www.azahcccs.gov/fraud/reporting/onlineform.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.

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.

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

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

**SECTION B  
PROVIDER RESPONSIBILITIES**



**Compliance Issue Reporting Form**

**Date:** \_\_\_\_\_ **Your Phone Extension:** \_\_\_\_\_ **Your Name/Department (optional):** \_\_\_\_\_

**Type of compliance issue (check any that apply):**

- \_\_\_\_\_ *Reportable compliance event*
- \_\_\_\_\_ *Suspected fraud, waste or abuse (refer to examples on backside or page2)*
- \_\_\_\_\_ *Privacy incident (e.g. unlawful or accidental disclosure of health information)*
- \_\_\_\_\_ *Security Incident*
- \_\_\_\_\_ *Other: search warrant, interview/Investigation, risk management issue, sanction, etc.*

**Type of individual/entity involved (check any that apply):**

- \_\_\_\_\_ *Member*
- \_\_\_\_\_ *Provider*
- \_\_\_\_\_ *Employee*
- \_\_\_\_\_ *Other (e.g. subcontractor, PHP/AAHP)*

**If applicable, please prove the following:**

- Provider/Member Name:* \_\_\_\_\_
- Provider/Member ID #:* \_\_\_\_\_
- Prior authorization/claim number(s):* \_\_\_\_\_

**Please explain how you become aware of the issue you are reporting** (on a call with a member or provider, reviewing a claim, by an anonymous tip, etc.):

***Please explain the issue you are reporting*** (Who, what, where, when, etc.)  
Please attach any documentation that may help in reviewing the issue.  
Please attach an additional sheet if you need more room to explain the issue:

***Please forward this form WITH SUPPORTING DOCUMENTATION***  
to Tina Lee by hand or via email at [tlee@abrazohealth.com](mailto:tlee@abrazohealth.com)

## SECTION B PROVIDER RESPONSIBILITIES

### Personnel shall report the following to the Compliance Officer (or designee):

#### 1. Subpoenas, other legal issues, risk management issues, and sanctions

- a) **Subpoenas/ Records Request**– Typically involve a request for records, such as of a member or an employee
- b) **Search Warrants**– Usually issued by law enforcement, i.e. investigating a crime involving an employee
- c) **Interviews/Investigations** – By an agent from a legal or regulatory agency (e.g. the State Attorney General or Medicaid Fraud Control Unit, Office of the Inspector General, Office of Civil Rights, etc.)
- d) **Risk management issues** – Notice of litigation, media inquiries over adverse outcome, unexpected member death, or other incidents that pose or could pose legal risk to the Health Plan
- e) **AHCCCS material change** – Refers to any change in overall business practice that could have an impact on 5% or more of the members, providers, or AHCCCS program, or may significantly impact the delivery of services provided by the health plan.
  - Examples include a change in transportation vendor, dialysis providers, etc.
- f) **Sanctions** – Penalty, fine or other punishment (e.g., enrollment freeze or capitation withhold) threatened or imposed, verbally or in writing, for failure to comply with any of the following:
  - (1) Federal, state or local law;
  - (2) AHCCCS RFP or Medicare contract requirement; or
  - (3) Medicaid, Medicare ADOI or other agency policy.

#### 2. Privacy Issues

- a) **Privacy requests/incidents** – Privacy requests (verbal or written), such as for a copy of a member's records, and complaints (e.g. about a Plan use or disclosure). Privacy incidents include accidental, inadvertent or other disclosure which violates state and/or federal privacy laws. Also applies to reports of **PHI left unattended at printer/copier stations**.
- b) **Review of Proposed Disclosures** – Requests to disclose the following information:
  1. Communicable disease (e.g. AIDS/HIV)
  2. If applicable, any disclosure:
    - a) For marketing, fundraising or research purposes
    - b) Containing psychotherapy notes or alcohol and substance abuse treatment
    - c) Genetic testing information

#### 3. Security Issues

- a) Defined as any act of violating an explicit or implied security policy, including the following categories:
  1. Human Life & Safety
    - a) Life threatening activity or impending bodily injury on or at premises
    - b) Assault, stalking or suspicious activity on premises
  2. Systems & Data
    - a) Unauthorized use of a system for processing or storage of data
    - b) Unauthorized access and/or use or abuse of proprietary data
    - c) Attempts [failed and successful] to gain unauthorized access to system or its data

## **SECTION B PROVIDER RESPONSIBILITIES**

- d) Unwanted disruption or denial of service
- 3. Facilities
  - a) Unauthorized access to or destruction of Plan offices or
  - b) (b) Theft or misappropriated company assets or property

### **4. Fraud, Waste and 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

#### **Abuse of a Member**

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

#### **Administrative / Financial**

Kickbacks/Stark Violations  
Fraudulent Credentials  
Fraudulent Enrollment Practices  
Fraudulent Re-coupment Practices  
Embezzlement

#### **Member Fraud**

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

#### **Delivery of Services**

Denying Access to Services/Benefits  
Failure to Refer to a Needed Specialist  
Limiting Access to Services/Benefits  
Under-utilization  
Over-utilization

#### **Employee**

Theft of Company assets or property (e.g. laptops, office supplies, etc)  
Illegal use of Company computers, computer systems, software and data  
Misuse of copy machines or faxes  
Misrepresentations:

- (i) In conducting business negotiations
- (ii) On employment application
- (iii) On timesheet or business trip expense forms

### **5. Other Compliance Issues**

The following are examples of reportable compliance events:

- Failure to adequately arrange for or provide access to medically necessary, covered services for a one or more members more than once in a month (e.g. transportation for dialysis services).
- A pattern of failing to notify or provide information to members as required by legal or contractual standards (e.g. PA denials, appeal decision letters, etc.)
- Less than 85% compliance with the standards applicable to a discrete function or activity, e.g., the handling of appeals/grievances (complaints) or from members, timely encounter submissions, notice of prior authorization decisions, timely distribution of ID cards, etc.

## **SECTION B**

### **PROVIDER RESPONSIBILITIES**

- Failure to obtain regulatory approval in advance of an action (including but not limited to communications to providers, members or prospective members) as required by legal or contractual standards.
- Any failure to provide a regulatory agency a report in an acceptable format or a piece of information (e.g., network change) on a timely basis as required by legal or contractual standards (unless the deadline is extended by the agency and the extension is confirmed in writing).
- Any failure on a monthly, quarterly or annual basis to meet plan financial or performance benchmarks as required by legal or contractual standards.
- Any written or oral communication from a federal, state or other regulator or licensing agency that raises any issue regarding non-compliance with any contractual provision or regulatory or other legal requirement, requests corrective action, or imposes or threatens to impose sanctions on the plan due to non-compliance by the plan or one of its subcontractors.
- The existence of any other non-compliance with legal or contractual standards that if not corrected could reasonably be expected to result in a finding of less than substantial compliance during an agency licensing or an operational/financial audit or the threatened or actual imposition of sanctions, whether identified internally or by a regulatory agency.