1 Introduction to Health Choice Arizona

Reviewed/Revised: 10/10/2017, 02/01/2017, 02/15/2016, 09/16/2015

INTRODUCTION

Thank you for choosing Health Choice Arizona!

Health Choice Arizona is owned by Steward Health Care Network who covers 680,000 lives in Arizona, Florida and Utah. Steward Health Care is the largest private hospital operator in the United States which includes, Mountain Vista Medical Center, St. Luke's Medical Center and Behavioral Health Hospital, and Tempe St. Luke's Hospital. Steward Health Care Corporate offices are located in Boston, Massachusetts. Health Choice Arizona was established in October 1990, serving as an Arizona Health Care Cost Containment Systems (AHCCCS) Managed Care Organization (MCO). Located in Phoenix, Arizona, Health Choice Arizona's mission is to improve the health and well-being of our members and treat them exceptionally when they need us the most. We are committed to providing quality, cost-effective health care to AHCCCS members.

Health Choice Arizona currently serves eight Arizona counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, and Pinal. Together we are highly motivated and compassionate people, using advanced systems and technology to become the healthcare provider of choice and to improve the quality of life for the individuals and communities we serve. Health Choice Arizona employees, physicians and volunteers share these guiding and enduring values:

- Be Kind: We care about people, treating our patients and each other with dignity, compassion, and respect.
- Own Outcomes: We act with honesty and integrity. We are accountable, one to another and as an organization, to build and maintain trust.
- Team Up: We encourage innovative thinking and leadership excellence, which promotes the advancement of quality and healthcare delivery.
- Live Fully and Serve Others: We persevere and strive constantly to become better.

OVERVIEW

This manual is designed to provide basic information about the administration of the Health Choice Arizona AHCCCS program, and to furnish providers and their staff with information, covered services, and claim/encounter submission requirements. This provider manual is an extension of the Health Choice Arizona Subcontractor Agreement, executed by the participating provider. The participating provider agrees to abide by all terms and conditions set forth in this manual.

HEALTH CHOICE ARIZONA NETWORK MANAGEMENT

Health Choice Arizona is responsible for coordinating covered services that are provided to members through a comprehensive provider network of Health Choice Arizona contracted physicians and facilities. The network consists of but is not limited to: primary care physicians, nurse practitioners, specialists, dentists, medical facilities, ancillary service providers, pharmacy, behavioral health services and non-emergent medical transportation.

Health Choice Arizona's network has been strategically developed to include contracted health care providers, facilitating our ability to meet or exceed the AHCCCS minimum requirements ensuring member access to quality care and services through appointment availability and network adequacy by geographic service area. Our robust network includes a diverse selection of qualified primary care providers, specialists, hospitals, and ancillary providers who agree to accept and follow Health Choice Arizona managed care policies and procedures. Contracted health care providers are required to coordinate care within the Health Choice Arizona provider network for all members. This standard of practice enables us to monitor, evaluate and maintain our well-established network.

In the event a referral(s) is needed outside of the contracted network, prior authorization is required. Questions concerning the Health Choice Arizona network should be directed to the attention of your Provider Service Representative.

Our Network Services Department is staffed with qualified, experienced professionals who are dedicated to developing partnerships with providers, and committed to providing personalized assistance such as staff orientation, education and training on claims or billing/coding issues, AHCCCS standards, prior authorization requirements, and compliance matters. Our goal is to collaborate on innovative approaches to maximize effectiveness and efficiency, and identify resources to help reduce administrative burden.

Provider Service Representatives are assigned by territory and/or service type. Please use Exhibit 1.1 as a guide to contact your representative. The Provider Service Representatives are available to assist you with your questions or requests and respond within 3 business days. Please do not hesitate to contact your Provider Service Representative whenever necessary. For a list of the Provider Services Representatives and other useful department numbers, see Exhibit 1.1, Network Services Contact Information.

PROVIDER REIMBURSMENT

Health Choice Arizona reimburses providers for services in the following ways:

1. Providers receive a prepaid capitation payment each month for each eligible member assigned to them.

2. Health Choice Arizona reimburses providers on a negotiated fee-for-service basis for services rendered to eligible members.

Health Choice Arizona cannot reimburse members.

HEALTH CHOICE ARIZONA WEB SITE

Health Choice Arizona encourages providers to utilize our Provider Portal link, available on our website, www.healthchoiceaz.com. Specifically designed to streamline provider access to information and resources, our provider portal serves as a valuable tool for locating health plan and provider-specific information which includes but is not limited to the following:

- *Claim Status* - provides an on-line search whereby current information and status of provider's claims within the Health Choice claims system can be retrieved.
- *Claim Dispute Search* - allows providers to see verification of a Dispute, the Dispute number, date the Dispute Decision was issued, the Certified Mail number (used only when a Dispute is denied), the decision, when the claim was sent for payment (including CRN when completed), and if a State Fair Hearing was requested, the date the file was sent to AHCCCS and the date AHCCCS sets for hearing.
- *Member Eligibility Search* - is an on-line search utility for retrieving the eligibility information for members within the Health Choice system.
- *Prior Authorization* – gives providers access to check PA Guidelines, information on submitting requests and PA status.
- *Explanation of Benefits (EOB)* - Health Choice Arizona provides a link from within the Provider Portal to allow providers to download a printable copy of their EOB. For providers that do not have systems capable of automatically posting payments via the ERA but want the quick payment afforded by the EFT, a downloadable remit serves as an ideal complement. Each Friday, the EOBs for that week's adjudicated claims are made available for download. In order to access the downloadable EOB, follow these steps:

    1. Go to the Health Choice Provider Portal at: https://www.healthchoicearizona.com/ProviderPortal/login/
    2. Log in using the Tax ID, User ID, and Password for the user's account.
    3. Once logged in, look for the "Claims" button on the top of your screen, click on this "Claims" link.
    4. You will see a listing of current claims and the processing status (system defaults to show the last 3 months of claims, click the "Clear Filters" to see all claim history.
    5. You can click on any looking glass icon to search within that field. S earch for adjudicated claims, those with a Paid or Denied status, by a specific date of service or by member (subsequent pages are shown at the bottom of your screen).
    6. Adjudicated claims will have an underlined link under the Claim Number. Clicking this link allows you to open or save a PDF file containing the EOB for not only that claim, but for all claims adjudicated in that week.

Various forms are available online at www.healthchoiceaz.com including but not limited to:

- Health Choice Arizona Prior Authorization Forms
- Claims Forms (EFT request)
- Health Choice Arizona EPSDT Forms
- Health Choice Arizona Transportation Referral Form
- Health Choice Arizona Formulary Request Form

Physician Directories are available upon request.

COVERED SERVICES

(Members enrolled in the SOBRA Family Planning program are only eligible for family planning services.)

Health Choice Arizona provides medically necessary covered services specified by AHCCCS, which are mandated by federal and state law. Non-emergent covered services must be provided or arranged by a Member's PCP.

Medical necessity may be determined through professional review for appropriateness of services provided in conjunction with established criteria related to severity of illness and intensity of services. Documentation submitted by providers is the key to the determination of medical necessity. Failure to submit documentation that substantiates medical necessity may result in a denial of your request and/or claim.

Coverage of services is subject to Health Choice Arizona and AHCCCS rules, policies, and requirements, including, but not limited to:

- Prior authorization
- Concurrent review
- Claims review
- Post payment review
- Special consent requirements
- Eligibility

This list is intended to provide basic information and is not intended to be an in depth description of benefits. Additionally, some services may require prior authorization. Refer to Chapter 6: Medical Authorizations and Notifications for prior authorization requirements.

Covered Services

- Audiology
- AHCCCS-approved Organ and Tissue Transplants and related prescriptions
- Behavioral Health Services, (See Chapter 18: Behavioral Health Services)
- Breast Reconstruction After Mastectomy
- Case Management
- Dental Services, (See Chapter 20: Oral Health Services)
- Medically necessary emergency dental care is covered for persons age 21 years and older who meet the criteria for a dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology of trauma.(See Chapter 20: Oral Health Services)
- Dialysis
- Emergency Medical Services
- Hospice
- Eye Care, for medical conditions affecting the eyes
- Health Risk Assessments and Screening Tests, (with limitations)
- HIV/AIDS Treatment
- Home Health Services
- Hysterectomy Services
- Immunizations
- Inpatient and Outpatient Hospital Care, including Observation and Surgical Services

- Laboratory Services
- Maternal and Child Services, including family planning
- Medical Supplies, Durable Medical Equipment and Orthotic/Prosthetic Devices
- Rehabilitation Therapies (Occupational, Physical, Speech) (PT-limited to 15 visits per year for members age 21 and older) (See Chapter 2, Member Eligibility and Member Services, for additional coverage details)
- Physician Services
- Post-Stabilization Care
- Prescription Drugs, (See Chapter 17: Pharmacy and Drug Formulary)
- Radiology and Medical Imaging
- Respiratory Therapy
- Transportation
- Nursing Home Services, (up to 90 days a year in lieu of hospitalization)
- Insulin Pumps, (prior authorization is required)

ADDITIONAL SERVICES FOR CHILDREN (under age 21)
(See also Chapter 16: Women and Children's Services)

- Bone Anchored Hearing Aids
- Cochlear Implants
- Conscious Sedation, (with limitations)
- Chiropractic Services
- Eye Exams and Prescriptive Lenses
- Nutritional Assessment and Therapy
- Oral Health Screenings; Preventive, Therapeutic and Emergency Dental Services
- Podiatry Services
- Speech and Occupational therapy

ADDITIONAL SERVICES FOR ADULTS

Preventive health risk assessment and screening test services for non-hospitalized adults include, but are not limited to:

- Hypertension Screening, (annually)
- Cholesterol Screening, (once, additional tests based on history)
- Routine Mammography, (annually after age 50 and at any age if considered medically necessary)
- Well Exams for Adults age 21 and older (non QMB dual Medicare primary members (see Chapter 14: Medicare and Other Insurance Liability)
- Well-Woman Preventative Care Services (see Chapter 16: Women and Children Services)
- Colon Cancer Screening (digital rectal exam and stool blood test, annually after age 50)
- Sexually Transmitted Disease Screenings (at least once during pregnancy, other based on history)
- Tuberculosis Screening (once, additional testing based on history)
- HIV Screening
- Immunizations
- Prostate Screening (annually after age 50, screening is recommended annually for males 40 and older who are at high risk due to immediate family history)

- Physical Examinations, (periodic health examinations or assessments for members under 21 years of age for early detection of disease, detect the presence of injury or disease, establish a treatment plan, evaluate the results or progress of treatment plan or the disease, or to establish the presence and characteristics of a physical disability which may be the result of disease or injury).

- Effective October 1, 2014, AHCCCS has implemented new Orthotic and Prosthetic limitations Please refer to the Health Choice Arizona PA Grid and/or the AHCCCS Medical Policy Manual Chapter 300, policy 310-P (also see Chapter 6: Medical Authorizations and Notifications for additional details).

Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

ADDITIONAL SERVICES FOR QUALIFIED MEDICARE BENEFICIARIES (QMBs)

Some Health Choice Arizona members are also Dual Eligible in that they also have Medicare coverage. Additionally, some Medicare members are also categorized as Qualified Medicare Beneficiaries (QMBs). Medicare is the primary payor for these members, with Health Choice Arizona as the secondary or payor of last resort. Providers should bill Medicare first and then bill Health Choice Arizona with a copy of the Medicare EOB attached.

Providers can identify Medicare members by the "rate code" assigned to them by AHCCCS. The rate code appears on their AHCCCS ID card. Rate codes that denote Medicare as the primary payor include the following:

If the third digit of the rate code is a "0", then the member is Medicare Dual – Eligible.
If the third digit of the rate code is a "2", then the member is a QMB Medicare member.

QMB members can have their co-pays and deductibles covered by Health Choice Arizona for the following additional services as defined by Medicare:

- Chiropractic Treatment
- Inpatient and Outpatient Occupational and Speech Therapy
- Respite Services
- Any services covered by traditional Medicare but not covered by AHCCCS

NON-COVERED SERVICES

Examples of services that are not covered by Health Choice Arizona:

- Services that are not medically necessary
- Pregnancy Terminations that are not medically necessary (as defined in Chapter 400 of the AHCCCS AMPM)
- Pregnancy Termination Counseling
- Bone Anchored Hearing Aids or Cochlear Implants for adults 21 years of age or older
- High-frequency Chest-wall Oscillation (percussive) vests for lung disease
- Dental Services, (effective 10/01/2017, HCA will pay for emergency dental services for adults up to $1,000 per membership year)
- Services or items for Cosmetic purposes
- Services provided by a Podiatrist (Doctor of Podiatric Medicine; DPM) for adults 21 years of age or older (see Chapter 2: Member Eligibility and Member Services, for additional information)

- Services or items furnished free of charge, or for which charges are not usually made
- Services provided in an institution for the treatment of tuberculosis
- Hearing Aids for adults 21 years of age or older
- Eye examinations solely for prescriptive lenses for adults 21 years of age or older Services determined by the Health Choice Arizona Medical Director(s) to be experimental or provided primarily for the purpose of research
- Sex change operations and reversal of voluntarily induced infertility (sterilization)
- Physical Therapy prescribed for maintenance only
- Artificial or mechanical hearts and xenograft
- Routine Circumcision for an eligible newborn male infant, (unless medical necessity is documented)
- Care for TMJ-related disorders
- Penile implants or vacuum assist devices for erectile dysfunction
- Chiropractic services for adults 21 years of age or older
- Outpatient speech and occupational therapy for adults 21 years of age or older
- Genetic Counseling/Testing for predisposition to cancer
- Physical examination performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

    - Qualification for insurance
    - Pre-employment physical examination
    - Qualifications for sports or physical exercise activities
    - Pilots examinations (Federal Aviation Administration)
    - Disability certification for the purpose of establishing any kind of periodic payments, or
    - Evaluation for establishing third party liability