

INDEX

Advance Directives	20	EPSDT	14
American Sign Language Interpretation	19	Family Planning	14
AHCCCS Adult Benefit Changes	5	Formulary.	16
AHCCCS Mandatory Copays.	5	Fraud, Waste & Abuse.	10
Appointment Availability & Wait Time Standards.	21	Hearing Services.	19
ASIS	12	Laboratory Services.	19
AzEIP	12	Member Eligibility	22
Baby Arizona	12	Modifiers.	7
Behavioral Health	13	Multiple Page Claims	4
Case Management.	13	Multiple Services.	4
Children’s Rehabilitative Services (CRS)	14	National Provider Identification (NPI) Number	3
Chiropractic Services.	19	OB/GYN Services	17
Claim Address	3	Optometry/Vision	19
Claim Customer Service	3	Outpatient Rehab Services.	20
Claim Dispute & Appeal Process	11	PEDS Tool.	15
Claim Forms	3	Prior Authorization.	9
Claim Liaison	3	Procedure Codes & Age Ranges	6
Contact Us.	2	Provider Directories & Website Search Function	22
Coordination of Benefits.	6	Provider Manuals.	22
Cultural Competency.	19	Refunds	8
Data Validation	21	Remittance Advices Available on Website	5
Dental Services	18	Resubmissions/Corrected Claims.	8
Diagnostic Vision Services.	6	Scanning Tips	4
Disease Management	13	Specialty Medications Purchasing Program	16
DME & Home Care.	16	Timely Filing Guidelines	3
Duplicate Claims.	4	Translation Services.	19
Electronic Data Interchange (EDI)	4	Transportation Services.	20
Electronic Funds Transfer (EFT).	5	Vaccines for Children (VFC) Program	8, 15

Topics are applicable to all lines of business unless otherwise designated in the topic header.

CONTACT US

Care1st

602.778.1800 or 866.560.4042

DEPARTMENT	PHONE	FAX
Case Management	Extension 8301	602.778.1810
Claims Customer Service	Options 5, 4	602.778.8346
Claim Disputes and Appeals	Options 5, 9	602.778.8371
Claim Liaison	Extension 8374	602.778.8346
Disease Management	Extension 8301	602.778.1810
Hospital/SNF Admission Notification	See Prior Authorization – Medical	602.778.8386
Interactive Voice Response	Options 5, 2	N/A
Member Services	Options 5, 3	602.778.1814
Prior Authorization-Dental	Options 5, 6, 1	602.778.8394
Prior Authorization-Medical		602.778.1838
Status Inquiry	Options 5, 6, 2	
All Other Urgent Telephonic Requests or Revisions to Existing Prior Authorizations	Options 5, 6, 3	
Prior Authorization-Pharmacy	Options 5, 5	602.778.8387
Provider Network Operations	Options 5, 7	602.778.1875

ONECare

602.778.8345 or 877.778.1855

DEPARTMENT	PHONE	FAX
Case Management	Extension 8301	602.778.1810
Claims Customer Service	Options 5, 4	602.778.8346
Claims Disputes and Appeals	Options 5, 9	602.778.8371
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Contact Us



Visit our website www.care1st.com/az



CLAIMS & REIMBURSEMENT

Claims Customer Service

Claim status can be checked 24 hours a day, seven days a week online at www.care1st.com/az.

Our Claims Customer Service Team is also available to assist you during the business hours listed below:

Monday – Friday 8:00 a.m.-12:00 p.m. & 1:00 p.m.-4:30 p.m.
Care1st Ph. 602.778.1800/866.560.4042 (options in order 5,4).
ONECare Ph. 602.778.8345/877.778.1855 (options in order 5, 4).

Claims Liaison

Our *Claims Liaison* is an excellent resource and is available to assist your office via phone 602.778.1800 x8374 or in person with questions regarding claim submission and processing.

Timely Filing Guidelines

When Care1st & ONECare are primary, the initial claim submission must be received within six months from the date of service. Secondary claim submissions should include a copy of the primary payor's EOB and be received within 60 days of the date of the primary payor's EOB or six months from the date of service, whichever is greater. Resubmissions/reconsiderations must be received within the greater of 12 months from the date of service or within 60 days of the date of recoupment for consideration.

Claim Address

Direct claim submissions to:
Attention Claims Department
2355 East Camelback Rd #300
Phoenix, AZ 85016

Effective November 1, 2010, Bridgeport Dental Services, Inc. (Bridgeport), manages the dental benefits provided to Care1st & ONECare members on behalf of Care1st. Claims for dates of service on and after November 1, 2010 are processed by Bridgeport.

Dental Claim Submission for Dates of Service on and after November 1, 2010:

Bridgeport Dental Services, Inc
C/O Solutions Data Systems
1051 Cassens Industrial Court
Fenton, MO 63026

For questions on dental claim submissions, please contact Bridgeport at 800.429.0495.

See page 4 for our EDI Payer I.D.!

Note: Please address Claim disputes and appeals to the attention of "Provider Claim Disputes" (see page 11 for additional information).

Claim Forms

The Centers for Medicare and Medicaid Services (CMS) now requires providers to submit all claims on the newest version of each claim form. The claim forms incorporate the required NPI fields:

- Practitioners – CMS-1500 (08/05)
- Facilities – UB-04
- Dental – J400 (ADA 2006 version)

National Provider Identification (NPI) Number

Care1st & ONECare requires all providers to submit the rendering/servicing provider's NPI on every claim. Care1st & ONECare requires that when applicable, the prescribing, referring, attending and operating provider NPI(s) also be present on claim submissions. Claims without the required NPI(s) will be denied. Please work with your billing team to ensure that NPI(s) are submitted appropriately with each claim submission and call us if you have any questions or need assistance.

- To apply for your Individual NPI and/or Organizational NPI online, go to www.nppes.cms.hhs.gov or call 800.465.3203 to request a paper application.
- If you have not yet notified Care1st & ONECare of your NPI(s), please fax a copy of your NPI(s) confirmation to Provider Network Operations at 602.778.1875.



Scanning Tips

All paper claims are input into our system using a process called data lifting.

1. Printing claims on a laser printer creates the best possible character quality
2. If a dot matrix printer must be used, please change the ribbon regularly
3. Courier 12 pitch non proportional font is best for clean scanning
4. Use black ink for all claims submissions
5. Always attempt to 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)
6. Ensure that the claim form is lined up properly within the printer prior to printing
7. If a stamp is required, refrain from red ink as this may be removed during the scanning process
8. Make every effort to avoid placing 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)
9. Use an original claim form as opposed to a copied claim form as much as possible
10. 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)

Multiple Page Claims

When a claim is greater than one page, place the grand total dollar amount for the claim on the bottom of the last page; do not enter sub-totals on each individual page.

Multiple Services

All services for the same date of service (less than 6-lines on a CMS-1500) are submitted on a single claim form.

When multiple units are performed for the same service and date of service, the service is submitted on one line with the appropriate number of units.

For additional guidelines on bilateral procedures, refer to page 7 for Modifier 50 information.

Duplicate Claims

Care1st & ONECare receive a large number of duplicate claim submissions as a result of claims frequently being resubmitted within 30 days from the date of initial submission. To avoid duplicate claims, we recommend allowing 60 days prior to resubmission of a claim. The 60 days allows us to meet our goal of paying claims within 30 days from the date of receipt and also allows enough time for billing staff to post payments.

In an effort to reduce duplicate claim billings and duplicate denials, we recommend that you verify claim status prior to resubmitting a claim. For your convenience, claim status can be verified 24-hours a day, seven days a week on our website. Utilizing our website reduces administrative costs caused by duplicate submissions. We recommend that you validate claim status after 14 days following submission.

Reminder regarding ONECare and Care1st members:

Care1st & ONECare automatically crosses over the claim when a member is ONECare primary and Care1st secondary. Duplicate submissions are not required. Please contact our Claims Customer Service Team if you have not received a remit for both lines of business within 90 days.

Electronic Data Interchange (EDI)

Care1st & ONECare encourage you to submit your medical claims electronically.

Advantages include:

- decreased submission costs
- faster processing and reimbursement
- allows for documentation of timely filing

We work with Emdeon (WebMD) 800.215.4730 for acceptance of EDI claims. Our Emdeon (WebMD) Payer I.D. is 57116. Claims may be submitted electronically directly to Emdeon (WebMD) or from your clearinghouse to Emdeon (WebMD). UB-04 submitters may also submit electronically through SSI (contact SSI's help desk 800.880.3032)

Electronic Data Interchange (EDI) (continued)

NOTE: EDI is for primary claims only, any claims that require secondary payments continue to be sent on paper with a copy of the primary EOB attached.

Dental Electronic Claim Submission for Dates of Service on and after November 1, 2010:

You may submit claims to Bridgeport electronically in two ways:

1. Through the Bridgeport web site at www.bridgeportdental.com. Claims for services that require the inclusion of x-rays or reports may be submitted electronically by using www.NEA-FAST.com to attach the required documentation or by attaching the x-rays as a TIF or JPG document.
2. Via Clearinghouse. Bridgeport works with Emdeon (WebMD) ph. 800.215.4730 for acceptance of EDI claims. Bridgeport's Emdeon (WebMD) Payer I.D. is CX028. Claims may be submitted electronically directly to Emdeon (WebMD) or from your clearinghouse to Emdeon (WebMD).

For questions on dental claim submissions, please contact Bridgeport at 800.429.0495.

Electronic Funds Transfer (EFT)

EFT allows payments to be electronically deposited directly into a designated bank account without the need to wait for the mail and then make a trip to the bank to deposit your check!

The EFT form is available on our website under the *Forms* section of the "Providers" link. If you do not have internet access, contact Provider Network Operations and we will provide you with the form.

Remittance Advices Available on Our Website

For your convenience, remittance advices are available for reviewing and printing on our website minimizing delay between receipt of dollars and the ability to post payment. Contact Provider Network Operations to obtain a login or confirm your login status. Care1st & ONECare turned off paper remittance advices mailed via the USPS to EFT providers effective June 1, 2011. EFT providers can review and/or print remittance advices from our website.



Visit our website www.care1st.com/az

ONECARE

AHCCCS Adult Benefit Changes Effective October 1, 2010 (Care1st)

In response to significant fiscal challenges facing the State and continuing growth in the Medicaid population, effective October 1, 2010, AHCCCS implemented several changes to the adult benefit package.

The changes to the benefit package impact **all** adults 21 years of age and older, unless otherwise specified. This population includes both Acute Care AHCCCS members as well as members in the Arizona Long Term Care System (ALTCs). At this time, these changes also apply to American Indians regardless of whether they receive services through managed care or fee for service.

Complete information regarding benefit changes can be found at www.azahcccs.gov/reporting/legislation/sessions/2010/BenefitChanges.aspx.

Please note effective April 1, 2011 AHCCCS restored coverage of transplants, previously covered, for adults members.

AHCCCS Mandatory Copays Effective October 1, 2010 (Care1st)

As a result of changes in Federal and State laws and regulations, including provisions of the Deficit Reduction Act of 2005, AHCCCS expanded member copay requirements effective October 1, 2010. The expanded copay requirements, which are described in AHCCCS Final Rule A.A.C. R9-22-711, include mandatory copays for certain populations, higher optional (nominal) copay amounts for certain populations, and clarification of the services and populations that are exempt from both mandatory and optional copays.

Mandatory Copays:

AHCCCS members who have mandatory copays for certain services beginning October 1, 2010 are:

Transitional Medical Assistance (TMA) members (Copay Level 50)

AHCCCS members who have mandatory copays for certain services beginning November 1, 2010 are:

"Childless Adults" and MED members (also referred to collectively as the "AHCCCS Expansion Population" or the "TWG (Title XIX Waiver Group) Population.") (Copay Level 40)

TMA Copays (Copay Level 50)

Pharmacy	\$2.30
Office Visits	\$4.00
Outpatient Professional Therapies	\$3.00
Surgeries (In Office; Outpatient non-emergent; ASCs)	\$3.00

TWG (Childless Adults and MED Members) Copays (Copay Level 40)

Generic Prescriptions and Brand Name Prescriptions when there is no generic	\$4.00
Brand Name Prescriptions when there is a generic that can be used	\$10.00
Non-emergency use of an emergency room	\$30.00
Office Visits	\$5.00

AHCCCS Online, <https://azweb.statemedicaid.us/Home.asp>, has the most current eligibility and copay information for all AHCCCS members. If you are not registered to use this system, register by choosing the “Click Here” link under “New Account”. The Co-Payment section at the bottom of the first page of the member’s eligibility screen indicates the member copay level and provides a link to the AHCCCS Copay Grid, which provides you the detail on the mandatory copay levels and applicable services.

Ongoing updates from AHCCCS regarding copayment requirements can be found at:

www.azahcccs.gov/commercial/ProviderBilling/copayments.aspx

Anesthesia Services

Anesthesia time is required for all anesthesia services and the total number of minutes is required in the unit field (25G). The start and end time must also be indicated on the claim form. The QX modifier is billed with the CRNA service when medical direction is provided by a physician. The QY modifier is billed by the supervising physician to indicate medical direction was provided to the CRNA. As a reminder, the anesthesia record is required anytime the anesthesia starts and stops during a procedure.



Visit our website www.care1st.com/az

ONECARE

Coordination of Benefits

Please verify if other coverage exists at the time of appointment. When Care1st or OneCare is secondary, all pages of the primary payor’s remittance advice/EOB are submitted with the claim, including the remark code/remittance comments section of the remittance advice/EOB. Please verify that the remittance advice/EOB copy is legible prior to submission. The claim is automatically crossed over when a member is ONECare primary and Care1st secondary. Duplicate submissions are not required.

Diagnostic Vision Services

Please reference the guidelines on page 7 for common questions on Modifier requirements for diagnostic vision services.

- 92135 is considered unilateral and should be billed with LT or RT modifier as appropriate
- 92225, 92226, and 92235 are considered bilateral in nature and the services must be billed with modifier 50 and a unit of 1 when services are performed on a single date of service for both eyes and a unit of 1.

Procedure Codes & Age Ranges

Below are CPT codes and associated age ranges that are frequently billed incorrectly, resulting in a denial. Please double check the member’s age prior to billing for these procedures.

EPSDT visits

New Patient	CPT Code	Established Patient	CPT Code
Ages 0 – 12 months	99381	Ages 0 – 12 months	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

Vaccines

CPT Code	CPT Description	Age Range
90633	Hepatitis A Vaccine	1 – 21 years
90649 (7/1/10 and forward)	HPV Vaccine – Gardisil	Males and Females 9 – 20 years; Coverage for 9 – 10 years is limited to high risk <i>only</i>
90650 (7/1/10 and forward)	HPV Vaccine – Cervarix	Females <i>only</i> Ages 9 – 20 years; Coverage for 9 – 10 years is limited to high risk <i>only</i>
90657	Influenza Virus Vaccine	6 months – 35 months
90658	Influenza Virus Vaccine	3 years and older
90680	Rotavirus Vaccine	1 month – 7 months
90698	DTaP – Hib – IPV	6 weeks – 260 weeks
99472	Subsequent inpatient pediatric critical care	29 days – 744 days

Modifiers

Below are a few commonly used modifiers and tips on appropriate usage:

EP Modifier (Care1st)

Modifier EP is billed in conjunction with 96110 for reimbursement of developmental testing. Providers must first complete the PEDS tool training to be eligible for reimbursement of this service. Refer to the PEDS Tool Information on page 15.

Modifier 25 (Separate identifiable E&M service)

When an EPSDT visit (99381-99385 or 99391-99395) is performed in conjunction with a sick visit (99201-99245) for members less than 21 years of age, modifier 25 is required on the sick visit CPT code in order to be reimbursed for both the EPSDT visit and the sick visit. The sick visit is reimbursed at 50% of the applicable fee schedule. Please remember that both visits must be billed on the same claim form.

SL Modifier (State supplied vaccine) (Care1st)

Vaccines administered to members 18 years and younger are ordered through the Vaccines for Children (VFC) program. For a complete listing of eligible VFC codes, refer to

www.azdhs.gov/phs/immun/act_aipo.htm. Vaccines supplied through the VFC program are billed with modifier SL in order to be eligible for reimbursement.

EXAMPLE: Billing sick visit, EPSDT visit and vaccine code(s) for single date of service

Patient (18 or younger) makes appointment because of an earache. Office determines that it is time for EPSDT evaluation and vaccine. Office bills appropriate E&M code with modifier “25”, EPSDT code and vaccine with “SL” modifier

- Both the sick and well diagnosis codes are billed
- Sick visit is billed with E&M (99201- 99245) with modifier “25”
- EPSDT visit is billed with appropriate E&M (99381-99385 or 99391-99395)
- VFC vaccine code is billed with “SL” modifier

Modifier 50 (bilateral procedure)

Modifier 50 is required for all bilateral procedures. Please refer to the current coding guidelines for a listing of appropriate bilateral procedures.

Bilateral procedures are billed on one line with the 50 modifier:

EXAMPLE: Line 1: 69436, with “50” modifier, full dollar amount, 1 unit

Total payment: 150% of fee schedule

Modifier 59 (distinct procedural service)

Modifier 59 is required to identify a truly distinct and separate service and should not be used if the procedure is performed on the same site. Care1st & ONECare apply NCCI bundling edits to claims. Claims submitted with modifier 59 are subject to medical review and office notes/operative reports are required with the claim submission for consideration. As a reminder, it is not appropriate to use this modifier with the following CPT ranges: 77421-77427 or 99201-99499.

Modifier 76 (repeat procedure by same physician)

Modifier 76 is required to identify repeat procedures performed by the same physician. When multiple procedures are performed by the same provider, both services are submitted on the same claim. Claims submitted with modifier 76 are subject to the medical review and records are required with the claim submission in order to be considered.

Modifiers (continued)

Modifier 77 (repeat procedure by a different physician)

Modifier 77 is required to identify repeat procedures performed by different physicians. Claims submitted with modifier 77 are subject to medical review and records are required with the claim submission in order to be considered.

Modifier SG (Ambulatory Surgical Center facility service)

Modifier SG is required on surgical procedures to identify the facility billing and is not used for professional services.

Additional Modifier Requirements

Don't Forget! Modifiers are required for all DME, Prosthetics and Orthotics and Ambulance services.

Operative Report

An operative report is required for the following surgical procedures:

- Multiple procedures with a total allowed amount greater than \$5000.00
- Any surgical procedure billed with modifier(s) 59, 62, 66, 76, 77, or 78
- Any unlisted procedures
- Any surgical procedure billed for a higher level of care than originally prior authorized

Refunds

When submitting a refund, please include a copy of the remittance advice, a letter or memo explaining why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payor's remittance advice (if applicable). Place the words "Attention Finance" on the envelope. If multiple claims are impacted, submit a copy of the applicable portion of the remittance advice for each claim and note the claim in question on the copy. When a refund is the result of a corrected claim, please submit the corrected claim with the refund check.

Resubmissions/Corrected Claims

When submitting a corrected claim, please include an attachment indicating the reason for resubmission along with the corrected claim/resubmission and

the original claim number to expedite handling. If you feel that you have identified a billing issue that may result in a larger volume of resubmissions, please work directly with your Provider Network Representative or our Claims Liaison.

Vaccines for Children (VFC) Program (Care1st)

PCPs seeing children under the age of 19 and covered by AHCCCS must participate in the VFC program. Many vaccines have specific age requirements. Refer to the Procedure Codes & Age Ranges section on page 6 for additional information.

When E&M services and VFC services are performed on the same day, they are submitted on the same claim. One administration fee is reimbursed for each immunization, including combination vaccines. To receive reimbursement for the administration of a VFC vaccine, bill the vaccine CPT code with an SL modifier. Refer to the SL modifier information on page 7.



For the most up to date information, visit our website:

www.care1st.com/az

ONECARE

PRIOR AUTHORIZATION TIPS

Authorization Forms

Prior authorizations for medical services (including in-office injectables) are requested using the *Treatment Authorization Request Form (TAR)*. Requests for nonformulary drugs are submitted on the *Pharmacy Prior Authorization Form*. The *TAR* and the *Pharmacy Prior Authorization Form* are available on our website www.care1st.com/az under the *Forms* section of the "Providers" link. The Prior Authorization Guidelines and Formularies also are available on our website under the "Providers" link. You may also contact Provider Network Operations for a copy to be mailed to your office.

For dental prior authorization information refer to the Dental Services section on page 18.

For Total OB prior authorization information refer to the OB/GYN Services section on page 17.

Prior Authorization Number Submission on Claim

A prior authorization number is issued by the Prior Authorization Department when a treatment authorization is approved. The prior authorization number must be included on the claim in order for claim adjudication and payment to occur.

1. UB-04 – place authorization number in field 63
2. CMS 1500 – place authorization number in field 23

A denial may occur if the prior authorization number is not included. Procedures for obtaining prior authorization are described in detail in the Provider Manual:

Care1st Manual – Section IX
ONECare Manual – Section X

Other

1. Please refer to our Prior Authorization Guidelines for prior authorization requirements. Prior authorization is required for some services when Care1st is the secondary payer.
2. Direct members to contracted providers including when Care1st is the secondary payer. All services requested for a non-contracted provider require prior authorization.
3. For specialties that require authorization for the initial consult (AHCCCS covered only) and/or follow-up visits, all visits and in-office procedures performed must fall within the authorization date range approved.
4. Your prior authorization request will be processed more expeditiously if you fax the completed request with all applicable notes and records to 602.778.1838. Allow sufficient time to process your request (especially on Friday afternoons following hospital discharges).
Urgent – Our goal is to process and return within one working day from the date received by the Prior Authorization Team as long as all necessary medical documentation is included for review.
Routine – Our goal is to process and return within three working days from the date received by the Prior Authorization Team.
5. To request an urgent prior authorization over the telephone or to revise an existing prior authorization, please call 602.778.1800 (Options 5, 6, 3).
6. Please contact Care1st & ONECare at 602.778.1800 (Options 5, 6, 2) to check the status of your prior authorization request before sending a duplicate request.

Documentation

- Provide the past year's medical records and/or any supporting documentation to justify your request. Failure to submit supporting documents may delay processing.
- Provide laboratory results such as cultures and sensitivities or cholesterol panels to expedite the medical necessity reviews for both medical and pharmacy requests.

Pharmacy Non Formulary & Five Day Overrides

- Prior authorization is required for all non-formulary drugs.
- A five day supply of medication following a hospital or ER discharge may be obtained by calling MedImpact at 800.788.2949.

FRAUD, WASTE & ABUSE

Care1st & ONECare prohibit fraud, waste, or abuse and are committed to responding appropriately in the event potential or suspected fraud, waste, or abuse is committed by employees, vendors, subcontractors, contracted providers, or business associates.

Our Fraud Waste & Abuse Compliance Program is organized to follow, in sequence, the core elements of a compliance plan built in accordance with the Office of the Inspector General's (OIG) Guidelines.

Health care fraud is a serious and costly reality. It places patients at risk and increases the cost of health care for all of us. The following are highlights of our Fraud, Waste & Abuse Program:

1. The purpose of the Fraud, Waste & Abuse policy is to articulate our commitment to doing the right thing when it comes to fraud, waste, and abuse.
2. We are committed to being compliant with all government requirements associated with fraud, waste, and abuse.
3. We work to prevent fraud, waste, and abuse through awareness training and communication just like this.
4. We develop our Fraud, Waste & Abuse infrastructure to assess risk, monitor and audit our systems to detect signs of fraud, waste, or abuse.
5. Allegations of fraud, waste, or abuse are investigated and where appropriate, corrective action is taken. Corrective action may include operational or policy changes, disciplinary action up to and including termination, and legal action.

Health care fraud is a serious problem that concerns everyone in our health care system and a reality that we can not afford to ignore.

Reporting Potential Fraud Waste and Abuse

Medicare Fraud Hotline of the HHS office Inspector General
800.447.8477

Arizona Health Care Cost Containment System (AHCCCS) Office of Inspector General
602.417.4045

Care1st/ONECare Anonymous Compliance Hotline
877.837.6057

Care1st/ONECare Compliance Officer

Compliance Officer
Care1st Health Plan Arizona/ONECare by Care1st Health Plan
2355 E. Camelback Road Suite 300
Phoenix, AZ 85016
602. 778.8318

There is no tolerance for retaliation against any employee, physician, vendor, or contractor for making a good faith report of possible wrongdoing. Retaliation is against the law, and it is a violation of our policy. If you wish, you may also call our Hotline anonymously.

Additional educational materials are available on our website under the *Fraud, Waste & Abuse/Compliance Resources* section of the "Providers" link.

Excluded Participation in Federal Health Care Programs

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

CLAIM DISPUTE & APPEAL PROCESS

Care1st

Care1st encourages providers to check claim status on our website www.care1st.com/az or contact Claims Customer Service for assistance with questions or issues regarding claim payment, partial payment, or non-payment. As a reminder, claims must be received within six months from the date of service. A claim payment, payment reduction or claim denial may be disputed 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.
(Please submit one Claim Dispute Form or a letter for each disputed claim. You may download the Claim Dispute Form from our website (under the *Forms* section of the “Providers” link) or contact Provider Network Operations for a copy.
2. A copy of the original claim and remittance advice.
3. Supporting documentation for reconsideration. For provider disputes with a clinical component (such as denied inpatient days, or services denied for no prior authorization), additional documentation should include a narrative describing the situation, an operative report and medical records as applicable.

Mail the completed form(s) and documentation to:

Care1st Health Plan Arizona
Provider Claim Disputes
2355 East Camelback Road, Ste 300
Phoenix, AZ 85016

Note: Disputes that fail to detail the facts of the case, the legal argument or are submitted with incomplete information will be denied without medical review. Care1st will not solicit supporting documentation. Corrected claims (adding or subtracting a modifier, changing units or CPT codes, etc.) are not considered claim disputes and may be addressed directly to our Claims Department for review and adjudication.

- Care1st acknowledges claim dispute requests within five business days of receipt. The dispute is reviewed and a decision issued within 30 calendar days of receipt (15 calendar days for DDD). An extension of up to 30 calendar days may be requested if a need for additional information is established.
- Care1st issues ALL decisions, whether approved or denied, in writing.

ONECare

Providers should check claims status on our website www.care1st.com/az and contact Claims Customer Service for assistance with questions or issues regarding claim payment, partial payment, or non-payment. As a reminder, claims must be received within six months from the date of service.

Provider Appealing on Behalf of a ONECare Member

If ONECare denies your request for services for a member, in whole or part, you may file an appeal on behalf of the member within 60 calendar days of the original denial notice. You have all of the rights and responsibilities of a member in obtaining an organization determination or managing the levels of the appeal process.

MEDICAL SERVICES

ASIIS (Care1st)

The State of Arizona (ARS 36-135 and AAC R9-6-706 and R9-6-707) requires that immunizations administered to children and covered by AHCCCS be reported to the Arizona State Health Department ASIIS system. ASIIS, which stands for the Arizona State Immunization Information System, requires all immunizations to be reported at least monthly, and it is recommended that high volume immunization providers report more frequently. Your office can report to ASIIS electronically or by paper, and ASIIS also accepts data exports directly from a patient management/billing systems. Training by Arizona Department of Health Services is provided free of charge.

Contact Information:

- ASIIS website www.azdhs.gov/phs/asiis
- For Technical Support call 602.364.3899 or 877.491.5741
- For free ASIIS web-based application call 602.364.3899 or 877.491.5741
- For paper forms call 602.364.3899 or 877.491.5741
- For assistance with other methods of electronic data transfer call 602.364.3619

AzEIP (Care1st)

The Arizona Early Intervention Program, also known as AzEIP offers support and services to families of children (birth to three) with disabilities or developmental delays. During an EPSDT visit, if concerns about a child's development are identified, a referral to AzEIP should be made.

Following the referral, AzEIP contacts the family and arranges for an assessment that also includes the development of an Individualized Family Service Plan (IFSP). The IFSP outlines desired outcomes related to the child's development and identifies strategies, activities as well as support available and services related to reaching those outcomes.

A copy of the IFSP is sent to Care1st. Care1st forwards the IFSP to the PCP and works with the PCP who is responsible for reviewing the IFSP and for

coordinating services that are identified as medically necessary with Care1st. AzEIP is responsible only for services that are determined not to be medically necessary. All medically necessary are coordinated through Care1st. Care1st coordinates care with AzEIP to ensure that members receive medically necessary EPSDT services in a timely manner. Open communication between the PCP, Care1st and AzEIP continues as long as coordination of care is required.

Contact Information:

- AzEIP website www.azdes.gov/AzEIP
- Phone 602.532.9960
- Fax 602.200.9820
- E-mail allazeip2@azdes.gov
- Care1st CRS Coordinator 602.778.1800 x8363

Baby Arizona (Care1st)

Baby Arizona provides early and continuous prenatal care to qualified low income pregnant women and encourages women to begin care early in their pregnancies, reducing the chance for maternal and neonatal complications. OB/GYN practitioners play an important role in this effort and we encourage OBGYNs to participate in the Baby Arizona program for the following reasons:

- Baby Arizona makes it easier for low income pregnant women to apply for medical insurance by shortening the application form and waiving the interview requirement.
- Free training is provided to participating practitioner offices on the prescreening process and how to assist members with the streamlined application process at the first visit – this also helps the office to stay on top of the patient's AHCCCS eligibility status and ensuring reimbursement.
- Upon approval of AHCCCS eligibility, the patient is immediately activated and is covered for pregnancy related services from the beginning of the month they apply until approximately 60 days postpartum.

Please visit www.babyarizona.gov for more information on how to become a participating provider and help ensure more health babies are born in Arizona.



Behavioral Health

Care1st

Providers may obtain assistance for AHCCCS members with behavioral health issues by contacting the Regional Behavioral Health Authority (RBHA) in their county. Although members may self refer, we strongly encourage providers to call our Behavioral Health Team and allow us to assist members with the referral process.

RBHA for Maricopa County: Magellan Health Services of AZ, Inc.

Magellan Customer Service Line 800.564.5465 or 602.914.5809 (TTY)

Member Self-Referral:

The member may call Magellan directly, select a language preference, and speak to a Magellan Customer Service Associate for referral to an agency close to the member's home or work.

PCP/Provider Referral:

- The provider may give a member the Magellan phone number, contact our Behavioral Health Team, or fax a Behavioral Health Services Referral Form to Magellan at 866.892.5023 to request behavioral health services.
- For more details, please refer to the Access to Behavioral Health Care for PCP's link found on our website (under the Forms section of the "Providers" link).

The Behavioral Health Services Referral Form is available in the Forms section of our website. You may also contact our Behavioral Health Coordinator at 602.778.1800 x1826 for a copy of either document.

ONECare

Providers may obtain assistance for ONECare members with behavioral health issues by contacting the Behavioral Health Supervisor at 602.778.8345 x1834. The type of behavioral health provider available for a ONECare member will depend on the member's individual benefits and secondary insurance, so communication with the Behavioral Health Supervisor is encouraged to assist with accessing services.

Member Self-Referral:

The member may contact the Behavioral Health Supervisor for assistance with a behavioral health referral.

PCP/Provider Referral:

The provider may contact the Behavioral Health Supervisor for assistance with a behavioral health referral.

Care1st and ONECare

Crisis Referral

If there is any indication that a member is currently a danger to themselves, to others, or is otherwise in need of immediate behavioral health services, call 911.

If the situation is not imminently dangerous, the member or their PCP may call the Maricopa 24-Hour Crisis Line at 602.222.9444 or 800.631.1314 or 602.274.3360 (TTY).

For questions regarding behavioral health, please contact the Behavioral Health Team during business hours.

- Behavioral Health Supervisor • Care1st 602.778.1800 x1834 • ONECare 602.778.8345 x1834
- Behavioral Health Coordinator • Care1st 602.778.1800 x1826 • ONECare 602.778.8345 x1826

Case Management & Disease Management

Services are available to members who have complex medical conditions or needs including asthma, diabetes, CHF/COPD. We partner with providers, community programs, and family members to help members achieve optimal outcomes.

Our objectives include:

1. Increasing member engagement with the PCP and PCP-referred to specialists
2. Decreasing unnecessary hospital admissions
3. Increasing member understanding and use of plan benefits
4. Increasing member awareness of community resources available to help improve their quality of life
5. Providing licensed professional support for transplant and high risk OB members
6. Decreasing unnecessary emergency room utilization

Contact our Team at 602.778.1800 x8301 for more information and assistance. Guidelines are also available on our website under the *Disease Management* section of the "Providers" link.

Children's Rehabilitative Service (CRS) (Care1st)

CRS serves individuals under 21 years of age with a qualifying chronic or disabling condition as established by the Arizona Department of Health Services. The State of Arizona mandates that AHCCCS eligible members receive services through CRS for qualifying conditions.

An application is submitted to CRS as soon as the diagnosis is confirmed to ensure the child does not have a delay in treatment. For a list of the most common qualifying CRS diagnoses please contact our CRS Coordinator 602.778.1800 x8363 or visit the website referenced below.

CRS applications are available at azdhs.gov/phs/ocshcn/crs/crs_az.htm. Please complete and submit the application with supporting documentation applicable to the diagnosis to:

APIPA-CRS
Attn: Eligibility and Enrollment
PO. Box 33320
Phoenix, AZ 85067
Or
Fax to 866.623.1692

For CRS enrolled members, all requests for services, procedures, xrays, labs, etc. related to the CRS diagnosis must be obtained directly from CRS. CRS does not provide primary care services.

If unsure what documentation is required for submission with the CRS application, need assistance with completing the application or have other questions, please contact our CRS Coordinator 602.778.1800 x8363.

EPSDT (Care1st)

EPSDT (Early and Periodic Screening, Diagnostic and Treatment – synonymous with well-child visit) services cover comprehensive healthcare for members less than 21 years of age through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems. PCPs provide the health screening/preventative care in compliance with the AHCCCS EPSDT Periodicity

Schedule. If a member comes in for a sick visit and is due for an EPSDT visit, please take advantage of this opportunity and perform both the well visit and the sick visit at the same time. You will be reimbursed at the full fee schedule for the well visit and 50% of the fee schedule for the sick visit. Use the appropriate medicine CPT code when billing for EPSDT services (Refer to the Modifier 25 section on page 7).

The periodicity schedules are found on our website www.care1st.com/az (See *Practice & Preventive Health Guidelines* under the “Providers” link).

EPSDT forms may be obtained/ordered by:

Downloading the *EPSDT Order Form* from our website www.care1st.com/az (See *Forms* section under the “Providers” link). Complete and fax per the instructions on the form. EPSDT forms will be mailed to your office.

Or print the forms from the AHCCCS website:

www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf

Remember! Please return the yellow copy of each completed form or a copy of your electronic medical record to our EPSDT Team.

If your office uses Electronic Medical Records (EMR), the EMR is acceptable but must contain all required elements on the EPSDT forms.

Family Planning (Care1st)

Family planning services for male and female members are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Members may self refer for family planning services. Each year, physicians and other practitioners should discuss and document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. Family planning and family planning extension services include covered medical, surgical, pharmacological and laboratory benefits specified below. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about the specific family planning methods available.

Family Planning (Care1st) (continued)

Family planning services include the following medical, surgical, pharmacological, and laboratory services:

- Contraceptive counseling, medications, supplies and associated medical and laboratory examinations, including, but not limited to, oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams, and suppositories.
- Voluntary sterilization (male and female over the age of 21)
- Natural family planning education or referral to qualified health professional.
- Postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse. Note: Mifepristone also known as Mifeprex or RU 486 is not postcoital emergency oral contraception.

The following are not covered for the purpose of family planning services:

- Infertility services
- Pregnancy termination counseling
- Pregnancy terminations including the use of Mifepristone (Mifeprex or RU 486) and hysterectomies

PEDS Tool (Care1st)

PEDS (Parents' Evaluation of Development Status) is a standardized, quick and inexpensive screening for developmental and behavioral problems in children from birth to 8 years. It meets the standards set by the American Academy of Pediatrics for such measures. It uses the parents' own assessment of the child's development, as determined to be significant by full, peer-reviewed scientific validation studies, to assess the risk of the child having developmental or behavioral problems. The PEDS screening can be conducted at each EPSDT well child visit for those children that were born on or after 01.01.06 and who were in NICU following birth.

In order to bill for the use of the PEDS Tool and to receive additional AHCCCS determined reimbursement:

- Complete the PEDS training (go to www.azpedialearning.org for additional information)

- Bill CPT 96110 with the "EP" modifier when the tool is used during an EPSDT visit
- Submit the PEDS score and interpretation form to the Care1st Quality Management Department along with the yellow copy of the EPSDT Form. As medically necessary services are identified using the PEDS Tool, they may be obtained by following our Prior Authorization Guidelines. Care1st provides a monthly list of all children assigned to you who are due for EPSDT visits. In addition, when a NICU graduate is assigned to you, Care1st sends a letter identifying the baby as a NICU graduate along with an identification sticker that may be used on your chart.

VFC Program (Care1st)

Providers that see children under the age of 19 must coordinate with the Arizona Department of Health Service Vaccines for Children (VFC) program in the delivery of immunization services. Through the VFC program, the federal government purchases and makes available to the states, free of charge, vaccines for children under the age of 19 who are Title XIX eligible, Native American, or Alaskan Native, not insured, or whose insurance does not cover immunizations. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule which is found at www.cdc.gov/vaccines or on our website www.care1st.com/az (See *Practice & Preventive Health Guidelines* under the "Providers" link). For more information regarding the VFC program or to enroll as a VFC provider please call 602.364.3642.

For information on how to bill for the administration of a VFC vaccine(s) please refer to the SL Modifier section on page 7.

PHARMACY SERVICES

Formulary

The Care1st & ONECare formularies are available on our website www.care1st.com/az. You may also contact Provider Network Operations for a copy. Please ensure your office is prescribing medications listed on the current formularies. Before submitting the *Pharmacy Prior Authorization Request Form* for a non-formulary medication, consider all formulary alternatives. Prior authorization requests and supporting documentation should be faxed to 602.778.8387. A five day supply of medication following a hospital or ER discharge can be obtained by calling MedImpact at 800.788.2949.

MedImpact is our Prescription Benefit Manager and manages all prescription drug transactions and pharmacy networks for all lines of business.

Specialty Medications Purchasing Program

Specialty injectable drugs may be obtained through our contracted vendor, Bioscrip. Please use the following procedure to procure mail-order specialty drugs:

Prior Authorization Process:

- Complete the Pharmacy Authorization Form and fax to us at 602.778.8387.
- Once approved, the Pharmacy Department faxes back the approval to the practice.
- The practice then completes the Bioscrip request form (form is provided by the Pharmacy Team at the time of approval) and faxes the script and the completed Bioscrip form to Bioscrip fax 866.488.5809/ph. 877.316.8921
- Bioscrip completes the order and ships the medication.

Prior authorization requests first come to the health plan before an order is placed. If prior authorization is not obtained before the order is placed, the health plan decision and patient care may be delayed.

* *This program does not include vaccines. Please review the Prior Authorization Guidelines for J and Q codes that require prior authorization. In addition, all unclassified drugs (i.e. J3490, J9999) are evaluated on a case by case basis for approval and reimbursement.*



DME & HOME CARE

DME & Medical Supplies

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

Covered durable medical equipment and medical supplies must be medically necessary and prescribed by a contracted provider and may require prior authorization.

Preferred Homecare Phone: 480.446.9010
Fax: 480.446.7695

Enteral

Requires prior authorization

Option 1 Nutrition Solutions Phone: 480.883.1188
Fax: 480.883.1193

Home Health

(Skilled Nursing and Home Therapy)

Home Health for ONECare members requires prior authorization

Professional Cares Phone: 602.395.5114
Fax: 602.395.5135

Preferred Homecare (High Risk OB/GYN) Phone: 480.446.9010
Fax: 480.446.7695

Home Infusion

May require prior authorization

Preferred Homecare Phone: 480.446.9010
Fax: 480.446.7695

Glucose Monitors

Care1st & ONECare members use Blood Glucose Monitors by Home Diagnostics like TrueTrack, TRUEtest and TRUE2go. Once a physician script is written, members obtain the meter, test strips and lancets at a contracted pharmacy.

Peak Flow Meters

In order to ensure that asthma is managed as effectively as possible, it is vital that a PCP driven asthma action plan be developed for each member as they use the peak flow meter. When a peak flow meter is indicated, the physician/practice contacts the contracted DME provider who sends the peak flow meter to the member.

OB/GYN SERVICES

All OB care requires authorization within 30 days of pregnancy confirmation. To request a total OB authorization, fax a copy of the completed ACOG Form to 602.778.1838.

Care1st reimburses obstetrical care as a total OB (TOB) package. To qualify for a TOB package, a minimum of five antepartum visits must be rendered in addition to the delivery. To confirm this requirement was satisfied, the appropriate delivery CPT procedure code is billed in addition to the antepartum visits. Antepartum visits are billed with a 99213 CPT code with the units' field indicating the total number of antepartum visits performed.

EXAMPLE:

OB physician performs 10 antepartum visits between January 1 and April 30 and delivery May 5.

- Line 1: Antepartum visits are billed with CPT code 99213. The "to" and "from" dates are January 1 and April 30 respectively and the units field contains 10.
- Line 2: Appropriate delivery CPT code.

All services included in the TOB package are billed with the delivery.

If a patient transfers care following the receipt of a TOB authorization or if the minimum number of visits are not performed, contact Care1st to revise the authorization.

Services Included in the Total OB Package:

- Physical Exams
- Initial and subsequent history
- Weight and blood pressure
- Breast stimulation studies
- Genetic counseling
- Artificial rupture of membrane
- Follow up visits
- Fetal scalp monitoring
- Induction of labor
- Delivery (includes multiple births)
- 5+ prenatal visits & 1 post partum (pap smear included)
- Laboratory services and handling fees
- Family planning
- Maternity counseling
- Nutritional Evaluation
- Non-stress test
- Inpatient services
- Wet preps and wet mounts
- External cephalic versions
- Risk Screening per ACOG Standards
- All Prenatal Visits, including EPSDT and Sick visits
- Delivery (includes multiple births)
- WIC Referrals for Medically Eligible Members



Visit our website www.care1st.com/az

ONECARE

Services Excluded from the Total OB Package & Reimbursed Separately:

Prior authorization may be required.

- Amniocentesis
- Amnioinfusion
- OB Ultrasound (3 or more 2D ultrasounds require prior authorization)
- Post-partum Tubal Ligation
- RhoGAM Injection
- Surgical Assist

High risk OB care (including consults, follow up visits, procedures and medical services) provided by a Perinatologist requires prior authorization.

High Risk Prenatal Home Care Infusion Services

Preferred Homecare Phone: 480.446.9010

Our Case Management Team is available to assist with high risk members. Call 602.778.1800 x1823 for assistance.

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

Return appointments are scheduled per the ACOG standards indicated below:

- Monthly through 28 weeks
- Bi-weekly between 29 and 36 weeks
- Weekly after the 36th week

DENTAL SERVICES

Covered Dental Services (Care1st)

Dental services are covered for all EPSDT members age 20 and younger. This includes medically necessary emergent dental services such as dental screenings, preventive services, therapeutic dental services, medically necessary dentures, and pre-transplantation dental services.

Effective October 1, 2010 AHCCCS covers medical and surgical services related to dental (oral) care for adult members 21 years and older. Covered dental services for members 21 yrs of age and older must be related to the treatment of a medical condition such as acute pain (excluding TMJ), infection, or fracture of the jaw. Covered dental services include a limited problem focused examination of the mouth, required x-rays, care of fractures of the jaw or mouth, giving anesthesia and pain medications and/or antibiotics. Certain pre-transplant services and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

Covered Dental Services (ONECare)

Contact ONECare Member Services for benefit information or view Section III of the current Summary of Benefits available on our website at www.care1st.com/az.

Effective for Dates of Service November 1, 2010 and After

Bridgeport Dental Services, Inc. (Bridgeport), manages the dental benefits provided to Care1st & ONECare members on behalf of Care1st. Claims for dates of service on and after November 1, 2010 are processed by Bridgeport.

Prior authorizations, claim submissions and claim inquiries for dates of service November 1, 2010 or after must be submitted to Bridgeport.

The “At a Glance Guidelines” identifies prior authorization requirements and claim submission requirements for Care1st members. More detailed information on the clinical guidelines and criteria is available on Bridgeport’s website www.bridgeportdental.com under the “Provider Reference Manual and Clinical Guidelines” (review of the criteria online requires provider registration. To register please follow these instructions:

1. Go to Bridgeport’s website at www.bridgeportdental.com.
2. From the main page, select and click on the “Providers Area” section.
3. This will take you to the provider registration section.
4. Select and Click the “Register” option.
5. Complete the Provider Registration Form following the instructions and click on the “Submit” button.
6. You will receive an e-mail confirmation of your successful registration with the user name and the password you selected.

Bridgeport’s website secured features include:

1. Verifying member eligibility
2. Viewing claims history and claims status
3. Submitting claims
4. Reviewing and printing a Remittance Advice (RA)
5. Submitting prior authorizations requests
6. Reviewing and downloading clinical guidelines and administrative policies and procedures.

If you cannot submit prior auth requests through the website, you may submit them via mail by submitting the ADA form (check the Prior Determination Box) along with any x-rays and additional documentation, or by mailing Bridgeport’s Prior Auth Form to:

Bridgeport Dental Services, Inc.
Suite 14
Prior Auth Department
9735 Landmark Parkway Drive
St. Louis, MO 63127

If you do not have internet access, you may contact Bridgeport directly at 800.429.0495 and request hard copies of their Clinical Criteria and Guidelines.

ADDITIONAL SERVICES

Chiropractic Services

Prior authorization is required.

Care1st

Covered services are available for members under age 21 and “QMB” (Qualified Medicare Beneficiaries). Members are limited to manual manipulation of the spine to correct subluxation.

ONECare

Medicare covered chiropractic services are limited to manual manipulation of the spine to correct subluxation. Members may contact ONECare Member Services for additional information.

Cultural Competency

Care1st & ONECare are aware of the diverse backgrounds of our members. We offer services that are sensitive to differences in race, ethnic background, language, age, religion, and that respect the traditions of our members. We offer a choice of qualified doctors and hospitals to meet member needs in a culturally appropriate manner. We provide interpretation services upon request or when a language need is identified. Listed below are two of the services available to our providers and members:

Translation Services

Care1st & ONECare have an agreement with CyraCom International to provide quality translation services. These services are provided at no cost to members and providers. Please contact Provider Network Operations if you have not received your CyraCom Card.

American Sign Language Interpretation

Valley Center for the Deaf is contracted to provide American Sign Language Interpreters. Services are available and arranged through Member Services at least 7 days in advance at no cost to members or providers.

Hearing Services

Care1st

Hearing evaluations and treatment (hearing aids) are covered for members under age 21. Prior authorization is required for hearing aids.

Hearing evaluations are covered for members age 21 and older.



Visit our website www.care1st.com/az

ONECARE

ONECare

One Medicare approved diagnostic hearing exam per year is covered as well as some additional benefits. Contact ONECare Member Services for benefit information or view Section III of the current Summary of Benefits available on our website at www.care1st.com/az.

Laboratory Services

Care1st & ONECare have an exclusive contract with Sonora Quest laboratories. All outpatient laboratory services are sent to Sonora Quest for processing.

Sonora Quest patient service locations are available at www.sonoraquest.com by clicking on the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling system is available 24-hr a day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

No Show Appointment Log

When a Care1st/ONECare member “no shows” to a scheduled visit, please use our No Show Appointment Log to notify us. Member outreach and education will occur immediately. The No Show Appointment Log is available on our website under the *Forms* section of the “Providers” link. You may also contact Provider Network Operations and a copy will be faxed/mailed to your office. If you have any questions about the Log or the outreach process, please contact our EPSDT Team at 602.778.1800 x1827.

Optometry/Vision

Care1st

Covered services are available for members under age 21. Members may self refer to Nationwide Vision. Covered services per contract year (i.e. October 1st through September 30th) include:

- 1 exam
- 1 pair of prescription lenses and glasses if medically necessary
- 1 repair of prescription lenses

ONECare

Glasses are covered for members under age 21 and/or following post operative cataract surgery. Additional benefits may vary, please contact ONECare Member Services for information or view Section III of the current Summary of Benefits available on our website at www.care1st.com/az.

Care1st & ONECare are now contracted with Nationwide Vision Medical Centers to provide diabetic eye exams in addition to the following services:

- Evaluation and treatment of diseases and problems of the cornea, conjunctiva
- Red eye work ups and treatment
- Inflammation of the anterior segment of the eye and it's treatment
- Foreign body removal from the cornea or the conjunctiva
- Dry eye treatments
- Eyelid diseases and treatments
- Treatment of disease of the anterior segment of the eye
- Evaluation of ocular discomfort or pain
- Evaluation of transient loss of vision
- Evaluation of flashes and floaters
- Evaluation of hypertension in the fundus
- Evaluation of cataracts
- Evaluation of macular degeneration
- Evaluation of choroidal nevus
- Evaluation of collagen vascular effects on the eye

Outpatient Rehab Services**Care1st**

Prior Authorization is required for all DDD members and AHCCCS members under 21. PT for AHCCCS adults 21 and older does NOT require prior authorization. Speech Therapy and Occupational Therapy are not covered benefits for AHCCCS and DDD members 21 and older.

ONECare

Prior Authorization is required.

Transportation Services**Care1st**

Members are responsible for contacting Member Services to arrange transportation three business days prior to a routine appointment.

ONECare

Contact ONECare Member Services for benefit information or view Section III of the current Summary of Benefits available on our website at www.care1st.com/az.

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. Care1st & ONECare as well as AHCCCS and CMS must comply with this Act, and request your cooperation. 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. For paper charts, stamp the front of the member's chart or place a "sticker" on the chart with the above statements(s). Please be sure to address the above questions with the member.

For more information on health care directives, the following organizations offer assistance and resources:

Arizona Medical Association	www.azmedassn.org
Arizona Hospital & Healthcare Association	www.azhha.org
Arizona Aging and Adult Administration	www.azdes.gov/aaa
American Academy of Family Physicians	www.aafp.org
American Association of Retired Persons	www.aarp.org
American Hospital Association	www.putitinwriting.org



Appointment Availability & Wait Time Standards

PCP	SPECIALTY/DENTAL	MATERNITY
<i>Emergency</i> Same day of request	<i>Emergency</i> Within 24 hours of referral	<i>First Trimester</i> Within 14 days of request
<i>*Urgent</i> Within 24-48 hours of request	<i>*Urgent</i> Within 3 days of referral	<i>Second Trimester</i> Within 7 days of request
<i>Routine</i> Within 21 days of request	<i>Routine</i> Within 45 days of referral	<i>Third Trimester</i> Within 3 days of request
		<i>High Risk Pregnancies</i> Within 3 days of identification of high risk by health plan or maternity care provider, or immediately if an emergency exists

Appointment wait time standards: no more than 45 minutes (unless unforeseen circumstances/emergency).

** Urgent is defined as an acute, but not necessarily life or limb threatening disorder, which, if not attended to, could endanger the patient's health.*

Appointment availability standards are measured for both "Established" and "New" patients for Primary Care, Specialist and Dental providers.

An "Established" Patient is defined as 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.

A "New" Patient is defined as 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.



Data Validation (Care1st)

Each year as part of a federal requirement, AHCCCS requests medical records from practitioners and hospitals for services provided to AHCCCS members during a previous AHCCCS contract year (October 1st through September 30th). This process is referred to as Data Validation. In 2009, the methodology was revised by AHCCCS to request medical records from all practitioner types and facilities that rendered care during the requested time frame to the sample of members selected for the study. The study audits the integrity of claims submitted to AHCCCS health plans and ultimately to AHCCCS Administration. Quality indicators are affected by the accuracy of the claims submitted and reimbursement to your practice can be negatively impacted by inaccurate claims submission.

Omission and correctness errors are two examples of common data validation errors.

- An omission error is defined as an encounter for a medical record entry of a service that a plan paid a provider for but did not submit claim data to AHCCCS (or provider did not bill the service to the plan). Also, if a claim is inappropriately deleted from AHCCCS historical files, or voided and not resubmitted it is an omission.
- A correctness error is defined as an inconsistency between the medical record documentation and the claim submitted in respect to procedure, diagnosis, and/or date of service.

Following the tips below will reduce the errors defined above and will help to ensure each Data Validation study is successful:

1. Medical record copies must be legible. Please check the ink in your printers or review the quality of the photocopies before records are packaged and mailed.
2. Physician signatures must be legible on all documentation per Medicare requirements. If the signature is not legible, the printed name should be included under the signature and must be legible.
3. All medical record documentation must have the date of services and the patient's name on every page.
4. Documentation for office visits/consults must support the level of service being billed.

Data Validation (Care1st) (continued)

5. Documentation must support the number of units billed.
6. Documentation for time based services (i.e. anesthesia) must include the time element.
7. Diagnoses must be reported to the highest level of specificity.
8. Ambulance mileage must be documented on the medical record.

Care1st appreciates and values your assistance and partnership during the annual data validation study.

Member Eligibility

Providers are responsible for verifying member eligibility for all medical services provided. Verify member eligibility using the following methods:

Website www.care1st.com/az

Our website offers member eligibility, claims status and online remittance advice viewing and printing. A one-time registration process is required in order to obtain a log on and temporary password. To complete the registration process:

1. Choose Provider Login in the top right hand corner of the home page
2. Complete the Request Access On-Line Form
3. You will receive your login and temporary password via e-mail

Interactive Voice Response (IVR)

IVR is also available to verify Care1st AHCCCS member eligibility, or claims status

1. Call 602.778.1800; (options 5,2)
2. IVR prompts the caller to enter the provider's login number (the provider's 6-digit AHCCCS provider number)
3. IVR then prompts the caller to enter their PIN (set as 654321 for all providers as a default)
4. Continue to follow/listen to option prompts.

Member Services

Care1st 602.778.1800 or 866.560.4042 (options 5,3)
ONECare 602.778.8345 or 877.778.1855 (options 5,3)

Provider Directories & Website Search Function

Our practitioner and ancillary directories/listings are available on-line at www.care1st.com/az under the *Our Network* section of the "Providers" link.

Also available on our website under *Our Network* of the "Providers" link is a "Provider Search" function. This option allows you to search by provider name, specialty, language or zip code and provides real time information from our system.

Please use the *Provider Listing Correction Request Form* available on our website in the *Forms* section of the "Providers" link to notify us of inaccurate information displayed in the provider directories/listings. Fax completed forms to Provider Network Operations at 602.778.1875.

If you have questions or do not have internet access and wish to request paper directories/listings, please contact Provider Network Operations.

Provider Manuals

Care1st & ONECare Provider Manuals are also available on our website.

To access:

1. Go to www.care1st.com/az
2. Click on Care1st or ONECare
3. Click on the "Providers" link
4. Click on "Manual" in the menu under the "Providers" link

If you have any questions or do not have internet access and wish to request that a copy be mailed to your office, please contact Provider Network Operations.