Banner
University Health Plans

Q1 2021 October - December Communication Directory

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Stay Connected

Thank you for your ongoing commitment to caring for our community through your partnership with Banner – University Health Plans (B – UHP).

Please utilize the provider website, www.BannerUHP.com, to view the most current updates, news and events, and materials.

Our Websites

B – UHP Provider Website

www.BannerUHP.com

***I have been instructed how to access Banner University Health Plan Manuals and a printed copy will be delivered upon request. ***

Member Websites

B – UFC / ACC

- www.BannerUFC.com/ACC

B – UFC / ALTCS

- www.BannerUFC.com/ALTCS

B – UCA

www.BannerUCA.com

eServices

eServices is B – UHP's Provider Portal. We know your time is important, so we are offering a simple tool that allows you to access member enrollment information and the status of claims you have submitted to any of our health plans.

Use eServices to access the following services:

- Member Lookup
- Claims Lookup
- Enrollment Verification

Social Media

Social Media is one way we can connect with you in your everyday lives. Stay up to date on provider-related news, health tips, initiatives, and community events!

Click Here to like us on Facebook!

Click Here to follow us on Twitter!

Click Here to follow us on Instagram!

Provider Communications

To ensure you receive the most current updates, please visit our Provider website at www.BannerUHP.com. Check out our Notifications and Newsletters sections.

Pharmacy Benefit Manager Update

Express Scripts to manage RX plan

Beginning Jan. 1, 2022, all Banner Medicare Advantage and all Banner University Health Plans prescription plans will be managed by Express Scripts®. We have selected a list of covered drugs that most closely matches our members' needs. Our goal is to minimize changes to prescription coverage, but there may be some differences in the medications that are covered. There may also be minor changes to the pharmacies that can fill members' prescriptions. You will find the list of medications and pharmacies on the BUHP provider website or on the e-services portal. For questions, reach out to your care transformation specialists.

HEDIS Audits

What are they and how can they support you?

Healthcare Effectiveness Data and Information Set (HEDIS) is widely used to measure and improve health care quality and is relied on by government regulators, health plans, provider organizations, employers and others to identify quality and compare plan performance.

***Please respond quickly to requests from the Health Plan to assist with this annual audit.**

Requests will be sent early 2022.

Referring, Ordering, Prescribing, Attending (ROPA)

Referring, Ordering, Prescribing, Attending (ROPA) Providers Required to Register with AHCCCS

The Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) require that all health care providers who **refer** AHCCCS members for an item or service, who **order** non-physician services for members, who **prescribe** medications to members, and who **attend**/certify medical necessity for services and/or who take primary responsibility for members' medical care must be registered as AHCCCS providers. AHCCCS calls this initiative, and these providers, "ROPA."

Until these acts passed, referring, ordering, prescribing, and attending providers were required to obtain and maintain a National Provider Identifier (NPI), but were not required to be registered as an AHCCCS provider, but with the implementation of ROPA requirements any registrable healthcare provider who is not already registered as an active AHCCCS provider must register or be identified as an Exception non-registerable provider*, if applicable.

As of May 27, 2021, due to the continuing public health emergency and in an effort to ensure that no members experience disruptions in care, the ROPA registration deadline has been extended to the end of the public health emergency. This extension will help impacted providers:

Work through the analysis of who still needs to be registered and who does not, and

Ensure denials and access to care impacts are limited and/or negated.

In order to ensure that providers meet this extended deadline, AHCCCS will release additional guidance on this web page specifically for referring and ordering providers, prescribing providers, and attending providers in June 2021.

*****There are limited types of providers who can refer, order, prescribe or attend who are not registerable provider types with AHCCCS, including pharmacists, residents, and interns. The providers in the following list will not be required to formally register with AHCCCS but will be tracked for validity through an alternative tracking system.

[Reference: AHCCCS https://www.azahcccs.gov/PlansProviders/NewProviders/ROPA.html]

For additional information about ROPA, visit the AHCCCS ROPA web page.

To begin the enrollment process, visit AHCCCS Provider Enrollment.

AHCCCS/Medicaid Updates

Pre-adjudication Claims Edits, ROPA Registration Tips

Pre-adjudication edits needed to process claims in a timely manner. Have you received a claim denial or a claim recoupment for any of the following?

- NPI not registered with AHCCCS on the Date of Service – Edit P378
- Provider not active on the Date of Service – Edit P281
- Provider type not eligible – Edit 353
- Provider not eligible for Category of Service – Edit 330

B – UHP and other AHCCCS Health Plans are required to follow AHCCCS guidelines in Claims processing and procedure. B – UHP has identified 4 common processing errors that result in payments that later result in a recoupment. Payments followed by recoupments result in additional work for your billing and office staff as well as to B – UHP.

B – UHP has implemented a change that will alert providers when these Edits occur. However, the notification will be made before a claim is paid. B – UHP is working to ensure that providers can be notified immediately through your Clearinghouse with a 277 "Pre-Adjudication Rejection File" if submitting claims electronically. Claims submitted on paper will be denied as well.

This change occurred on June 1, 2021.

B – UHP has created tips to assist in reducing denials. During the AHCCCS registration process providers are assigned category of service and provider type, based on the licensing submitted by the provider. Furthermore, AHCCCS mandates that prior to payment of claims, Health Plans ensure providers have an NPI registered with AHCCCS on the date of service and that the billing provider be active on the date of service.

As provider groups grow and/or change, licensing may change. Licensing changes must be submitted to AHCCCS to ensure the causes for the Encounter Edits are corrected prior to providing services. When not updated timely or if there is a lapse in registration, claims payments are impacted. For providers that have been impacted, AHCCCS may grant retrospective approval. Contact AHCCCS if you need to:

- determine if AHCCCS has your current provider registration and NPI
- determine if AHCCCS has the correct COS registration for services billed by provider(s)
- determine if provider type is eligible to bill
- ask questions about other information that can affect billing practices

Please contact AHCCCS via the contact information below.

Provider Enrollment

In Maricopa County: 602-417-7670 and select option 5

Outside Maricopa County: 1-800-794-6862

Email: PRNotice@azahcccs.gov

Call Center Hours: Mon.-Fri., 8 a.m.-12 p.m. and 1 p.m. - 4 p.m.

AHCCCS Registration TIPS for Providers

The Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) require that all health care providers who provide services to, order (refer), prescribe, or certify health care services for AHCCCS members must be enrolled as an AHCCCS provider.

Prior to these Acts being passed, referring, ordering, prescribing, and attending (ROPA) providers were required to obtain a National Provider Identifiers (NPI's) but were not required to be enrolled as an AHCCCS provider. **This has now changed!**

All ROPA providers who are currently submitting claims are strongly encouraged to register as an AHCCCS provider **as soon as possible.**

In addition, service providers whose claims include ROPA providers who are not registered with AHCCCS should work with these providers to complete their registration.

To ensure payment of claims when submitting for items and/or services attended, ordered, referred, or prescribed by another provider, the rendering provider must ensure that the ordering/referring/prescribing provider is actively registered with AHCCCS.

A provider who chooses to attend, order, refer, or prescribe items and/or services for AHCCCS members, but does not to submit claims to AHCCCS directly, **must still be registered** with AHCCCS to ensure payment of those items and/or services where he attended, ordered, referred or prescribed.

Examples of Claims that will be denied in the future based on ROPA:

A Non-registered provider prescribes a medication. The non-registered provider and the pharmacy will not be reimbursed.

A registered provider refers a member to a non-registered (lab, PT, OT, etc.); the lab and/or therapy will not be reimbursed.

A non-registered provider orders DME to a non-registered home health or medical equipment provider. Neither will be reimbursed for service or DME.

To facilitate communication as to these requirements and provide related guidance, AHCCCS has developed and posted the FAQ's outlined below.

https://www.azahcccs.gov/PlansProviders/NewProviders/ROPA.html

Please visit B – UHP's ROPA news article for more information:

https://www.banneruhp.com/resources/notifications/04222021-provider-news-brief

Health Current

Top Reasons Banner Health Providers Connect to Health Current

INCREASE EFFICIENCY & IMPROVE QUALITY

Health Current (**healthcurrent.org**) is the statewide health information exchange (HIE) in Arizona that helps partners transform care by bringing together communities and information.

The HIE connects the electronic health record (EHR) systems of healthcare providers, allowing the secure sharing of patient information to better coordinate care.

Since 2007, we have worked to become Arizona's primary resource for health information technology and exchange, integrating information with the delivery of care to improve the wellbeing of individuals and communities.

Health Current is a trusted partner that gives providers comprehensive patient health records to make better clinical decisions and keep people healthy.

HIE Testimonial "The HIE is a huge part of our daily work, we use it all the time. We receive patient alerts from Health Current and task them out to the appropriate providers. All of our physicians and medical assistants prepare for each appointment early in the morning—or sometimes the night before—by looking up the patient's information through the HIE portal." – Pediatrics Practice Manager

FINANCIAL INCENTIVES

The Arizona Health Care Cost Containment Systems (AHCCCS), the Arizona State Medicaid Agency, offers financial incentives to providers for connect to the HIE. The two incentive options are:

• For Providers *New to the HIE*

Providers new to Health Current participate in the ***HIE Onboarding Program*** and receive an administrative offset payment once bidirectional connectivity (sharing and receiving data) is complete. The financial payments are based on the size of the practice:

• Community Provider (1-25 providers) $5,000

• Community Provider (26+ providers) $10,000

- Hospital $20,000
- FQHC, FQHC Look-Alike & RHC $10,000

Find Out More:

To obtain additional program information and to determine your organization's eligibility, contact Health Current by email at recruitment@healthcurrent.org or by phone at (602) 688-7200.

To connect to the HIE, visit: **healthcurrent.org/join.**

• For Providers Already Connected to the HIE

healthcurrent

Imagine more complete data . . .

New patient labs and records only a few clicks away

✓

Real-time alerts when your high-needs patients areadmitted or discharged from the hospital

✓

Better coordination of patient care teams throughsecure electronic sharing of messages, notes andrecords

Sound good? That's Why Arizona Healthcare Organizations are partnering with Arizona's HIE

Healthcare organizations are partnering with Health Current, Arizona's non-profit health information exchange (HIE). There are no participation fees and include these key benefits:

- One connection to save time and resources

Making connections to other providers, hospitals, reference labs and health plans takes time and valuable resources from your practice. One connection saves time and allows real-time transfer ofdata from hospital encounters, reference lab results and other community provider encounters.

- New patient information

Connection to the statewide HIE provides the ability to view current information and historical medical records in the HIE. Additionally, this information can be queried and downloaded to theelectronic health record (EHR) of your practice.

- Timely information to coordinate care

Clinicians who participate in the statewide HIE can “subscribe” to a list of their high-need patients that they need to track closely. With information on more than 90% of hospital admissions, discharges and transfers (ADTs), the HIE can send a real-time notice of ADTs as well as lab resultsand transcribed reports.

Secure communication

The use of the HIE’s Direct Trust-certified, HIPAA-compliant secure email system facilitates theeasy and secure exchange of patient information between providers, care team members and healthcare facilities.

Health Information Exchange (HIE) Services

The following are the services available through the HIE:

Alerts

Notifications sent to designated clinicians or individuals based upon a patient panel.

A patient panel is a practice or payer provided list of patients/members they wish to track. Alerts include:

- Inpatient Alerts
- Emergency Department (ED) Alerts
- Ambulatory Alerts
- Clinical Result Alerts
- Patient Centered Data Home ™ (PCDH) Alerts
- COVID-19 Lab Results

Direct Email

Direct Email is a HIPAA compliant, secure email account that provides the means for registered users to exchange patient protected health information with other DirectTrust-certified email accounts. Direct Email isoften used to receive Alerts.

Portal

Secure web-based access that allows selected patient data to be viewed online.

Data Exchange

Electronic interfaces between patient tracking systems and the HIE. Data exchange services include:

- Unidirectional Exchange
- Bidirectional Exchange

Clinical Summary

A comprehensive Continuity of Care Document (CCD) containing up to 90 days of the patient’s most recent clinical and encounter information. Clinical Summaries include:

- Automated Clinical Summary
- Query/ Response Clinical Summary

- PCDH Clinical Summary

Controlled Substances PMP Program

Integrated with the Arizona state Controlled Substances Prescription Monitoring Program (PMP) HIE participants who are connected to the HIE portal have a simple set up process to access the state PMP.

To sign up for this free service, contact recruitment at Health Current: recruitment@healthcurrent.org or 602-688-7216.

For more information on Health Current HIE Services, visit www.healthcurrent.org/hieservices

Model of Care

Applicable to: Banner Medicare Advantage Dual HMO SNP

Special Needs Plans Background

Special Needs Plans (SNPs) were created by the Medicare Modernization Action (MMA) of 2003. The MMA authorized SNPs to limit enrollment to specific vulnerable populations.

- Chronic Condition (C-SNP)
- Dual Eligible (D-SNP)
- Institutional (I-SNP)

Banner – University Health Plans (B – UHP) manages Banner University Care Advantage Dual HMO SNP (B – UCA) D-SNP plan (eligible for both Medicaid and Medicare). B – UHP serves dual eligible members residing in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Yuma and Santa Cruz counties.

SNP plans were mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to have a Model of Care (MOC) to ensure that these vulnerable populations receive the care and services necessary to help them manage and improve their health status. The MOC is the framework for Provider Network, Case Management, Quality Management policies, procedures and operational systems. The MOC sets guidelines for:

- Description of the SNP Population: that includes a complete description of the most vulnerable beneficiaries;
- Description of the SNP Population: that includes a complete description of the most vulnerable beneficiaries;
- SNP Provider Network: detailed description of the specialized expertise available to the beneficiaries, provider use of appropriate clinical practice guidelines and nationally recognized protocols, and provider training on the Model of Care;
- Quality Measurement & performance Improvement: a quality performance improvement plan, measurable goals and health outcomes, measuring patient experience of care, ongoing performance improvement evaluation, and dissemination of SNP quality performance.

Through the MOC, every member is evaluated annually via a Health Risk Assessment. The Interdisciplinary Care Team (ICT) works with members, caregivers, and families as appropriate in order to develop an individualized Plan of Care that meets each member's needs. Through the assessment process members are also directed to the appropriate B – UHP case management program. The case managers and PCPs work closely together to monitor the member's progress against the goals established in the Plan of Care. The case managers also work to help members identify problems and barriers to care, provide health education, coach members, and offer community resources when appropriate.

The partnership with the providers is a critical component to the success of the MOC. The MOC offers the opportunity for B – UHP and providers to work together to benefit our members, your patients.

The Providers Role in the Model of Care as a B – UHP contracted provider, you play an important role in the delivery of the MOC. As a key partner in the MOC your role is to:

- Know who your SNP members are
- Outreach and assist members with scheduling the annual wellness visit
- Communicate with the B – UHP case managers regarding the care needs of your member
- Collaborate with the B – UHP ICT as needed
- Contribute to the development of the member's Plan of Care
- Maintain the Plan of Care as part of the member's medical record
- Assist the member to navigate the health care delivery system, including transition of care

Below is a summary of the approach B – UHP has taken in implementing the MOC for B – UCA plans:

Description of SNP Population:

- Dual eligible: members qualify for both Medicare and Medicaid;
- Younger in comparison to the general Medicare population and tend to be single;
- A larger percentage of minority members;
- A population that has a high poverty rate;
- Typically, in poor physical and mental health;
- Over half of the population have four (4) or more chronic medical conditions;
- Over half of the population have a positive screen for depression.

SNP Model of Care Coordination:

- Qualified personnel responsible for enrollment, coordination of benefits and assist with access to care;
- Utilization of a comprehensive health Risk Assessment tool to measure all aspects of the member's physical health, cognitive status, medication regimen, medical history, surgical history, behavioral health status, cultural preferences, linguistic needs, pregnancy state, nutrition status, functional need and psychosocial needs;
- A team of staff review, analyze and stratifies the health care needs of the members;
- All members are assigned a case manager who oversees the member's needs and assists with the development of the individualized care plan;
- The health plan utilizes HRAs, Medical Risk Assessments, utilization claims data, pharmacy data, input from providers, and predictive modeling with a goal of creating an Individualized Care Plan(ICP) for each enrollee;
- The patient's primary physician is notified via phone or letter when there are changes to the ICP in order to obtain their input. The health plan has adopted an Interdisciplinary Care Team (ICT)approach The ICT is shared with the member;
- Provide coordinated planned and unplanned care transitions for the members with the assigned case manager the primary contact for the member and caregiver.

SNP Provider Network:

- B – UHP ensures that all contracted providers are vetted through a credentialing review process. B – UHP contracts with a full spectrum of medical specialists, sub specialists, inpatient facilities, dialysis facilities, pharmacies, PCPs, nursing professionals, outpatient clinics, durable medical equipment (DME) vendors, behavioral health professionals, and other health services providers;
- B – UHP supports physician management of chronic conditions my disseminating best practice, and evidence-based guidelines to promote the delivery of quality care to our members;
- B – UCA monitors the network on a bi-annual basis to assess, address and manage beneficiaries' access to care and ensure that the needs are met;
- Network Development utilizes GeoNetworks to ensure covered services are provided promptly and are reasonably accessible in terms of locations and hours of operation. Ninety five percent of current members travel 5 miles or less to reach a contracted PCP or dentist;
- The PCP is the gatekeeper for members and directs services for the members;
- The health plan assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols. The health plan relies on both nationally recognized evidenced based medical tools such as Milliman and Hayes and our clinical practice guidelines which are based upon nationally accepted standards.

Quality Measurement and Performance Improvement

- B–UHP uses standardized quality improvement outcome and process measure to assess the performance of the Model of Care and measure member health improvements. Sources for this data include but is not limited to:
    - Healthcare Effectiveness Data and Information Set (HEDIS);
    - Chronic Condition Improvement Programs (CCIP);
    - Health Outcome Survey (HOS);
    - Consumer Assessment of Health Plan and Provider Survey (CAHPS);
    - Utilization metrics.
- **HEDIS:** Quality Management works closely with the assigned PCP to assure the member receives needed preventative health and wellness services;
- **CCIP:** The health plan offers a disease management program to assist the members manage their chronic health condition;
- **QIPs:** The health plan participates in national quality improvement projects overseen by CMS, such as the reduction in hospital readmissions;
- **HOS:** Quality Management assesses the members self-reported physical and mental health assessment over time and initiates quality improvement projects to improve the member's health;
- **CAHPS:** Annually the SNP members are surveyed by CMS about:
    - How quickly they receive care
    - Getting needed care
    - Care coordination
    - Overall rating of their health care

- Getting needed prescription drugs
- Communication with their doctor
- Rating of specialists

Summary

B – UHP's Model of Care for B – UCA provides a comprehensive process and infrastructure to meet the unique needs of our dual eligible population. Through the establishment of measurable goals, the delivery of care through a specialized network of provider, and services B – UHP can ensure that members receive needed care. In addition, through the assessment, interdisciplinary care team and case management services, B – UHP is able to provide individualized care that meets the unique medical, psychosocial and functional needs of our members.

Model of Care Training

Banner Health

Model of Care Training

Why am I taking this Model of Care Training?

- CMS requires providers who are caring for Special Needs members to be trained on the Model of Care (MOC).
- Banner University Care Advantage (B-UCA) provides benefits to members who qualify for both Medicare and AHCCCS (Medicaid) – known as a D-SNP plan.
- D-SNP plans are mandated by CMS to train providers regarding this program.

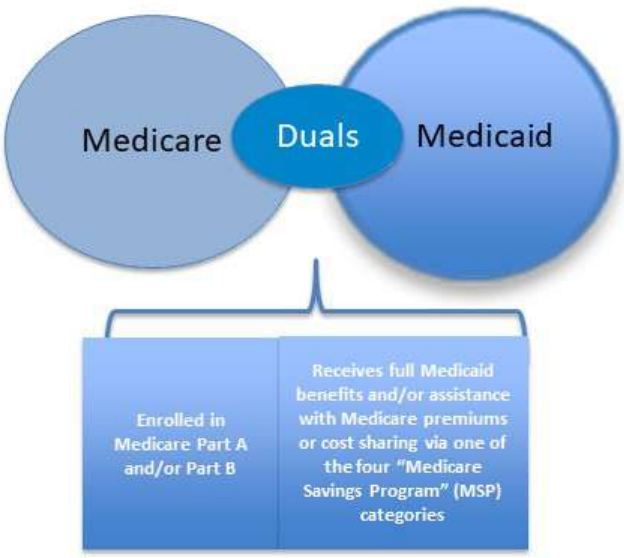
Banner Health

What is included in this training?

- This MOC training will provide a high-level overview of:
  - Which members are eligible for the Special Needs programs.
  - What is a "Model of Care."
  - How a member's needs are evaluated.
  - Who is involved in an Interdisciplinary Care Team.
  - The Individualized Care Plan that will be shared with you.

Banner Health

Who is eligible for the CMS Special Needs program?



Certain individuals who are eligible for both Medicare and Medicaid programs and thus are considered 'dually eligible'.

Primary Coverage for dual eligibles:

- Medicare is always primary
- Medicaid is the payer of last resort and supplements Medicare coverage

How do people become dual eligible?

- Meet State financial criteria for the State; and
- Be eligible for, or enrolled in Medicare Part A; or
- Have full Medicaid coverage groups (e.g. SSI) or optional coverage groups such as institutionalized, home and community based, or medically needy individuals

Banner Health

What is the D-SNP Model of Care?

- The MOC is a plan for delivering care management and care coordination designed to meet the specific needs of D-SNP members.
- Medicare mandates that all D-SNP Plans have a MOC plan, so each member receives the care and services necessary to help manage and improve their specific health needs.

Banner Health

Model of Care Goals

- The goals of each MOC include:
  1. Improve quality
  2. Increase access
  3. Create affordability
  4. Integrate and coordinate care across specialties
  5. Provide seamless transitions of care
  6. Improve use of preventive health services
  7. Encourage appropriate use and cost effectiveness
  8. Improve members' health

Banner Health

Health Risk Assessment

- First step in developing the ICP is the Health Risk Assessment (HRA)
  - Done by the Health Plan within 90 days of member enrollment in a D-SNP, and annually thereafter.
- The standardized risk assessment tool evaluates the member's medical, mental, psychosocial, cognitive, and functional needs, and their Social Determinates of Health.
- The assessment is completed by Health Plans in various methods:
  - Members - mailing in the Health Risk Assessments
  - Telephone
  - Face-to-Face interview/meeting
- The results of the assessment are then used to develop an Individualized Care Plan for each member.

Banner Health

The Individualized Care Plan

- The Individualized Care Plan (ICP) is the mechanism used to deliver the appropriate care to the member as identified by the HRA.
- The ICP must include members self-management goals and objectives, personal healthcare preferences, a description of services specifically tailored to the member's needs and identification of goals (met or not met).
- The ICP is reviewed and revised annually, or when the member's health status changes.
- The ICP is shared with:
  - The member's Primary Care Physician (PCP)
  - The member, caregiver or representative
  - Relevant Interdisciplinary Care Team members as needed

Banner Health

The Interdisciplinary Care Team

The Interdisciplinary Care Team (ICT) includes but is not limited to the following health care professionals:

- Physicians
  - Primary Care and Specialists, and including B-UCA Medical Director
- Case Managers
- Pharmacists
- Therapists
- Social Workers
- Disease Managers
- Health Educators

- The ICT assists in care coordination for high-risk members and assisting in the development of their Individualized Care Plan

Banner Health

The Provider's Role

As a B-UCA provider, you play an important role in the delivery of the MOC. As a key partner in the MOC, your role is to:

- Know who your D-SNP members are
- Outreach and assist members with scheduling the annual wellness visit
- Communicate with the B-UCA Case Managers regarding the care needs of your member
- Participate with the B-UCA ICT as needed
- Contribute to the development of the member's ICP
- Maintain the ICP as part of the member's medical record
- Assist the member to navigate the health care delivery system, including transition of care
- Complete the MOC Training annually

Banner Health

Data Sharing

- Based on their contract with The Centers for Medicare & Medicaid (CMS), Health Plans may collect and share relevant quality data.

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Summary

- This information about the Model of Care has been shared with you as a provider that may care for the D-SNP members.
- You may be asked to participate in an ICT or you may receive an ICP that has been developed for your patient after the HRA has been completed.
- Your participation in this process is essential as it can create better outcomes for your patients.

Banner Health

Contact Information:

- **Provider Experience Center**
- **Phone: 800-582-8686**
- **Email BUHPProviderInquiries@bannerhealth.com**
- **For more information on the Model of Care, you can access our Provider Manual at www.banneruhp.com**

END OF MODEL OF CARE TRAINING

Once the Model of Care Training has been reviewed, please sign the training attestation by paper or online form.

Paper Form – Please see the last page of Packet

Online Attestation Form- https://bannerhealth.formstack.com/forms/moc_attestation

Star Ratings

How Does Performance Impact Your Practice?

The value-based arrangements B – UHP has with various payors include performance on the patient experience.

The Centers for Medicare and Medicaid Services (CMS) also uses a Star Rating System to measure how well Medicare Advantage plans perform in several categories, including the patient experience.

Ratings range from 1 to 5 stars, with five being the highest and one being the lowest. While plans receive an individual rating in each evaluation category, Medicare assigns one rating to summarize a plan's overall performance.

The Medicare Star Rating System helps patients measure the quality of a plan while giving them confidence in knowing that their Medicare Advantage provider is committed to delivering an exceptional patient experience.

Patients with a Medicare Advantage plan may switch to another Medicare Advantage plan with a 5-star rating one time outside of the open enrollment period (typically mid-October through early December). This means the number of Medicare Advantage patients you care for could increase.

What are Some Ways to Improve Performance?

Below are some tips for improving the overall experience. More detailed tips can be accessed on the Provider website.

Consumer Assessment of Healthcare Providers and Systems

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks patients to report on and evaluate their experiences with health care and their provider. The survey covers topics that are important to consumers and focuses on aspects of quality that consumers are best qualified to assess.

CAHPS survey questions incorporate the following topics:

- Communicating with your physician
- Getting appointments and care quickly
- Overall health care quality
- Getting needed prescription drugs
- Ease of getting needed care

Why is the CAHPS survey important?

Research shows that a positive healthcare experience for patients is associated with positive clinical outcomes and better business outcomes, including lower medical malpractice risk and less employee turnover.

CAHPS Questions and Provider Impact

Providers can affect how patients assess their healthcare experience in response to CAHPS survey questions. The table below lists some key CAHPS survey questions along with tips to assure patients have a positive experience.

Measure	Sample Survey Questions to Patient

Getting appointments and care quickly	• In general, how would you rate your health?
	• Does your health now limit you in these activities?
	  o Moderate activities like vacuuming or bowling
	  o Climbing several flights of stairs
	• During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
	  o Accomplished less than you would like
	  o Were limited in the kind of work or other activities you were able to perform
	• During the past four weeks, how much did pain interfere with your normal work

Tips for success

- Patients are more tolerant of appointment delays if they know the reasons for the delay. When the provider is behind schedule:
  - Front office staff should update patients often and explain the cause for the schedule delay. Offer reasonable expectations of when the patient will be seen and consider allowing the patient to leave temporarily to return at the expected time.
  - Staff members interacting with the patient should acknowledge the delay with the patient.
  - Implement Delay Rounding process (located on the provider portal in the Patient Satisfaction section).
- If using more traditional scheduling methodologies, consider:
  - Leaving a few appointment slots open each day for urgent visits, including post-inpatient discharge visits.
  - Offering appointments with a nurse practitioner or physician's assistant to patients who want to be seen on short notice.
  - Asking patients to make routine check-ups and follow-up appointments in advance.

Measure	Sample Survey Questions to Patient
Annual flu vaccine	Have you had a flu shot since July 1?

Tips for success

- Administer flu shot as soon as it's available each fall.
- Eliminate barriers to accessing flu shots and communicate the options for patients to get their shot (walk-in appointments, flu shot clinics, flu shots at every appointment type if the patient's eligible).

Measure	Sample Survey Questions to Patient
Care Coordination	• When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • When your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • When your personal doctor ordered a blood test, X-ray, or other test for you, how often did you get those results as soon as you needed them? • How often did you and your personal doctor talk about all the prescription medicines you were taking? • Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • How often did your personal doctor seem informed and up to date about the care you got from specialists?

Tips for success

- Before walking in the exam room, review the reason for the visit and determine if you need to follow up on any health issues or concerns from previous visits.
- Implement a system in your office to assure timely notifications of test results, including asking patients how they would prefer to receive test results and communicate clearly with patients on when they can expect to receive test results.
- Use a patient portal for test results and consider automatically releasing the results once they are final.
- Ask your patients if they saw another provider since you last saw them. If you know patients received specialty care, discuss their visit and the treatment plan they received, including any newly prescribed medication.
- Do medication reconciliation at every visit.

Measure	Sample Survey Questions to Patient
Getting Needed Care	• How often did you get an appointment to see a specialist as soon as you needed? • How often was it easy to get the care, tests or treatment you needed?

Tips for success

- Set realistic expectations about the time it could take from when the patient schedules an appointment with the specialist to when the appointment takes place, if the appointment is not urgent.
- If applicable, advise your patient on how you can help secure an appointment sooner if your clinic has an established relationship with a specialist.
- Help the patient understand why you are recommending certain types of care, tests or treatments, especially if the patient requested or asked about other types.
- Review with the patient what steps he or she is responsible for in securing care, tests or treatment (e.g., scheduling with specialists, timely appointments).

Health Outcomes Survey (HOS)

Why is the HOS important?

The goal of the HOS is to gather clinically meaningful health status data from Medicare Advantage patients to support quality improvement activities, monitor health plan performance and improve the health of this patient population.

HOS questions and provider impact

Providers can significantly impact how patients assess their health care experience in response to HOS questions.

In addition to using the Let's Talk Questionnaire (located on the provider portal in the Patient Experience section), below are tips to ensure patients feel well supported in the areas included in the HOS.

Measure	Sample Survey Questions to Patient
Improving or maintaining physical health	In the last 6 months: • How often did you see the person you came to see within 15 minutes of your appointment time? • When you needed care right away, how often did you get care as soon as you needed? • How often did you get an appointment for routine care as soon as you needed?
Tips for success • Ask patients if they have pain, and if so, whether it is affecting their ability to complete physical activities they would like to do in their daily lives. Ask about goals the patient has that better pain management would allow them to achieve. Then, identify ways to improve your patient's pain problem. • Determine if your patient could benefit from a consultation with a pain specialist, rheumatologist or other specialist. • Consider physical therapy and cardiac or pulmonary rehab when appropriate.	

Measure	Sample Survey Questions to Patient
Improving or maintaining mental health	• During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems? o Accomplished less than you would like o Didn't do work or other activities as carefully as usual • How much of the time during the past four weeks: o Have you felt calm and peaceful? o Did you have a lot of energy? • Have you felt downhearted or blue? • During the past four weeks, how much of the time have your physical or emotional problems interfered with your social activities?
Tips for success • Empathize with the patient. • Discuss options for therapy with a mental health provider, when appropriate.	

Measure	Sample Survey Questions to Patient
	• Offer ideas to improve mental health: Take daily walks, socialize, stay involved with family, own a pet, do crossword puzzles, volunteer, participate in a church, go to senior community centers or meditate. • Consider a hearing test when appropriate, as loss of hearing can feel isolating. • Refer to Pyx

Measure	Sample Survey Questions to Patient
Monitoring Physical Activity	In the past 12 months, did: • You talk with a doctor or other health care provider about your level of exercise or physical activity? • A doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?
Tips for success • Talk to patients about their physical activity and the health benefits of staying active. Studies show that having patients fill out a questionnaire is not enough to gauge their activity level. Show interest in ensuring patients remain active. • Offer physical activity suggestions based on the patient's physical ability. • Offer ideas where patients can engage in activities (e.g., senior classes at the Area Agency on Aging, YMCA and community centers) to increase social interaction. • Refer patients with limited mobility to physical therapy to learn safe and effective exercises.	

Measure	Sample Survey Questions to Patient
Improving Bladder Control	• In the past six months, have you experienced leaking of urine? • There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other health care provider about any of these approaches?
Tips for success • Ask patients if they have any trouble holding their urine. If yes, ask the following questions: o When do you notice leaking (exercise, coughing, after urinating)? o Is there urgency associated with the leaking? o Do you have any issues emptying your bladder (incomplete, takes too long, pain)? o How often do you empty your bladder at night? During the day? o Do you have pain when you urinate? o Have you noticed a change in color, smell, appearance or volume of your urine? o How impactful are your urinary issues to your daily life? • For men, ask all the same questions, plus: o Is there any change in stream? o Any sexual dysfunction (new, historical or changing)? • Communicate that urinary leakage problems can be common as we grow older, but there are treatments that can help. Discuss potential treatment options such as behavioral therapy, exercises, medications, medical devices and surgery. • Use informational brochures and materials as discussion starters for this sensitive topic.	

Measure	Sample Survey Questions to Patient
Reducing the risk of falling	• In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? • Did you fall in the past 12 months? • In the past 12 months, have you had a problem with balance or walking?

Measure	Sample Survey Questions to Patient
	• Has your doctor or health provider done anything to help you prevent falls or treat problems with balance or walking?

Tips for success

- Promote exercise, physical therapy and strengthening and balance activities (tai chi, yoga).
- Review medications for any that increase fall risk.
- Discuss home safety tips, such as removing trip hazards, installing handrails and using nightlights.
- Suggest the use of a cane or walker, if needed.
- Recommend a vision or hearing test.

Customer Experience Team

The Customer Experience Team, how we can assist your practice.

What is the difference between Customer Experience Compared to Customer Service and Customer Satisfaction?

- Customer service is the mindset involved when addressing a customer's need at a certain touchpoint.
- Customer satisfaction is a measure of a customer's feeling about a specific aspect of a touchpoint.
- Customer experience is the resulting, overall perception based on each touchpoint throughout a customer journey.

There are many customer experience touchpoints:

Experience at each touchpoint = Overall perception of your organization!

Where the CX team can assist is with the journey. The journey is more important than the destination,

- Organizations tend to make the score received on a survey the focal point.
- This can distract from what's most important – addressing the key drivers identified in the results.
- Rather than focusing on a score, focus on continuously improving the experience and consistently using standard tools and processes proven to improve the experience.
- Focusing time and energy here will result in an exceptional experience, regardless of the tool used to capture customer feedback.

The Customer Experience team can assist with Key Drivers and sharing best practices and tools to assist your practice with your customer experience journey. Here are some of the tools we have to offer:

- Customer Experience training and introduction for staff
- CAHPS overview
- HOS overview
- Assist with survey process
- Let's Talk Discussion guide
- Delay Rounding
- Key Phrases that assist with preventative care, here are some examples:
  - Annual Wellness Visit
  - Flu Shot
  - Chronic Care management
- Clinician Experience Project (CEP) a tool for care providers to assist with their well-being, communication with staff and their patients
- Pyx Health a tool for patients who may be socially isolated and lonely

Let's Talk

LET'S TALK

During today's visit, use this handout as a guide to discuss health concerns or needs with your doctor or health care provider.

LET'S TALK // FALLS

- ☐ Have you fallen in the past year? Y // N
- ☐ Do you feel unsteady standing or walking? Y // N
- ☐ Do you use a cane or a walker? Y // N
- ☐ Have you seen a physical therapist in the past year? Y // N

LET'S TALK // PHYSICAL HEALTH

- ☐ How often does physical health interfere with your daily activities? Almost never / Occasionally / Frequently
- ☐ Approximately how many days each week are you physically active? Almost never / Occasionally / Frequently
- ☐ Are you as active as other persons your age? Y // N
- ☐ How often do you choose to take the stairs over an elevator or escalator? 0-1 days / 2-3 days / 4 days or more

LET'S TALK // MEDICATIONS

- ☐ Remembering to take your medications can sometimes be challenging. In the last two weeks, have you forgotten to take your medications? Y // N
- ☐ Understanding how and when to take medication and knowing why it was prescribed is important. Do you have any questions on how and when to take your medications or why they were prescribed? Y // N
- ☐ Some medications are difficult to afford, even with help from copayments. Do you have any medications that are not affordable? Y // N
- ☐ Every medication can have side effects. Do you have any unanswered worries or questions related to your medications or their side effects? Y // N

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LET'S TALK // BLADDER CONTROL

- ☐ Is bladder control a problem for you? Y // N
- ☐ In the past 60 days, has urine leakage changed your daily activities or interfered with your sleep? Y // N
- ☐ If urine leakage is a problem for you, would you be willing to try:
  - Medications Y // N
  - Exercise Y // N
  - Surgery Y // N

LET'S TALK // EMOTIONAL HEALTH

- ☐ How would you describe your emotional health? Calm / Energetic / Sad
- ☐ In the last month, has your emotional health (feeling anxious or depressed) interfered with your daily activities? Y // N
- ☐ How many hours of sleep do you typically get each night? 5 or less hrs. / 6-7 hrs. / 8 hrs. or more
- ☐ In the last month, have you accomplished less than you would like or been more careless at work or while performing daily activities? Y // N

NOTES

HABLEMOS

Durante su visita hoy, use este volante como guía para hablar sobre sus preocupaciones o necesidades de salud con su doctor o proveedor de servicios médicos.

HABLEMOS // SOBRE CAÍDAS

- ☐ ¿Se ha caído durante el último año? S // N
- ☐ ¿Se siente inestable al estar parado o al caminar? S // N
- ☐ ¿Usa bastón o una caminadora? S // N
- ☐ ¿Ha visto a algún terapeuta físico durante el último año? S // N

HABLEMOS // SOBRE SU SALUD FÍSICA

- ☐ ¿Qué tan seguido su salud física interfiere con sus actividades diarias? Casi nunca / A veces / Con frecuencia
- ☐ Aproximadamente, ¿cuántas veces a la semana hace actividad física? 0-1 días / 2-3 días / 4 o más
- ☐ ¿Es tan activo como otras personas de sus edad? S // N
- ☐ ¿Qué tan seguido decide usar las escaleras en vez del elevador o las escaleras eléctricas? Casi nunca / A veces / Con frecuencia

HABLEMOS // SOBRE SUS MEDICAMENTOS

- ☐ Recordar tomar sus medicamentos puede ser difícil a veces. En las últimas dos semanas, ¿ha olvidado tomar sus medicamentos? S // N
- ☐ Entender cómo y cuándo tomarse sus medicamentos y saber por qué se los recetaron es importante. ¿Tiene alguna pregunta sobre cuándo y cómo tomar sus medicamentos y por qué se los recetaron? S // N
- ☐ Algunos medicamentos son caros, aún con ayuda para los copagos. ¿No puede pagar algunos de sus medicamentos? S // N
- ☐ Cada medicamento tiene efectos secundarios. ¿Tiene alguna preocupación o dudas que no le hayan contestado sobre sus medicamentos o sus efectos secundarios? S // N

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HABLEMOS // SOBRE EL CONTROL DE ESFÍNTERES

- ☐ ¿El control de esfínteres es un problema para usted? S // N
- ☐ En los últimos 60 días, ¿la incontinencia urinaria ha cambiado sus actividades diarias o interferido con el sueño? S // N
- ☐ Si la fuga de orina es un problemas paras usted, ¿estaría dispuesto a intentar: S // N
  - Medicamentos S // N
  - Ejercicio S // N
  - Cirugía S // N

HABLEMOS // SOBRE SU SALUD EMOCIONAL

- ☐ ¿Cómo describiría su salud emocional? Calmada / Energética / Triste
- ☐ Durante el último mes, ¿su salud emocional (ansiedad o depresión) ha interferido con sus actividades diarias? S // N
- ☐ ¿Cuántas horas duerme por lo general cada noche? 5 o menos horas / 6-7 horas / 8 o más
- ☐ Durante el último mes, ¿ha hecho menos cosas de las que quisiera o ha sido más descuidado en el trabajo o al hacer sus actividades diarias? S // N

NOTAS

Pyx Health Talking Points


Hola...
Conoce a Pyxir, ¡un nuevo amigo con quien puedes contar!
Todas las personas pueden usar un poco de apoyo adicional...
Urgent Support 24/7
Health Plan Resources
Find a Provider
Member Services
Community Services
Pyx Health Tools
ANDY
Pyxir is the best listener
I just need to talk to someone...
Encuentre recursos para apoyar su salud física y mental
Aprovecha al máximo lo que ofrece tu plan de salud
Siéntete mejor cada día con compañerismo y humor
Conéctate con personas compasivas para un chat amistoso o ayuda con recursos
Utilice su teléfono inteligente para inscribirse en el programa Pyx Health en www.HiPyx.com
Un beneficio proporcionado sin costo por Banner – University Family Care
Banner
University Family Care
¿Preguntas? Llame al (800) 582-8686. TTY 711
Pyx Health
¿Preguntas sobre PYX?
Llama al (855) 499-4777

Q.

Cultural Competency

B - UHP promotes Cultural Competency for its staff, provider network and members. Cultural Competency is an awareness and appreciation of customs, values and beliefs and the ability to incorporate them into the assessment, treatment and interaction with members.

We have a Cultural Competency Committee and Program as well as a Cultural Competency Liaison who creates education programs for the specific audiences of staff, providers and members. This education comes in the form of provider education sessions and in- services; member and provider newsletter articles, staff in- services and many other forms of communication forums.

The goal of the Cultural Competency Committee is to ensure that members are provided with culturally competent care and services by B - UHP staff and the provider network.

The purpose is to increase awareness of how our cultural assumptions and language affect interactions with others, including but not limited to, patient care. This does not mean each person will be competent in all cultures, but that each person should be aware that people may have different perceptions of health care based on their respective cultures.

The Cultural Competency Plan follows the guidelines set forth by Section 1557 of the Patient Protection and Affordable Care Act, which is the nondiscrimination provision. This law prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health program or actives. Section 1557 builds on standing Federal Civil Rights laws.

Additionally, the Cultural Competency Plan addresses the following:

- Ethnicity
- Religion
- Limited English Proficiency (LEP)
  Area of the country one is from
- Sexual orientation
- Life Experience
  Age
- Language(s) spoken
- Socioeconomic status
  Gender
- Family
- Length of residency in the United State

B - UHP will provide member education related to available services offered such as translation and interpretation. B – UHP and provider experiences help improve their health outcome.

Providers must maintain compliance with the Cultural Competency Plan (CCP) and Limited English Proficiency requirements.

For more information related to Cultural Competency and B – UHP, please visit:

https://www.banneruhp.com/about-us/cultural-competency

Language Interpretation and Language Services

B – UHP provides interpretive and translation services for its members. If you have a member who needs these services, please contact the Customer Care Center. Interpretive services are not based upon the non-availability of a family member or friend for translation. Members may choose to use family or friends; however, they should not be encouraged to substitute them for the interpretation service.

If you have questions or are interested in receiving additional information, please contact your Provider Relations Representative.

- An interpreter renders SPOKEN word from one language to another.
- A translator renders WRITTEN word from one language to another.

Interpretation Services for B – UHP

1. Call B – UHP's Customer Care Center
2. Provide the representative with member's AHCCCS ID number and the nature of the interpretation services required.
3. You will be placed on hold while the representative connects you with the interpretation services.

Banner – University Health Plans (B – UHP) Quick Reference

Language Interpretation Services

B – UHP Health Plan	Customer Care Phone Number	TTY Line
Banner – University Family Care/ACC	(800) 582-8686	711
Banner – University Family Care/ALTCS	(833) 318-4146	711
Banner Medicare Advantage - Dual	(877) 874-3930	711
Hearing Impaired Interpreter Services	**Contact Information**	**TTY Line**
Valley Center of the Deaf and Blind	(602) 267-1921 http://www.vcdaz.org	711
Community Outreach Program for the Deaf	(520) 445-8484 request@copdaz.org	711
Americans with Disabilities Act (ADA)	**ADA Information Line**	**TTY Line**
For information and technical assistance about the Americans with Disabilities Act (ADA) contact the ADA Information Line	(800) 514-0301 (voice)	(800) 514-0383

Appointment Accessibility and Availability Standards

PRIMARY CARE

Urgent care Appointments	Routine Care Appointments
As quickly as the member's health condition requires but no later than two business days of request	Within 21 calendar days of request

SPECIALTY CARE

Urgent Care Appointments	Routine Care Appointments
As quickly as the member's health condition requires but no later than two business days of request	Within 45 calendar days of request

DENTAL CARE

Urgent Care Appointments	Routine Care Appointments
As quickly as the member's health condition requires but no later than three business days of request	Within 45 calendar days of request

Wait Time

Members with an appointment shall not wait more than 45 minutes for treatment. Except when the provider is unavailable due to an emergency. If there is an emergency or delay, you should be given the option to reschedule your appointment within a reasonable period of time. B – UFC/ACC will actively monitor appointment wait times and ensure provider compliance.

MATERNITY CARE

FIRST TRIMESTER	SECOND TRIMESTER	THIRD TRIMESTER	HIGH RISK PREGNANCIES
14	7	3	3
Within 14 calendar days of request	Within 7 **calendar days** of request	Within 3 **business days** of request	Within 3 **business days** of identification of High Risk

High Risk Pregnancies

As the member's health condition requires and no later than three business days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.

BEHAVIORAL HEALTH

Urgent Need Appointments	Routine I. Initial Assessment	Routine II. First behavioral health service following the initial assessment	Routine III. All subsequent behavioral health services
As quickly as the member's health condition requires but no later than 24 hours from identification of need	Within 7 calendar days of referral or request for service	As expeditiously as the member's health condition requires but no later than Member age 18 years and older: 23 calendar days after initial assessment Member age under 18 years old: no later than 21 days after initial assessment	As quickly as the member's health condition requires but no later than 45 calendar days from identification of need

PSYCHOTROPIC MEDICATIONS

ASSESS THE URGENCY OF THE NEED IMMEDIATELY

Provide an appointment, if clinically indicated, with a Behavioral Health Medical Professional within a timeframe that ensures the member a) does not run out of needed medications, or b) does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need

ADOPTED CHILDREN

Routine I. Initial Assessment	Routine II. First behavioral health service following the initial assessment	Routine III. All subsequent behavioral health services
Within 7 calendar days after referral or request for service	As quickly as the member's health condition requires but no later than 21 calendar days after the initial assessment	As quickly as the member's health condition requires but no longer than 21 calendar days from the identification of need

If an adopted child does not receive services within these 7 and/or 21 calendar day timeframes, adoptive parent may contact the B – UHP Customer Care at (800) 582-8686 and the AHCCCS Clinical Resolution Unit at (800) 867-5808

Claims

The Claims Department will adjudicate all properly submitted, authorized claims that meet "clean claims criteria" within 45 days of receipt unless otherwise stipulated in your contract.

A claim is considered a "clean claim" if it is submitted on the appropriate form, contains the correct billing information according to CMS 1500, ADA 2002 and UB-04 requirements and has all the supporting documentation as required for medical and claims review ERAs and EFTs

B – UHP has partnered with ECHO to process Electronic Funds Transfer (EFT) and Electronic Remittance Advices (ERA) enrollments.

Electronic Remittance Advice (ERA): ERAs provide an electronic report of payments, reconciliations, and more. To enroll and receive ERAs, please fill out the form in the link below.

Electronic Funds Transfer (EFT): EFT allows us to send claims payments directly to our provider bank accounts. Use the link below to sign up for this payment method.

NOTE If the provider is contracted with more than one of B – UHP's Lines of Business (ACC, ALTCS and Banner Medicare Advantage-Dual) an individual form is required for each plan.

EFT/ ERA Enrollment Instructions

Fill out the EFT and ERA Enrollment Form and send directly to ECHO. (See form for mail, fax, and e-mail address.)

Select enrollment choice: 1) EFT, 2) ERA, or 3) both EFT and ERA.

E-sign or print and manually sign form. Mail, fax, or e-mail (secure email is recommended) to ECHO Health Inc.

*Please Note: A separate form will need to be filled out for each of our plans you want to enroll for:

a. Banner – University Family Care/ACC
b. Banner – University Family Care/ALTCS
c. Banner Medicare Advantage - Dual

Why Enroll in EFT/ERA?

- Enrollment is free
- Automatic payments
- Secure transfer of payments
- Access funds faster
- Much more efficient than paper

https://www.banneruhp.com/materials-and-services/claims#ERAs-and-EFTs

Electronic & Mail Submissions

Banner- University Family Care/AHCCCS Complete Care (BUFC/ACC)
P.O. Box 35699
Phoenix, AZ 85069-7169
Electronic ID: 09830

Banner- University Family Care/Arizona Long Term Care System (BUFC/ALTCS)
P.O. Box 37279
Phoenix, AZ 85069
Electronic ID: 66901

Banner- University Care Advantage (BUCA) (HMO SNP)
P.O. Box 38549
Phoenix, AZ 85069-7169
Electronic ID: 09830

RESUBMISSIONS-
Be sure to clearly mark "Resubmission" on the claim form or select the appropriate box on the claim form if sending electronically

APPEALS-
Banner- University Health Plans
Attn: Grievance and Appeals Department
2701 E. Elvira Road
Tucson, AZ 85756

Dental Claims
DentaQuest of Arizona, LLC
P.O. Box 2906
Milwaukee, WI 53201-2906
Office: (800) 440-3408
www.dentaquest.com

Banner Medicare Advantage Prime HMO
PO Box 35769
Phoenix, AZ 85021-9998
Electronic ID: 84323

Banner Medicare Advantage Plus PPO
PO Box 35277
Phoenix, AZ 85021-9998
Electronic ID: 84324

Claim Dispute/Appeals

A provider claim dispute is a dispute involving the payment or nonpayment of a claim. Provider may challenge the Health Plan's adjudication of a claim by filing a claim dispute, in writing, with the Grievance and Appeals Department. The claim dispute should include the following:

1. A cover letter on appropriate letterhead indicating reason for filing the claim dispute. Include information on letter:
    a. Date of request
    b. Claim number(s)
    c. Factual and legal basis for claim dispute and providers expected resolution
    d. The enrollee's AHCCCS ID number, full name, date of service, and the date of birth; and
    e. Writer's name, address, telephone number and/or email address
2. Supporting documentation, including:
    a. A copy of EOB or RA from B – UFC/ACC,
    b. A copy of original claim(s)
    c. Corrected claim(s), if applicable,
    d. A copy of the Medicare or primary insurer EOB(s), if applicable,
    e. A copy of authorization, if applicable, and
    f. If you are a contracted provider with specific rates in your contract, a copy of the applicable pages from your contract when challenging a rate of pay.

Claim Dispute/Appeals

Provider Claim Dispute timeframes: A claim dispute for claims payment issue must be received within 12 months from the date of service, or from the hospital claim within 12 months from the date of discharge, 12 months after the date of eligibility posting, or within 60 days after the date of timely claim submission, whichever is later.

Provider Claim Dispute Acknowledgement and Resolution: B – UHP will send an acknowledgement letter within 5 business days of receipt of claim dispute. Within calendar 30 days, B – UHP will mail Notice of Decision. If B – UHP decision is to approve the dispute, the claim will be reprocessed and paid within 15 days of the Notice of Decision.

State Fair Hearing: If the provider is not satisfied with the claim dispute decision, you may file a request for a State Fair Hearing with B – UHP. The request must be made in writing to B – UHP within 30 days of the date of the Notice of Decision or Notice of Appeal resolution. B – UHP will send appeal file to AHCCCS and provider will receive a Notice of Hearing from the Office of Administrative Legal Services when a hearing date is set.

Please submit the claims dispute letter and supporting documentation to:

Banner University Family Care/ACC Health Plan
Attn: Grievance & Appeals Department
2701 E Elvira Road Tucson, AZ 85756

Phone: 1-800-582-8686

Fax: 866-465-8340

Email: **BUHPGrievances&Appeals@bannerhealth.com**

Medicare Claims - Re-opening

Contracted providers have re-opening rights, not appeal rights. A re-opening is a review of a final determination or decision of a payment (claim) decision. Reasons available for reopening are:

1. Mathematical or computational mistakes
2. Inaccurate data entry
3. Denials of claims as duplicates; or
4. Additional evidence for consideration which was not available at the time of the decision.

Filing a Re-opening

A request for a re-opening must be submitted in writing, to the Grievance & Appeals Department. Re-opening request should include:

a. Member Name, date of birth, ID number
b. Claim Number
c. Date of service
d. Specific reason for requesting re-opening
e. Any additional documentation that supports request

NOTE: All request must be submitted individually with all required information and/or documentation

Re-opening Timeframes

One (1) year from the date of the determination or reconsideration.

Within 4 years from the date of the determination or reconsideration for good cause; at any time if there exists reliable evidence that the determination was procured by fraud or similar fault

At any time if the determination is unfavorable, in whole or in part, but only for the purpose of correcting a clerical error on which the determination was based.

At any time to effectuate a decision issued under coverage (National Coverage Determination) appeals process.

Please submit re-opening request to:

Banner Medicare Advantage - Dual
Attn: Grievance & Appeals
Department 2701 E Elvira Road
Tucson, AZ 85756

Phone: 877-874-3930

Fax: 866-465-8340

Email: BUHPGrievances&Appeals@bannerhealth.com

Credentialing

Provider Updates

a. Provider Update Form: https://www.banneruhp.com/materials-and-services/provider-data-update-form
b. This form is for use by providers who are already participating in our network to update or add; practitioner add, provider (group) add, practitioner update, panel add, provider (group) update
c. Please complete this form in its entirety including providing attachments (AzAHP forms, W9 etc.) to ensure your request is processed.
d. Incomplete forms will not be processed. Any missing or expired information will lead to processing delays.
e. Checking Status of previously submitted requests, please send an email to: BUHPProviderInquiries@bannerhealth.com
f. For Delegated Provider (Group) rosters, please send to BUHPDataTeam@bannerhealth.com

Credentialing Requirements:

Providers Must Not render services until credentialing is completed and an effective date is given by Banner University Health Plan. If the provider must render services, then Prior Authorization is required.

In order to be contracted with University of Arizona Health Plans, you must have:

- An NPI Number (except for Atypical Providers)
- Active registration with AHCCCS
- Have not opted out of Medicare
- CAQH Application Must be completed and current including all address

Please refer to the section below for credentialing requirements.

Who Requires Credentialing?	Other Required Documentation to Add Providers or for Contracting
• Physicians (Medical Doctor (MD) • Doctor of Osteopathic Medicine (DO) • Doctor of Podiatric Medicine (DPM) • Nurse practitioners (NP) • Physician Assistants (PA) • Certified Nurse Midwives acting as primary care providers, including prenatal care/delivering providers • Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD]) • Affiliated Practice Dental Hygienists • Psychologists • Optometrists • Certified Registered Nurse Anesthetists • Occupational Therapists • Speech and Language Pathologists • Physical Therapists • Independent behavioral health professionals who contract directly with the Contractor including: i. Licensed Clinical Social Worker (LCSW) - Licensed Professional Counselor (LPC) - Licensed Marriage/Family Therapist (LMFT) - Licensed Independent Substance Abuse Counselor (LISAC) - Peer/Recovery Support Specialists (must be identified as such on application) • Board Certified Behavioral Analysts (BCBAs) • Chiropractors • Audiologists **ORGANIZATIONAL FACILITIES THAT REQUIRE CREDENTIALING** • Hospitals • Home health agencies • Attendant care agencies • Habilitation Providers • Group homes • Nursing facilities • Dialysis centers • Dental and medical schools • Freestanding surgical centers • Intermediate Care Facilities • State or local public health clinics • Community/Rural Health Clinics (or Centers) • Air Transportation • Non-emergency transportation vendor • Laboratories • Pharmacies • Respite Homes/Providers • Community Service Agencies • Assisted Living Facilities • Skilled Nursing Facilities	Please email all AzAhp Forms to: BUHPDataTeam@bannerhealth.com: • AzAHP Facility Application • AzAHP Practitioner Data Form For the facility AzAhp Forms, please include: license, COI, W-9, accreditation letters (if applicable), site visits (if applicable), and policies and procedures if you are a behavioral health group that employes BHT's. Incomplete AzAhp Forms and missing supporting documentation may delay or cause termination of the credentialing process.

• Urgent Care Centers • Transportation Companies • Hospice • Durable Medical Equipment (DME) • Orthotic and Prosthetic Centers • Radiology Centers • Sleep Labs • Speech, Physical, and Occupational Therapy Centers • Mammography Centers • Free Standing Emergency Centers • Behavioral health facilities, including but not limited to: a. Independent Clinics b. Federally Qualified Health Centers c. Community Mental Health Centers d. Level 1 Sub-Acute Facility e. Level 1 Sub-Acute Intermediate Care Facility f. Level 1 Residential Treatment Center (secure and non-secure) g. Community Service Agency h. Crisis Services Provider/Agency i. Behavioral Health Residential Facility j. Behavioral Health Outpatient Clinic k. Integrated Clinic	

Contracting

- Providers with existing contracts requesting a termination or change to a practitioner or location should submit requests in writing. ***An AzAHP form is not required***. Please submit email requests to: BUHPDataTeam@bannerhealth.com
- Providers with an existing contract requesting to add a new practitioner to their contract should submit an AzAHP form. The AzAHP form can be found here: https://www.banneruhp.com/join-us/join-our-network Email this form to BUHPDataTeam@bannerhealth.com ***NOTE*** ***Please ONLY submit after AHCCCS registration has been verified and completed .***

For contract related inquiries and contract status please send an email to BUHP Contracting department containing the name of your organization and tax identification number (TIN) to: UAHNContractingMailbox@bannerhealth.com

Prior Authorizations & Referrals

- If Prior Authorization (PA) is required, the Primary Care Provider (PCP) or specialty care provider will complete the Prior Authorization Form or acceptable substitute, attach supporting documentation, and fax to the Prior Authorization Department. Some medications (including non-generic medications) require Prior Authorization. For Pharmacy Prior Authorization, please complete a non-formulary drug prior authorization and fax to the Hospital and Pharmacy Coordinator.
- Services that are outside the scope of the PCP, may be referred to a contracted specialty care provider. The PCP will complete a Referral Form or acceptable substitute and fax it to the specialty care provider's office along with applicable test results and other pertinent documents.
- Primary care providers, specialists, hospitals and vendors should fax Prior Authorization requests to the Prior Authorization Department.
- If PA is not required, per the Prior Authorization Grid, the PCP must refer the patient with a form of written instruction (i.e. note on prescription pad or Referral Form) with reason for visit (consult only – consult & treat, diagnosis, findings, etc.) to present to the specialty care provider.
- Specialty care providers must obtain Prior Authorization from the Prior Authorization Department for all services as listed on the Prior Authorization Grid.

Prior Authorization Forms

To request an PA, fax your request to the health plans and use the fax number on the PA form. We use RightFax Computer System, which reproduces the referral electronically. This is the preferred method for obtaining authorization. Submit your request on a completed Prior Authorization Form. Please ensure that the provider's name and fax number are clearly noted on the form. Please note whether the request is Standard or Expedited.

Please include ALL pertinent clinical information with your Medical/Pharmacy Prior Authorization (PA) request submission. To ensure that prior authorizations are reviewed promptly, submit request with current clinical notes and relevant lab work.

*Providers must use the **"Expedited"** request only when medically necessary. Note: Inappropriate Expedited requests may be downgraded to a Standard request by B – UHP.

Fax the appropriate form to:

Medical: (520) 874-3418 or (866) 210-0512

Pharmacy: (866) 349-0338

Referral forms can be found here: www.BannerUHP.com

Click on: Materials and Services

Choose from drop down: Provider Authorizations & Referrals

Choose form: Behavioral Health, Medical Prior Auth or Pharmacy Prior Auth

Compliance Program and Behavioral Health

Compliance Program

A. The Compliance Program is described in several documents including the Code of Conduct, policies and procedures, as well as the Fraud, Waste, and Abuse Plan. Please click on link: https://www.banneruhp.com/materials-and-services/compliance-program

B. **Complete** Annual Attestation form yearly

C. **Complete** Offshore Subcontracting Attestation if contracting with offshore entity

You can report member and/or provider fraud, waste and/or abuse or any non-compliance to the B – UHP Compliance Department using one of the methods below without fear of retaliation:

- Customer Care Center: (800) 582-8686
- **24-hour hotline - ComplyLine** (anonymous and confidential reporting): (888) 747-7989
- Email: BUHPCompliance@bannerhealth.com
- **Secure Fax:** (520) 874-7072
- **Mail:** 2701 E. Elvira Rd. Attn: B – UHP Compliance Dept., Tucson, AZ 85756
- Contact the Medicaid Compliance Officer, Terri Dorazio, via phone: (520) 874-2847 or email Theresa.Dorazio@bannerhealth.com
- Contact the Medicare Compliance Officer, Linda Steward, via phone: (520) 874-2553 or email Linda.Steward@bannerhealth.com

Behavioral Health

Materials and Forms can be found here www.BannerUHP.com

1. Click on *Materials and Services*

2. Select Behavioral Health from dropdown list:

- Application for Involuntary Evaluation
- Application for Emergency Admission for Evaluation
- Petition for Court-Ordered Evaluation
- And many more please go to link and drop down to search

B – UHP Contact List

Name	Functional Area	Direct Supervisor
Banner Customer Care (800) 582-8686	Assistance and entry into call center and connections to departmental areas.	Veronica Carrillo Director of Customer Care (520) 874-5349 Veronica.Carillo@bannerhealth.com
Behavioral Health Medical Management/Care Management/Prior Authorization		
Kristin Frounfelker Sr. Director of Behavioral Health Medical Management (480) 827-5931 Kristin.Frounfelker@bannerhealth.com	Adult and child behavioral health utilization, prior authorizations, care management, care transitions, crisis follow ups, T36/COT, High Needs/High Costs	Sue Benedetti Chief Health Services Officer (480) 827-5952 Susan.Benedetti@bannerhealth.com
Adult Prior Auth/Utilization Review		
Lynda Crooms Sr. Manager Adult Behavioral Health (480) 827-5962 Lynda.Crooms@bannerhealth.com	Adult medical management, prior authorization, care management, T-36	Kristin Frounfelker Sr. Director of Behavioral Health (480) 827-5931 Kristin.Frounfelker@bannerhealth.com
Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com	Adult inpatient psychiatric utilization management, adult BHRF, discharge planning, prior authorization for outpatient services	Lynda Crooms Sr. Manager Adult Behavioral Health (480) 827-5962 Lynda.Crooms@bannerhealth.com
Lindsay Wood Adult UM Reviewer (480) 827-5935 Lindsay.Wood@bannerhealth.com	Adult inpatient psychiatric utilization management, adult BHRF, discharge planning, prior authorization for outpatient services	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com
David Burden Adult UM Reviewer (480) 827-5893 David.Burden@bannerhealth.com	Adult inpatient psychiatric utilization management, adult BHRF, discharge planning, prior authorization for outpatient services	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com
Meaghan Younggren Adult UM Reviewer (520) 874-2621 Meaghan.Younggren@bannerhealth.com	Adult inpatient psychiatric utilization management, adult BHRF, discharge planning, prior authorization for outpatient services	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com

Amanda Pierce Adult UM Reviewer (480) 827-5874 Amanda.Pierce@bannerhealth.com	Adult inpatient psychiatric utilization management, adult BHRF, discharge planning, prior authorization for outpatient services	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com
Cheryl Dunham Adult UM Reviewer (480) 827-5872 Cheryl.Dunham@bannerhealth.com	Adult inpatient psychiatric utilization management, adult BHRF, discharge planning, prior authorization for outpatient services	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com
Linda Weinberg Adult UM Reviewer (480) 684-6175 Linda.Weinberg@bannerhealth.com	Adult inpatient psychiatric utilization management, adult BHRF, discharge planning, prior authorization for outpatient services	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com
Erika Huber Adult UM Reviewer (520) 874-5420 Erika.Huber@bannerhealth.com	Adult inpatient psychiatric utilization management, adult BHRF, discharge planning, prior authorization for outpatient services	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com
Lyndsay Morgan Adult UM Reviewer (602) 747-7563 Lyndsay.Morgan@bannerhealth.com	Adult inpatient psychiatric utilization management, adult BHRF, discharge planning, prior authorization for outpatient services	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com
Kimberley Joe Adult UM Reviewer (480) 827-5862 Kimberley.Joe@bannerhealth.com	Adult inpatient psychiatric utilization management, adult BHRF, discharge planning, prior authorization for outpatient services	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com
Liz Orozco Adult Discharge Coordinator (480) 827-5873 Lizette.Orozco@bannerhealth.com	Discharge coordination and planning, navigation of resources and referrals	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com
Jonathan Vaffis Adult Discharge Coordinator (520) 874-4034 Jonathon.Vaffis@bannerhealth.com	Discharge coordination and planning, navigation of resources and referrals	Linda Davis Supervisor, Adult Medical Management (480) 827-5833 Linda.Davis2@bannerhealth.com

Adult Care Management		
Toni Lofgren, Sr. Manager, Adult Behavioral Health Care Management (480) 827-5955 Toni.Lofgren@bannerhealth.com	SMI evaluations, SMI transitions, crisis follow up, High need High Cost, Care management, care transitions, discharge planning	Kristin Frounfelker Sr. Director of Behavioral Health Medical Management (480) 827-5931 Kristin.Frounfelker@bannerhealth.com
Reyna Santos Supervisor, Adult Behavioral Health Care Manager (520) 874-5587 Reyna.Santos@bannerhealth.com	Adult Care management, Crisis follow up, discharge calls, discharge planning	Toni Lofgren, Sr. Manager, Adult Behavioral Health Care Management (480) 827-5955 Toni.Lofgren@bannerhealth.com
Traci Benton Adult Behavioral Health Care Manager (480) 827-5864 Traci.Benton@bannerhealth.com	Adult Care management, Crisis follow up, discharge calls, discharge planning	Reyna Santos Supervisor, Adult Behavioral Health Care Manager (520) 874-5587 Reyna.Santos@bannerhealth.com
Tanya Fujisharo Adult Behavioral Health Care Manager (520) 827-5831 Tanya.Fujisharo@bannerhealth.com	Adult Care management, Crisis follow up, discharge calls, discharge planning	Reyna Santos Supervisor, Adult Behavioral Health Care Manager (520) 874-5587 Reyna.Santos@bannerhealth.com
Luis Ordonez Adult Behavioral Health Care Manager (520) 874-2552 Luis.Ordonez@bannerhealth.com	Adult Care management, Crisis follow up, discharge planning,	Reyna Santos Supervisor, Adult Behavioral Health Care Manager (520) 874-5587 Reyna.Santos@bannerhealth.com
Andrea Ayala Adult Behavioral Health Care Manager (480) 684-6188 Andrea.Ayala@bannerhealth.com	Adult Care management, Crisis follow up, discharge planning,	Reyna Santos Supervisor, Adult Behavioral Health Care Manager (520) 874-5587 Reyna.Santos@bannerhealth.com
Adult Care management, Crisis follow up, discharge planning		Reyna Santos Supervisor, Adult Behavioral Health Care Manager (520) 874-5587 Reyna.Santos@bannerhealth.com

Penny Toro Adult Behavioral Health Care Manager (480) 827-5953 Penny.Toro@bannerhealth.com	Adult Care management, Crisis follow up, discharge planning,	Reyna Santos Supervisor, Adult Behavioral Health Care Manager (520) 874-5587 Reyna.Santos@bannerhealth.com

Children's Care Management and Utilization Management		
Beth Pfile Sr. Manager of Children's Behavioral Health (480) 827-5901 Beth.Pfile@bannerhealth.com	Children's utilization management, hospitalizations, prior authorizations, crisis follow up, Out of state placements, care management	Kristin Frounfelker Sr. Director of Behavioral Health (480) 827-5931 Kristin.Frounfelker@bannerhealth.com
Alexa Vigenser Children's Behavioral Health Care Manager (602) 827-5996 Alexa.Vigenser@bannerhealth.com	Children's care management, crisis follow up, care transitions, discharge planning, care transitions, Birth – 5 specialist,	Beth Pfile Sr. Manager of Children's Behavioral Health (480) 827-5901 Beth.Pfile@bannerhealth.com
DeVisha Flagg Children's Behavioral Health Care Manager (602) 747-8781 Devisha.Flagg@bannerhealth.com	Children's care management, crisis follow up, care transitions, discharge planning,	Beth Pfile Sr. Manager of Children's Behavioral Health (480) 827-5901 Beth.Pfile@bannerhealth.com
Treasure Phillips Children's Behavioral Health Care Manager (602) 747-8749 Cynthia.Phillips@bannerhealth.com	Children's' care management, crisis follow up, care transitions, Acute Referrals, Discharge planning, Autism specialist, DDD specialist, Vocational Rehabilitation specialist	Beth Pfile Sr. Manager of Children's Behavioral Health (480) 827-5901 Beth.Pfile@bannerhealth.com
Alex Barreras Children's Behavioral Health Care Manager (480) 684-6195 Alex.Barreras@bannerhealth.com	Children's care management, crisis follow up, care transitions, discharge planning,	Beth Pfile Sr. Manager of Children's Behavioral Health (480) 827-5901 Beth.Pfile@bannerhealth.com

Stephanie Christman Children's Behavioral Health Care Manager (480) 827-5889 Stephanie.Christman@bannerhealth.com	Children's care management, crisis follow up, care transitions, discharge planning,	Beth Pfile Sr. Manager of Children's Behavioral Health (480) 827-5901 Beth.Pfile@bannerhealth.com
Children Utilization Management		
Renee Richardson Children's UM Reviewer (480) 827-5888 Renee.Richardson@bannerhealth.com	Children inpatient psychiatric utilization management, Children BHRF/BHIF, discharge planning, prior authorization for outpatient services	Beth Pfile Sr. Manager of Children's Behavioral Health (480) 827-5901 Beth.Pfile@bannerhealth.com
Mario Gutierrez Children's UM Reviewer (480) 827-5981 Mario.Gutierrez@bannerhealth.com	Children inpatient psychiatric utilization management, Children BHRF/BHIF, discharge planning, prior authorization for outpatient services	Beth Pfile Sr. Manager of Children's Behavioral Health (480) 827-5901 Beth.Pfile@bannerhealth.com
Rebecca Sharman Children's UM Reviewer (480) 827-5997 Rebecca.Sharman@bannerhealth.com	Children inpatient psychiatric utilization management, Children BHRF/BHIF, discharge planning, prior authorization for outpatient services	Beth Pfile Sr. Manager of Children's Behavioral Health (480) 827-5901 Beth.Pfile@bannerhealth.com
System of Care		
Guillermo Velez Complete Care Administrator (520) 820-1570 Guillermo.Velez@bannerhealth.com	Children and Adult System of care, housing, workforce development, Tribal Services/Relations, Court Coordination, voc/rehab services,	Jim Stringham Chief Executive Officer (520) 874-3101 James.Stringham2@bannerhealth.com

	behavioral health outpatient provider requirements,	
Michael Gardner Sr. Manager Justice System Liaison/ Crisis Liaison (480) 827-5096 Michael.Gardner@bannerhealth.com	Jail/legal and court liaison for adults and children, jail transitions, prison transitions	Guillermo Velez Complete Care Administrator (520) 820-1570 Guillermo.Velez@bannerhealth.com
Veronica Valencia Court Liaison Veronica.Valencia@bannerhealth.com (520) 262-8136	Court Liaison for all counties, mental health/drug court, Court Ordered Treatment	Guillermo Velez Complete Care Administrator (520) 820-1570 Guillermo.Velez@bannerhealth.com
Kayla McGhee Housing Liaison (602) 499-0940 HealthPlanHousing@bannerhealth.com	Housing resources	Guillermo Velez Complete Care Administrator (520) 820-1570 Guillermo.Velez@bannerhealth.com
Selena McDonald Workforce Development Manager Selena.McDonald@bannerhealth.com (520) 874-2991	Training for contracted behavioral health provider staff,	Guillermo Velez Complete Care Administrator (520) 820-1570 Guillermo.Velez@bannerhealth.com
Kimberly Yellowrobe Tribal Relations Coordinator (480) 340-7724 Kimberly.Yellowrobe@bannerhealth.com	Tribal relations, tribal court orders, tribal council,	Guillermo Velez Complete Care Administrator (520) 820-1570 Guillermo.Velez@bannerhealth.com
Cameron Cobb Sr. Manager, Children's System of Care (480) 827-5881 Cameron.Cobb@bannerhealth.com	Provider oversight, clinical practices, children's system of care, CFT, PCP and integrated care practices	Guillermo Velez Complete Care Administrator (520) 820-1570 Guillermo.Velez@bannerhealth.com
Alejandro Flores Sr. Manager, Adult System of Care (480) 827-5883 Alejandro. Flores@bannerhealth.com	Provider oversight, clinical practices, children's system of care, ART, PCP and integrated care practices, COE	Guillermo Velez Complete Care Administrator (520) 820-1570 Guillermo.Velez@bannerhealth.com
Colleen McGregor, Administrator Office of Individual and Family Affairs (480) 827-5988 Colleen.McGregor@bannerhealth.com	Peer and family support, member advocacy, veteran's advocacy, CRS advocacy	Guillermo Velez Complete Care Administrator (520) 820-1570 Guillermo.Velez@bannerhealth.com

Medical Directors		
Sandy Stein, M.D Medical Director of Integrated Care (520) 874-5772 Sandra.Stein@bannerhealth.com	Psychiatry, clinical oversight, utilization management, denials, care coordination,	Dr. Ed Clarke Chief Medical Officer/Insurance Division (602) 747-7399 Ed.Clarke@bannerhealth.com
Vicki Knight, M.D Behavioral Health Medical Director (520) 874-5910 Vicki.Knight@bannerhealth.com	Adult psychiatry, clinical oversight, T36/COT, denials, utilization management	Sandy Stein, M.D Medical Director of Integrated Care (520) 874-5772 Sandra.Stein@bannerhealth.com

Banner Health Urgent Care Flyer

Banner
University Health Plans

Getting Your Urgent Behavioral and Physical Heathcare Needs Met

Did you know many health care concerns can be handled at an urgent care? This can be easier and faster than going to an emergency department. Banner – University Health Plans (B – UHP) partnered with community behavioral health/integrated care providers and Banner Urgent Cares. Together we designed processes for these providers to coordinate care with Banner Urgent Cares to meet urgent physical and behavioral health care needs by working together. Any member can walk in or be referred by one of these behavioral health/integrated providers to any of the Banner Urgent Care sites across the state to receive on-site or telehealth services.

Providers will share information about symptoms and history prior to a member going to the Urgent Care when possible. After completion of treatment, coordination of care ensures follow up services are arranged.

Reasons to use the Banner Urgent Care

- Coordination of health care needs through referral or walk-in to expedite care
- Banner Urgent Cares:
  - Use fully certified medical staff
  - Allow for much shorter wait times than other emergency settings, such as emergency departments
  - Complete care usually within 1 hour
  - Open between 8 AM to 9 PM
  - Telehealth services can be provided

Banner Urgent Cares can treat common illnesses, minor injuries or behavioral health symptoms such as:

- Stomach pain, nausea, vomiting and diarrhea
- Urinary tract infections/burning on urination
- Cold and flu symptoms including fevers
- Cuts in needs of stitches
- Simple fractures or sprains
- Ear infections
- Headaches
- Back pain
- Routine heath care such as immunizations
- Anxiety/panic
- Depression
- Substance use
- Medication associated issues

For additional information related to Banner Urgent Care go to: https://www.bannerhealth.com/getcarenow/urgent-care-services

Banner Urgent Care Sites

There are 47 Banner Urgent Care sites across Arizona for your convenience. For locations and to schedule appointments please go to: https://urgentcare.bannerhealth.com

Banner Nurse Now (888) 747-7990. TTY 711

Banner
University Health Plans

Obtener que se Cumplan sus Necesidades de Salud Urgentes Comportamentales y Físicas

¿Sabía usted que muchos asuntos de salud pueden llevarse a cabo en un centro de urgencias? Esto puede ser más fácil y rápido que ir a la sala de emergencia. Banner – University Health Plans (B – UHP, por sus siglas en inglés) se ha asociado con proveedores comunitarios de salud comportamental/atención médica integral y Banner Urgent Cares. Juntos desarrollamos procesos para estos proveedores para coordinar atención médica con Banner Urgent Cares para satisfacer las necesidades de atención médica física y salud comportamental urgentes. Cualquier miembro puede ir sin cita o si es referido por alguno de estos proveedores de salud comportamental/integral a cualquier ubicación de Banner Urgent Care en todo el estado para recibir servicios en el centro de urgencias o por Telesalud.

Razones para usar Banner Urgent Care

- Coordinación de necesidades de salud a través de referencias o consulta médica sin cita previa para apresurar la atención médica
- Banner Urgent Cares:
  - Utilizan personal médico titulado
  - Menos tiempo de espera que otros entornos de emergencia, tal como las salas de emergencias
  - Atención médica completada generalmente dentro de 1 hora
  - Abierto de 8 a.m. a 9 p.m.
  - Pueden brindarse servicios Telesalud

Banner Urgent Care puede tratar enfermedades comunes, lesiones leves, o síntomas de salud comportamental tal como

- Dolor estomacal, nausea, vómito y diarrea
- Infecciones de la vía urinaria/ardor al orinar
- Síntomas de resfriado y gripe incluyendo fiebres
- Cortadas que necesitan puntos
- Fracturas o torceduras simples
- Atención médica de rutina tal como tal como inmunizaciones
- Infecciones del oído
- Dolores de cabeza
- Dolor de espalda
- Ansiedad/pánico
- Depresión
- Abuso de drogas
- Asuntos relacionados con medicamentos

Para información adicional relacionada con Banner Urgent Care vaya a: https://www.bannerhealth.com/getcarenow/urgent-care-services

Ubicaciones de Banner Urgent Care

Hay 47 ubicaciones de Banner Urgent Care en Arizona para mayor comodidad. Para ubicaciones y para programar citas favor de ir a: https://urgentcare.bannerhealth.com

Banner Nurse Now (888) 747-7990. TTY 711.

Electronic Visit Verification (E.V.V.)

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Jami Snyder, Director

Electronic Visit Verification
AHCCCS EVV System Model Design – Provider, MCO
September 2019
Decisions are Subject to Change

EVV System Model Design
➢ AHCCCS has selected Sandata Technologies as the State-Wide Electronic Visit Verification (EVV) vendor to comply with the 21st Century Cures Act (Cures Act).
➢ **System Model Design Objectives** • Ensuring, tracking and monitoring timely service delivery and access to care for members. • Reducing provider administrative burden associated with scheduling and hard copy timesheet processing; • Accommodating service provider business decisions and preserving existing investment in systems; and, • Generating cost savings from the prevention of fraud, waste and abuse.
➢ **Open Vendor Model** • AHCCCS plans to implement an open vendor model contracting with one statewide EVV vendor, Sandata Technologies, which will be an option available for use by providers and Managed Care Organizations (MCOs). • Providers and Managed Care Organizations (MCOs) may continue to use an existing EVV system or choose to use an alternate EVV vendor. • Sandata will offer a data collection system for providers without a legacy/alternate verification system and a mandated data aggregator. • AHCCCS will provide funding for the development and initial implementation of the statewide EVV system and additional funding options are currently being explored to compensate for ongoing vendor maintenance costs (e.g. devices and transaction fees) of the statewide EVV vendor for Medicaid members receiving services subject to EVV. Funding considerations include financial constraints, administrative and programmatic costs and provider assurances of cost neutrality. • Providers and MCOs choosing to use an existing or alternate system will incur any and all related costs, including costs related to system requirements necessary to transmit data to the Sandata data aggregator.
➢ **Services Requiring Electronic Visit Verification** • Services that will require Electronic Visit Verification can be found in Appendix A, see below. Any and all providers who bill for the included service codes will be required to comply with EVV mandated requirements.
➢ **Elimination of Paper Timesheets** • AHCCCS will be establishing criteria for limited exceptions to the EVV system requirements when technological infrastructure is limited, unreliable or nonexistent. In addition, when allowable, the use of paper timesheets will be required to be used in combination with a fixed device to generate a code with a time and date stamp to verify the beginning and end of service delivery.
➢ **Data Collection Devices** • Members and/or the responsible party will be able to choose a device or data collection modality, amongst a set of options, that best fits their lifestyle and the way in which they manage their care.
➢ **System Modules** The EVV System will include a: • Scheduling module to support providers and members/responsible parties in managing the schedule of the Direct Care Worker (DCW) • Authorization module to transmit the service authorization from the MCO to the provider • Multi-level escalating alerts whenever a scheduled visit does not occur on time
➢ **Verification** • The System will require visit verification from both the DCW and the member/responsible party • The DCW verification will occur both at the beginning and the end of the shift • The member/responsible party will be required to verify the services provided at the end of the DCW's shift • The system will include flexible options for member/responsible party verification including, but not limited to, options for services to be verified remotely and to delegate the verification responsibilities to another person of suitable age, discretion, and other defined criteria.

Appendix A:
Arizona Services Subject to EVV

Provider Description	Provider Type
Attendant Care Agency	PT 40
Behavioral Outpatient Clinic	PT 77
Community Service Agency	PT A3
Fiscal Intermediary	PT FI
Habilitation Provider	PT 39
Home Health Agency	PT 23
Integrated Clinic	PT IC
Non-Medicare Certified Home Health Agency	PT 95
Private Nurse	PT 46

Service	HCPCS Service Codes	DDD FOCUS Codes
Attendant Care	S5125	ATC
Companion Care	S5135	
Habilitation*	T2016 and T2017	HAH, HAI, HID
Home Health Services (aide, therapy, and part-time/intermittent nursing services)		
Nursing Home Health Aide Physical Therapy Occupational Therapy Respiratory Therapy Speech Therapy	G0299 and G0300 T1021 G0151 and S9131 G0152 and S9129 S5181 G0153 and S9128	
Private Duty Nursing (continuous nursing services)	S9123 and S9124	HN1, HNR
Homemaker	S5130	HSK
Personal Care	T1019	
Respite	S5150 and S5151	RSP, RSD
Skills Training and Development	H2014	

*Note: The Habilitation HCPCS Service Codes and DDD Focus Codes have been updated.

Place of Service Description	POS Code
Home	12
Assisted Living Facility	13
Other	99

The Arizona Vision

The Arizona Vision as established by the Jason K. Settlement Agreement in 2001, states, “In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child’s and family’s cultural heritage”.

The Twelve Principles for Children’s Service Delivery (12 Principles)

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family’s unique cultural heritage
11. Independence
12. Connection to natural supports

Adult and Children Guiding Principles

9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems

1. Respect

Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. Persons in recovery choose services and are included in program decisions and program development efforts.

A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. Focus on individual as a whole person, while including and/or developing natural supports

A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure.

A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. Integration, collaboration, and participation with the community of one's choice

A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscore one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust

A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. Persons in recovery define their own success

A person in recovery -- by their own declaration -- discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences

A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. Hope is the foundation for the journey towards recovery

A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

- Inclusion of member, family and family of voice and choice aspects of service deliverable and support.
- Patient centered treatment and support

12 Arizona Principles for children's behavioral health services

1. Collaboration with the child and family.

Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. Functional outcomes.

Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. Collaboration with others.

When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services.

4. Accessible services.

Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need.

5. Best practices.

Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice."

6. Most appropriate setting.

Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs.

7. Timeliness.

Children identified as needing behavioral health services are assessed and served promptly.

8. Services tailored to the child and family.

The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. Stability.

Behavioral health service plans strive to minimize multiple placements. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family's unique cultural heritage.

Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family.

11. Independence.

Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self- management.

12. Connection to natural supports.

The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Model of Care Training Attestation

Note: Even if you provide your contact information, your identity will be kept confidential. You may submit this form by mail, fax, or email. Anonymous reporting requires enough information to review the concern.

'*' Indicates required field.

Attestation

☐ *I attest that I have completed the Model of Care Training

*First Name: _____ *Last Name: _____

Job Title: _____ Tax ID: _____

Individual NPI: _____ Group NPI: _____

Group/Contact Name: _____

List of Practitioners

Please list the individual practitioners who have completed this training below, with the required information. If additional entries are required, please complete a separate attestation.

*Practitioner Name _____ Practitioner NPI: _____

*Practitioner Name _____ Practitioner NPI: _____

*Practitioner Name _____ Practitioner NPI: _____

*Practitioner Name _____ Practitioner NPI: _____

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*Practitioner Name _____ Practitioner NPI: _____

*Practitioner Name _____ Practitioner NPI: _____

*Practitioner Name _____ Practitioner NPI: _____

*Practitioner Name _____ Practitioner NPI: _____

Contact Information

Group Contact Email: _____ Direct Phone Number: _____

By signing below, I attest to the completion of the MOC Training for B – UCA

_____ _____

Signature Today's Date

Send this form by email to Provider Relations at:
BUHPModelofCareAttestations@bannerhealth.com

Banner Medicare Advantage 2022 Benefits at a Glance

Banner Medicare Advantage.

Banner Medicare Advantage Dual HMO D-SNP
2022 Benefits at a Glance

Premiums and Benefits – ACC & ALTCS Plans		
Description	**ACC Plans:** Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pinal, Santa Cruz, Yuma	**ALTCS Plans:** Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, Yuma
Monthly Plan Premium	$0	
Annual Plan Deductible	$0	
Annual Out-of-Pocket Maximum	$2,900	
Inpatient Hospital – Acute (up to 90 days per benefit period)	$0	
Inpatient Mental Health Care (up to 90 days per benefit period)	$0	
Skilled Nursing Facility (SNF) (up to 100 days per benefit period)	$0	
Outpatient Hospital – Surgery & Observation	$0	
Ambulatory Surgical Center	$0	
Ambulance (one-way trip)	$0	
Emergency Care	$0	
Urgently Needed Care	$0	
Primary Care Physician (PCP) Visit	$0	
Preventive Care & Immunizations	$0	
Specialist Visit	$0	
Diagnostic Procedures, Tests, Lab & X-rays	$0	
Diagnostic Radiology (e.g., CT, MRI)	$0	
Therapeutic Radiology	$0	
Home Health	$0	

Banner Medicare Advantage Dual HMO D-SNP has contracts with Medicare and Medicaid. Enrollment depends on contract renewal.

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Premiums and Benefits – ACC & ALTCS Plans		
Description	**ACC Plans:** Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, Yuma	**ALTCS Plans:** Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, Yuma
Durable Medical Equipment (DME)	$0	
Prosthetics & Orthotics	$0	
Renal Dialysis	$0	
Diabetic Supplies	$0	
Mental Health Services (individual and group sessions)	$0	
Physical Therapy, Occupational Therapy & Speech	$0	
Routine Chiropractic (up to 6 visits per calendar year)	$0	
Routine Podiatry (up to 6 visits per calendar year)	$0	
Medicare-covered Eye Exam	$0	
Annual Routine Eye Exam	$0	
Medicare-covered Eyewear (glasses or contacts after cataract surgery)	$0	
Routine Eyewear (1 pair of contacts or glasses)	$225 per calendar year	
Medicare-covered Hearing Exam	$0	
Annual Routine Hearing Exam	$0	
Hearing Aid Fitting/Evaluation (every 3 years)	$0	
Hearing Aids	$1,500 every 3 years	
Preventive & Comprehensive Dental	$3,500 per calendar year	
Over the Counter (OTC) Items	$250 per quarter (unused amount rolls over)	
Medicare Part B Drugs	$0	
Fitness Membership – Silver&Fit®	$0	Not covered
Post-Inpatient Meals (when ordered within 30 days of discharge)	12 meals	Not covered
Routine Transportation – 36 one-way rides	$0	Not covered
Annual Physical Exam	$0	Not covered

Banner Medicare Advantage.

Banner Medicare Advantage Prime HMO

2022 Benefits at a Glance

Premiums and Benefits		
Description	**Maricopa | Pinal | Yuma**	**Pima | Santa Cruz**
Monthly Plan Premium	$0	
Annual Deductible	$0	
Annual Out-of-Pocket Maximum	$2,775	
Inpatient Hospital – Acute (up to 90 days per benefit period)	Days 1-7: $195/day Days 8-90: $0/day	
Skilled Nursing Facility (SNF) (up to 100 days per benefit period)	Days 1-20: $0/day Days 21-100: $178/day	
Outpatient Hospital – Surgery & Observation	$175	
Ambulatory Surgical Center (ASC)	$175	
Ambulance (one-way trip)	$265	$250
Emergency Care	$90	
Worldwide Emergency/Urgent Care	$90 – Up to $25,000/calendar year	
Urgently Needed Care	$30	
Primary Care Physician (PCP) Visit	$0	
Preventative Care & Immunizations	$0	
Specialist Visit	$20	
Diagnostic Tests, Procedures & Lab Services	$10	
X-rays	$15	
Diagnostic Radiology (e.g., CT, MRI)	$125-$200	
Therapeutic Radiology	$60	
Home Health	$0	
Durable Medical Equipment (DME)	20%	
Prosthetics & Orthotics	20%	
Renal Dialysis	20%	
Diabetic Supplies	$0	

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Additional Benefits		
Description	Maricopa | Pinal | Yuma	Pima | Santa Cruz
Mental Health Services (individual & group sessions)	$25	
Physical Therapy, Occupational Therapy & Speech Therapy	$25	
Routine Chiropractic	$35 (up to 6 visits per calendar year)	
Medicare-covered Chiropractic	$20	
Medicare-covered Podiatry	$25	
Medicare-covered Eye Exam	$0	
Annual Routine Eye Exam	$0	
Medicare-covered Eyewear (glasses or contacts after cataract surgery)	20%	
Routine Eyewear (1 pair of contacts or glasses)	$25 $200 every 2 years	
Medicare-covered Hearing Exam	$0	
Annual Routine Hearing Exam	$0	
Hearing Aid Fitting/Evaluation (every 2 years)	$0	
Hearing Aids	$0 $1,000 every 2 years	
Preventive Dental	$0	
Over the Counter (OTC) Items	$50/quarter; unused amount rolls over	
Fitness – Silver&Fit®	$0	
Home-Delivered Meals (post-inpatient discharge from hospital or SNF)	$0 12 meals when ordered within 30 days of discharge	
Medicare Part B Drugs	20%	

Optional Supplemental Benefits – Comprehensive Dental	
Monthly Premium	$20.20
Comprehensive Dental (Non-routine Services; Diagnostic Services; Restorative Services; Endodontics)	$1,000/calendar year

Part D Prescription Drug Coverage	
Description	Maricopa | Pinal | Yuma | Pima | Santa Cruz
Annual Part D Deductible	$0
Retail – 31-day Supply	Tier 1: $0 / Tier 2: $5 / Tier 3: $47 / Tier 4: $100 / Tier 5: 33%
Mail Order – 90-day Supply	Tier 1: $0 / Tier 2: $10 / Tier 3: $141 / Tier 4: $300 / Tier 5: Specialty drugs not available through mail order

<Banner Medicare Advantage Prime HMO has a contract with Medicare. Enrollment depends on contract renewal.>

Banner Medicare Advantage.

Banner Medicare Advantage.

Banner Medicare Advantage Plus PPO

2022 Benefits at a Glance

Premiums and Benefits		
Description	**Maricopa | Pinal | Yuma**	**Pima | Santa Cruz**
Monthly Plan Premium	$25	
Annual Deductible	$0	
Annual Out-of-Pocket Maximum	In-Network $4,500 In-Network & Out-of-Network Combined $9,000	
Inpatient Hospital – Acute (up to 90 days per benefit period)	In-Network Days 1-5: $275/day; Days 6-90: $0/day Out-of-Network Days 1-90: 40%	
Skilled Nursing Facility (SNF) (up to 100 days per benefit period)	In-Network Days 1-20: $0/day; Days 21-100: $178/day Out-of-Network Days 1-100: $195/day	
Outpatient Hospital – Surgery & Observation	In-Network $250 Out-of-Network 40%	In-Network $275 Out-of-Network 40%
Ambulance (one-way trip)	In-Network & Out-of-Network $250	
Emergency Care	In-Network & Out-of-Network $90	
Worldwide Emergency/Urgent Care	In-Network & Out-of-Network $90 Up to $25,000/calendar year	
Urgently Needed Care	In-Network & Out-of-Network $30	
Primary Care Physician (PCP) Visit	In-Network $0 | Out-of-Network $35	
Specialist Visit	In-Network $30 | Out-of-Network $70	
Diagnostic Tests, Procedures & Lab Services	In-Network $10 | Out-of-Network 40%	
X-rays	In-Network $20 | Out-of-Network $27	
Diagnostic Radiology (e.g., CT, MRI)	In-Network $125 | Out-of-Network 40%	
Therapeutic Radiology	In-Network $60 | Out-of-Network 40%	
Home Health	In-Network $0 | Out-of-Network 50%	
Durable Medical Equipment (DME)	In-Network 20% | Out-of-Network 50%	
Prosthetics & Orthotics	In-Network20% | Out-of-Network 50%	
Renal Dialysis	In-Network 20% | Out-of-Network 40%	

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Additional Benefits		
Description	Maricopa | Pinal | Yuma	Pima | Santa Cruz
Diabetic Supplies	In-Network 0% | Out-of-Network 40%	
Mental Health Services (individual & group sessions)	In-Network $30 | Out-of-Network $40	
Physical Therapy, Occupational Therapy & Speech Therapy	In-Network $40 Out-of-Network 40%	In-Network $30 Out-of-Network 40%
Routine Chiropractic (up to 6 visits per calendar year)	In-Network $35 | Out-of-Network 40%	
Medicare-covered Chiropractic	In-Network $20 | Out-of-Network $70	
Medicare-covered Podiatry	In-Network $30 | Out-of-Network 40%	
Medicare-covered Eye Exam	In-Network $0 | Out-of-Network 50%	
Annual Routine Eye Exam	In-Network $0 | Out-of-Network 40%	
Medicare-covered Eyewear (glasses or contacts after cataract surgery)	In-Network $0 | Out-of-Network 40%	
Routine Eyewear – $200 every 2 years (In- & Out-of-Network Combined)	In-Network $0 | Out-of-Network 40%	
Medicare-covered Hearing Exam	In-Network $0 | Out-of-Network 40%	
Annual Routine Hearing Exam	In-Network $0 | Out-of-Network 40%	
Hearing Aid Fitting/Evaluation every 2 years (In- & Out-of-Network Combined)	In-Network $0 | Out-of-Network 40%	
Hearing Aids – $1,000 every 2 years	In-Network $0 | Out-of-Network 40%	
Preventive Dental (up to 2 visits per year)	In-Network $0 | Out-of-Network 40%	
Over the Counter (OTC) Items	$50/quarter unused amount rolls over to next period	
Fitness – Silver&Fit®	In-Network $0 | Out-of-Network 40%	
Home-Delivered Meals (12 meals ordered within 30 days of inpatient discharge)	In-Network $0 | Out-of-Network 40%	

Optional Supplemental Benefits – Comprehensive Dental	
Monthly Premium	$20.20
Comprehensive Dental (Non-routine Services; Diagnostic Services; Restorative Services; Endodontics)	$1,000/calendar year

Part D Prescription Drug Coverage	
Description	Maricopa | Pinal | Yuma | Pima | Santa Cruz
Annual Part D Deductible	$0
Retail – 31-day Supply	Tier 1: $0 / Tier 2: $5 / Tier 3: $47 / Tier 4: $100 / Tier 5: 33%
Mail Order – 90-day Supply	Tier 1: $0 / Tier 2: $10 / Tier 3: $141 / Tier 4: $300 / Tier 5: Specialty drugs not available through mail order

<Banner Medicare Advantage Plus PPO has a contract with Medicare. Enrollment depends on contract renewal.>

Banner Medicare Advantage

Banner Medicare

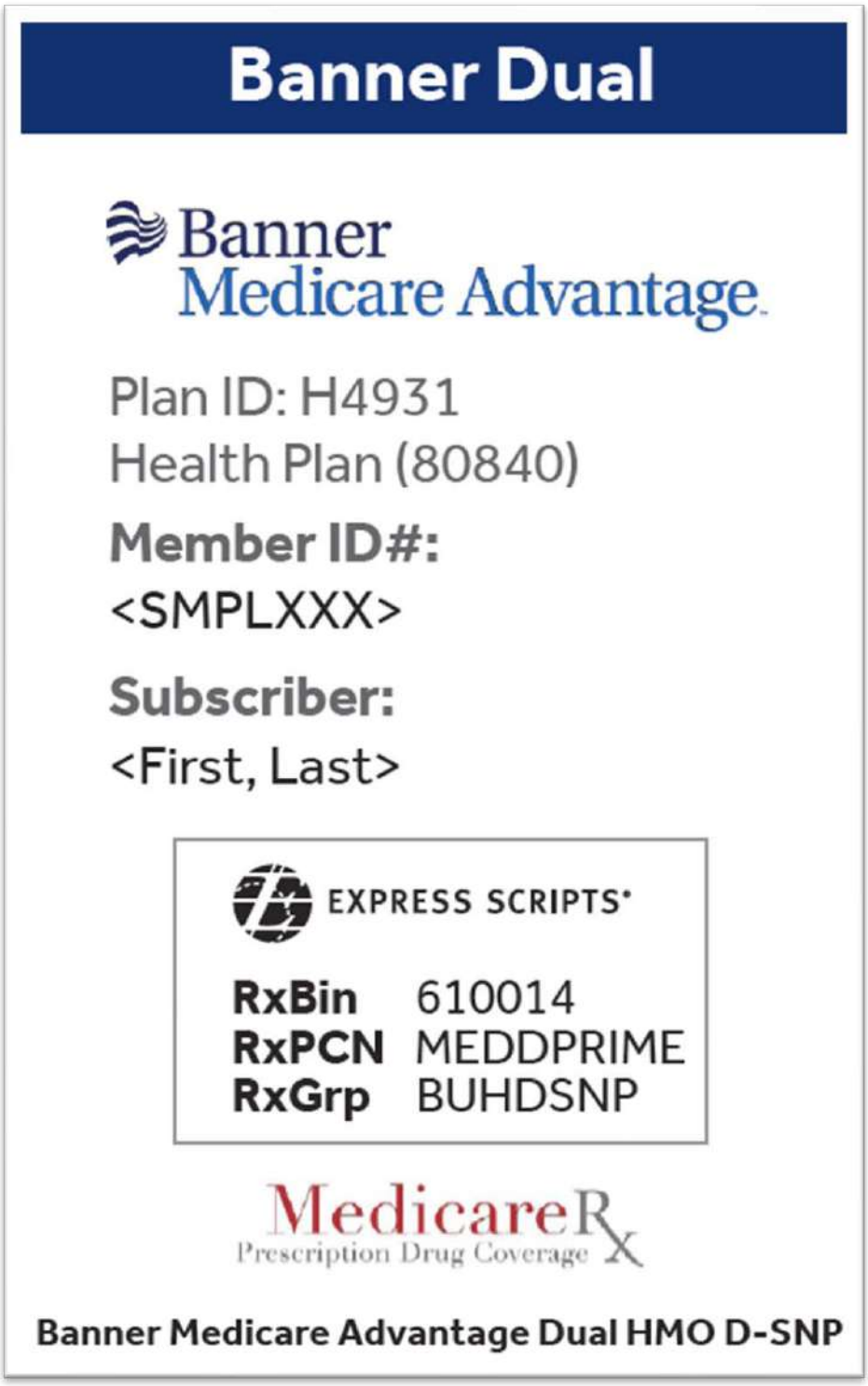
Banner Medicare Rx PDP
2022 Benefits at a Glance

		Banner Medicare Simple Rx PDP (001)	Banner Medicare Classic Rx PDP (002)	Banner Medicare Premier Rx PDP (003)
Monthly Plan Premium		$37.40	$39.30	$85.40
Annual Part D Deductible		$480	$480 (does not apply to Tiers 1 & 2)	$0
Retail, Out-of-Network & Long-Term Care Pharmacies One-Month Supply	Tier 1	$0		
	Tier 2	$11	$6	$4
	Tier 3	22%	$40	$40
	Tier 4	38%	37%	39%
	Tier 5	25%	25%	33%
	Select Insulins	N/A	$35	$35
Mail Order Three-Month Supply	Tier 1	$0		
	Tier 2	$22	$12	$8
	Tier 3	22%	$80	$80
	Tier 4	38%	37%	39%
	Tier 5	N/A		
	Select Insulins	N/A	$70	$70
Initial Coverage Limit (ICL)		$4,430		
Coverage Gap		After total drug costs reach $4,430, members enter the coverage gap (or donut hole) phase and pay 25% of drug costs.		
Catastrophic Coverage		After total out-of-pocket costs reach $7,050, members enter the catastrophic coverage phase and pay **the greater of**: 5% or $3.95 for generic or preferred multi-source drugs and $9.85 for all other drugs.		

Banner Medicare Rx PDP has a contract with Medicare. Enrollment depends on contract renewal.
S3147_BenefitsCY22_M

Banner Medicare Advantage Dual Sample Card

Front



Back

Banner Dual

BannerHealth.com/Medicare

Medical Claims:

Banner Dual Claims Dept.
P.O. Box 38549
Phoenix, AZ 85069-7169

Eligibility/Customer Care Center:

(877) 874-3930, TTY 711
8 a.m. to 8 p.m., seven days a week

Dental Claims:

DentaQuest
P.O. Box 2906
Milwaukee, WI 53201-2906
Phone: (800) 440-3408

Express Scripts:

Pharmacy Help Desk
(800) 864-1406

Prior authorization may be required for certain services.

Opioid Treatment Program Requirements

Opioid abuse is a serious public health problem in Arizona and in the United States. Banner – University Health Plans wants to ensure that our providers have the tools and resources to make appropriate health care decisions for our members.

Please visit https://www.banneruhp.com for detailed information, requirements, and resources. View the newly added section called AHCCCS Annual Requirements on our Opioid Management page.

Opioid Treatment Program (OTP) Requirements

As a result of ARS 36-.2907.14, AHCCCS and its contracted health plans have implemented new standards and reporting requirements for all Opioid Treatment Programs (OTPs) receiving AHCCCS reimbursement. These new standards and reporting requirements are in addition to all State or Federal licensing and registration requirements.

For more information and to view the AHCCCS Annual Requirements, please visit: Opioid Management

Psychiatry for Non-Psychiatrists Conference

AHCCCS Enrollment Portal (APEP) Re-registration and Re-validation Requested

During the COVID-19 public health emergency (PHE), AHCCCS adjusted the provider screening requirements in order to maintain our active provider directory and ensure members had continuous access to health care services. AHCCCS also launched the new Provider Enrollment Portal, APEP.

After implementing APEP in August 2020, AHCCCS asked providers to "re-register." All active providers were asked to create an account in APEP and confirm the data converted into the new portal is accurate and current. AHCCCS has not terminated providers during the PHE for non-compliance with this re-registration process.

Over the past 15 months, providers have received a written invitation by the US Postal Service that includes a temporary 14-digit application ID and instructions to create a user account to access their file. AHCCCS also transitioned away from paper-based updates, and encouraged providers to submit their updates directly into APEP. For many providers who have not completed the re-registration process, the paper update is being returned with instructions to report the update directly into APEP through the re-registration process.

Re-validation is a process that occurs after initial enrollment in which a provider is subjected to the same screening, disclosures, and as applicable, fingerprint-based criminal background check requirements as a new enrollment. It is during the periodic revalidation, a provider shall verify the accuracy of its enrollment information. This process occurs every four years from the initial date of enrollment or last revalidation approval. During the PHE, no re-validations were completed, however all active providers were asked to re-register.

Although we do not know exactly when the PHE will end, AHCCCS is planning for it now. Once it ends, AHCCCS will begin a review of the approved re-registration applications based on the categorical risk level of the provider in accordance with 42 CFR 455.450. For many providers, their approved re-registration application will serve as their completed re-validation. These providers will not be required to complete an application for another four years. Providers that require additional screening requirements based on their provider type, or providers who have not completed their re-registration application will be expected to complete a revalidation application. If a provider does not comply with re-validation requirements, AHCCCS will follow the standard process for terminating enrollment for that provider.

AHCCCS encourages providers who have received their written invitation but have not completed the re-registration process to do so now.

For more information regarding the provider re-registration invitation plan, please visit:
https://azahcccs.gov/PlansProviders/APEP/ProviderReRegistrationInvitePlan.html.
Email questions on the plan to:

APEPTrainingQuestions@azahcccs.gov.

EPSDT / Well-Child Visits – Tracking Forms

In accordance with AHCCCS policy [*AMPM Policy 430 Early and Periodic Screening, Diagnostic and Treatment (ESPDT) Services, Attachment E – AHCCCS EPSDT Tracking Forms*] – All providers offering care to AHCCCS members under 21 years of age, *MUST* use the AHCCCS EPSDT Tracking Forms to document age-specific, required information related to the EPSDT / Well-Child screenings and visits. Alternatively – the provider's Electronic Health Record may be used, so long as it includes ALL components present on the age-specific AHCCCS form.

- EPSDT Tracking forms may be downloaded via the AHCCCS website at: **www.azahcccs.gov › shared › Medical_Policy_Manual › 430_AttachmentE**
  https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/430_AttachmentE.docx

- A copy of each visit's EPSDT Tracking Form (or EHR), completed and signed by the clinician, must be:
  - Placed in the member's medical record AND
  - Sent to the member's Health Plan

Timely submission of forms is very important to member care coordination. Submitting EPSDT / Well-Child visit forms (or copy of suitable HER equivalent) to the Health Plan soon after the well-child visit allows us to:

- Outreach to members and caregivers, evaluate for and mitigate potential barriers to care
- Identify, follow-up and facilitate referrals initiated during the well-child visit.
- Evaluate for and mitigate potential barriers to care.

Submitting EPSDT / Well-Child Visit Forms

There are three easy ways to submit your EPSDT forms or EMRs after a visit.

Secure email: BUHPEPSDTForms@BannerHealth.com
Secure Fax: 520-574-7184
US Mail: Banner University Health Plans
Attn: EPSDT
2701 E. Elvira Rd.
Tucson, AZ 85756