Provider Handbook

Magellan Complete Care of Arizona (HMO SNP)

Addendum in Compliance with Executive Order 14042

Ensuring Adequate COVID-19 Safety Protocols for Federal Contractors for Subcontracts Over the Simplified Acquisition Threshold of $250,000

(a) Definition. As used in this clause "*United States or its outlying areas"* means:
- (1) The fifty States;
- (2) The District of Columbia;
- (3) The commonwealths of Puerto Rico and the Northern Mariana Islands;
- (4) The territories of American Samoa, Guam, and the United States Virgin Islands; and
- (5) The minor outlying islands of Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Palmyra Atoll, and Wake Atoll.

(b) Authority. This clause implements Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985).

(c) Compliance. The Provider, a subcontractor, shall comply with all guidance, including guidance conveyed through Frequently Asked Questions, as amended during the performance of this Agreement, for contractor or subcontractor workplace locations published by the Safer Federal Workforce Task Force (Task Force Guidance) at https:/www.saferfederalworkforce.gov/contractors/.

(d) Subcontracts. The Provider shall include the substance of this clause, including this paragraph (d), in subcontracts at any tier that exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award, and are for services, including construction, performed in whole or in part within the United States or its outlying areas."

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Section 1—Introduction

1.1 Purpose

Welcome to MCC of AZ (HMO SNP). The purpose of the Provider Handbook is to give our providers and their administrative and billing staff ready access to the information they need to efficiently and effectively care for our members and to conduct business with MCC of AZ for your patients in our DSNP plan.

1.2 Overview of the MCC of AZ (HMO SNP) program

In addition to our Medicaid plan, Magellan Complete Care of Arizona offers a Medicare Advantage Dual Eligible Special Needs Plan called MCC of AZ (HMO SNP). MCC of AZ (HMO SNP) is a Medicare Advantage SNP plan for members who qualify for and receive Medicare Parts A and B benefits and full Medicaid benefits. MCC OF AZ (HMO SNP) coordinates the member's Medicare, Medicaid and Part D Prescription Drug benefits.

All MCC of AZ (HMO SNP) members are assigned a care coordinator who works with the member's PCP to coordinate benefits, including medical, behavioral health, prescription drug, and vision services. Additionally, we coordinate a wide range of social and non-medical community-based services in order to enhance each member's health and ability to live independently.

Enrollment in MCC of AZ (HMO SNP) is available to individuals who meet the enrollment criteria and live in Maricopa, Gila or Pinal counties.

1.3 Our mission statement

To help every member live a vibrant, healthy life as independently as possible. To do the things they love and to have a choice and control over the decisions that affect their lives.

1.4 When this handbook and your contract differ

Your Provider Handbook is a supplement to your contract with MCC of AZ (HMO SNP). It provides detailed information to answer many day-to-day operational questions about us, our products and members, and your relationship with us. In cases where your contract and this document differ, your contract takes precedence.

1.5 Organization of this handbook

Each section is organized to answer the most commonly asked questions first. All forms and work aids can be found in the Appendices. Within each section, we've provided hyperlinks to the referenced forms and resources.

Section 1—Introduction

The handbook is organized for ease of use. We recommend you take a few minutes to familiarize yourself with the table of contents. Doing so will help when you need an answer quickly.

We update each section of the handbook, forms, and resources independently. We will note any revision dates and will review all parts of the handbook at least annually. For the most current version of any section, we recommend you visit our website.

Section 2—Compliance

2.1 Our commitment

MCC of AZ (HMO SNP) is committed to conducting our business operations honestly and ethically with members, provider/suppliers, governmental agencies and First Tier, Downstream and Related Entities (FDR) in a way that is in keeping with applicable federal and state statutes, ethical standards, rules and regulations, including but not limited to those pertaining to the Centers for Medicare and Medicaid Services (CMS) Part C and D programs and the Arizona Health Care Cost Containment System (AHCCCS) and AHCCCS Office of the Inspector General (OIG).

MCC of AZ (HMO SNP)'s Corporate Compliance Program is a comprehensive program designed to education all employees on the ethical standards and code of conduct that guides our operations and promotes reporting of inappropriate behavior and unlawful activity. The compliance program appliance to all lines of business.

The structure of our Compliance Program contains the following elements:

Oversite of Code of Conduct

- Compliance Officer and Compliance Committee oversight
- Development and implementation of code of Conduct and Policies and Procedures
- Creating awareness through training and publicized disciplinary standards and enforcement
- Assessing compliance through monitoring and auditing
- Maintaining compliance through monitoring and auditing
- Maintaining an effective reporting mechanism and prompt response to allegations of misconduct and potential fraud, waste and abuse

2.2 Fraud, Waste & Abuse training and reporting

We are committed to preventing, identifying, investigating and acting on resolutions of suspected fraud, waste and abuse. Our Fraud, Waste and Abuse (FWA) program is an integral part of our Compliance Program.

Anyone conducting business with MCC of AZ (HMO SNP) agrees to comply with all applicable federal and state statutes, regulations and other requirements, sub-regulatory guidance and contractual commitments related to the delivery of covered services which include but are not limited to federal and state False Claims Acts, anti-kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA) and other applicable statutes.

Section 2—Compliance

As a contracted provider, federal law requires that you and all your organization's employees take FWA training at the time of hire and on an annual basis. Click here to view regulation. Many providers already meet this requirement through their enrollment in the Medicare program.

If you are not a Medicare-participating provider or you still need to take FWA training for this calendar year, visit the standardized web-based training module developed by CMS. Download two training courses: *Combatting Medicare Parts C and D Fraud, Waste & Abuse Training* and *Medicare Parts C and D General Compliance Training*. Please ensure your employees, including contractor, part-time and temporary workers also follow this requirement. Keep a record of completion for all employees. CMS regulation requires that you keep these records for at least 10 years.

Definitions of Fraud and Abuse

Medicare fraud typically includes any of the following:

- Knowingly submitting, or causing to be submitted, false claims or making misrepresentation of fact to obtain a federal health care payment for which no entitlement would otherwise exist
- Knowingly soliciting, receiving, offering and/or paying remuneration to induce or reward referrals for items or services reimbursed by federal health care programs
- Making prohibited referrals for certain designated health services

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Abuse includes any practice inconsistent with providing patients with medically necessary services meeting professionally recognized standards. Examples of Medicare abuse include:

- Billing for unnecessary medical services
- Charging excessively for services or supplies
- Misusing codes on a claim, such as upcoding or unbundling
- Medicare abuse can expose providers to criminal and civil liability

Reporting

We take fraud, waste and abuse very seriously. If you suspect fraud, waste, abuse or any other kind of unlawful activity, you should promptly report it directly to MCC of AZ (HMO SNP) at the Molina AlertLine:

- Phone: 1-866-606-3889
- Online address to report: https://molinahealthcare.alertline.com

Section 2—Compliance

2.3 Regulatory compliance information for all contract providers

Because we are a Medicare Advantage Special Needs Plan, our contracted providers are required to adhere to the following federal, state and Medicare Advantage provisions which are incorporated into the *MCC of AZ (HMO SNP) Contracted Provider Agreement.*

Anti-discrimination federal funds

Contracted providers agree not to discriminate against a member based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment, or type of illness or condition.

Contracted providers are obligated to comply with all laws applicable to individuals and entities receiving federal funds, including without limitation (i) the Civil Right Act of 1964, (ii) the Age Discrimination Act of 1975 and (iii) the Americans with Disabilities Act.

HIPAA

MCC of AZ (HMO SNP) and its contracted providers agree to comply with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and the implementing regulations under HIPAA and HITECH, as modified from time to time. Furthermore, MCC of AZ (HMO SNP) reserves the right to audit the contracted provider's written information security program, no less than once every three (3) years, to determine whether the program meets the requirements of the security regulations issued under HIPAA and/or HITECH.

Certification regarding lobbying

Contracted providers agree that no federally appropriated funds have been paid or will be paid to any person by, or on behalf of, the contracted provider for the purpose of influencing, or attempting to influence, an officer or employee of any agency, a Member of Congress or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. Contract provider agree to complete and submit, if required, a "Certification Regarding Lobbying" if payments to the contracted provider by MCC of AZ (HMO SNP) under this Agreement exceed $100,000.

If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing, or attempting to influence, an officer or employee of any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement and payment to the contractor by MCC of AZ (HMO SNP) under the agreement exceed

Section 2—Compliance

$100,000, the contracted provider shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," if required, in accordance with its instructions.

Contracted providers shall include in their subcontracts that exceed $100,000 a provision substantially similar to this section, including the requirement that a subcontractor shall certify and disclose as required.

Fraud and Abuse Prevention Policy; Whistle-blower protection

In accordance with Section 6032 of the Deficit Reduction Act of 2005 (DRA), contracted providers shall comply with MCC of AZ (HMO SNP) 's Fraud and Abuse Prevention policy, as revised from time to time by MCC of AZ (HMO SNP). Contracted providers shall make available to all employees and agents, and to the extent required by DRA his or her contractors, a copy of the MCC of AZ (HMO SNP) Fraud and Abuse Prevention Policy, including specific discussion of the provisions of the MCC of AZ (HMO SNP) Fraud and Abuse Prevention Policy in an employee handbook, if such agent or contractor has an employee handbook.

False Claims Act and related state laws

The federal False Claims Act (FCA) sets forth liability for any person who knowingly submits a false claim for payment to the government. As a recipient of federal funding from the Medicare program, MCC of AZ (HMO SNP) and all our employees and agents are bound by the FCA. MCC of AZ (HMO SNP) also receives funding from state Medicaid programs and is therefore subject to similar FCA laws at the state level in both Massachusetts.

Collectively, these FCA laws extend liability to anyone who knowingly makes a false assertion to get a false claim paid by the government or who causes another person to submit a false claim to the government. FCA laws also cover improper acts designed to get money from the government, but to avoid having to pay money to the government, and for those who conspire to violate the law.

MCC of AZ (HMO SNP) encourages you to report fraud or suspected fraud by contacting the Molina AlertLine:

- Phone: 1-866-606-3889
- Online address to report: https://molinahealthcare.alertline.com.

Non-discrimination

Contracted providers shall provide services to members on the same basis as it provides services for all patients; and providers may only deny, limit or condition the provision of services to a member on the same grounds as it denies, limits or conditions the provision of such services to others, subject to any applicable MCC of AZ (HMO SNP) policies or terms of the agreement. Contracted providers shall provide

covered services to members in a culturally competent manner, including members with limited English proficiency, limited reading skill and diverse cultural and ethnic backgrounds.

Medicare Advantage provisions

Contracted providers agree to comply with all state and federal laws, rules and regulations governing the Medicare Advantage program and CMS instruction which, if applicable, are expressly incorporated into the agreement and are binding upon the parties to the agreement.

Copays, coinsurance and deductibles

MCC of AZ (HMO SNP) may impose copays, coinsurance or deductibles (collectively known as member expenses) for covered Medicare Parts A and B services, which may also be amended from time to time. For members eligible for both Medicare and Medicaid (dual eligible members), the amount collected for member expenses may not exceed the amount that could be collected had the member otherwise been enrolled in original Medicare and Medicaid. Dual eligible members will not be responsible or billed for any member expenses for Medicare Parts A and B services when the AHCCCS program or MCC of AZ (HMO SNP) is responsible for paying those amounts. Contracted providers may accept our payment as payment in full or bill Medicaid in accordance with 42 CFR § 422.504(g) (1) (iii), effective January 1, 2010.

Federally required disclosures

Contracted providers agree to comply with state and federal law and disclose information as to business ownership and control, business transactions and criminal convictions.

In the event of any inconsistency between the Provider Handbook Section 2.3 and the MCC of AZ (HMO SNP) Contracted Provider Agreement, both parties agree that then-current state or federal laws, rules and regulations governing the Medicare Advantage program and CMS instructions, whichever are applicable, shall govern in order to ensure contracted providers' full compliance with all such current laws, rules, regulations and requirements.

Section 3—Quick Reference Guide

The MCC of AZ (HMO SNP) Quick Reference Guide is available in job-aid format to answer most commonly asked questions. It lists important telephone numbers, fax numbers and web URLs for most commonly needed resources. Additional information on quick reference topics is provided in the appropriate section of this handbook. A link to the Quick Reference Guide is found in the Appendix.

3.1 How to contact us

The Member Services department is your main contact for MCC of AZ (HMO SNP). If a representative can't help you directly, he or she will connect you with the department best able to handle your question or concern.

Member Services	
Phone:	1-800-424-4509
Provider Relations	
Phone:	1-800-424-4509
Email:	MCCAZProvider@magellanhealth.com
Provider Relations Fax:	1-888-656-0369 (Attn: Provider Relations)
Claims Department	
Claims inquiries:	1-800-424-4469
Paper claims address:	MCC of AZ (HMO SNP) P.O. Box 1105 Elk Grove Village, IL 60009-0987
Direct Member Reimbursement claims requests:	1075 Main Street, Suite 400 Waltham, MA 02451
Clinical Services Phone	1-800-424-4509
U.S. Mail	MCC of AZ (HMO SNP) 5055 E. Washington St., Suite 210 Phoenix, AZ 85034

Section 3—Quick Reference Guide

Utilization Management (UM) - Authorizations	
After hours phone:	1-480-209-8403
UM Physical Health prior authorization fax:	1-888-656-2390
PCP assessment fax:	1-888-656-2391
UM Behavioral Health prior authorization fax:	1-888-656-2598

3.2 How to contact MCC of AZ (HMO SNP) sub-contracted vendors

We use vendors to administer certain benefits:

Vision: Vision Services Plan (VSP): 1-800-615-1883

Section 4—Referrals & Authorizations

4.1 Referrals and authorizations

MCC of AZ (HMO SNP) does not require referrals for participating providers. Please refer to the MCC of AZ (HMO SNP) Provider and Pharmacy Directory. Prior authorization is required for certain services for contracted providers, please check the prior authorization grid on the website, www.mccofaz.com/dsnp. Refer to the authorization grid in the Appendix to determine whether a particular service requires an authorization.

Prior authorization is required for all non-contracted providers and facilities.

4.2 Non-participating physician authorizations

Members who choose non-participating specialty providers may not receive services without an authorization from MCC of AZ (HMO SNP). The MCC of AZ (HMO SNP) Provider and Pharmacy Directory is available on our website.

To request services from a non-participating medical specialist, complete and fax the Medicare Medical Prior Authorization Form, found on our website, to the confidential clinical fax line at 1-888-656-2390. A link to the form can be found in the Appendix. For a non-participating behavioral health specialist, please complete the Medicare Behavioral Health Authorization Form and fax it to 1-866-656-2598. We will provide an organizational determination letter via fax within 14 calendar days unless more time is needed to make a decision. We will notify the provider if we need more time to make a decision.

4.3 Durable Medical Equipment (DME) authorizations

DME provider requests must be faxed to MCC of AZ (HMO SNP) at 1-888-656-2390. The DME provider will supply us with all required DME codes. All vendor requests much be faxed to 1-888-656-2390. If a DME item or service is urgently needed, the vendor should call the UM department to have the request expedited.

4.4 Home Health authorizations

All Home Health services require prior authorization. To request authorization, complete and fax the Medicare Medical Prior Authorization Request Form, available on our website, to the confidential clinical fax line at 1-888-656-2390. We will advise you of our decision within 14 calendar days unless additional information is required to complete the request.

Section 4—Referrals & Authorizations

4.5 Other services requiring authorization

Refer to the Prior Authorization Grid on our website to determine if a particular service requires an authorization. To request authorization for other services, complete and fax the Medicare Medical Prior Authorization Request Form found on the MCC of AZ (HMO SNP) website to the confidential clinical fax line at 1-888-656-2390. For Behavioral Health services, please use the Medicare Behavioral Health Authorization Request Form on the website and fax it to 1-888-656-2598.

We will advise you of our decision within 14 calendar days unless additional information is required to complete the request.

4.6 Retroactive authorizations

To request a retroactive authorization for any medical service requiring authorization, complete and fax the MCC of AZ (HMO SNP) Medicare Medical Prior Authorization Request Form via confidential clinical fax to 1-888-656-2390. For Behavioral Health services, please use the Medicare Behavioral Health Authorization Request Form on the website and fax it to 1-888-656-2598.

For all requests, provide a detailed explanation regarding why the authorization is needed on a retroactive basis. For services provided more than 5 days prior to the request, the claim may be submitted, denied by MCC of AZ (HMO SNP) and then appealed.

Behavioral health retroactive authorizations

Retrospective review: A retrospective review is the process of reviewing and making a coverage decision for services that have already been received (post-service decision). The provider may have received a denial notice via a claims Explanation of Payment (EOP) due to lack of prior authorization; or, the provider became aware prior to a claims submission that a service rendered required an authorization prior to payment. A retrospective review can be submitted up to five (5) business days from the date of the discharge. Requests for retrospective review can be submitted via fax to 1-866-656-2598. Please fill out the Medicare Medical Prior Authorization Request Form and mark the box for retrospective review. For timely review of these requests, please also send all relevant clinical information with authorization request.

Providers who are unable to request a timely retrospective review for inpatient hospital admissions as a result of the following circumstances may request a medical necessity review via the post-service provider appeal (i.e. claim appeal) within 60 days of the date of the Explanation of Payment (EOP) denial:

- Claim Legitimately Submitted to the incorrect MCO – provider will need to include both of the following:
    - A copy of the Admit Form documenting the name of the MCO the member was enrolled in

  - A copy of the Remittance Advice documenting the denial of the claim as not being enrolled in the plan within 30 calendar days of the date of the EOP

- "John" or "Jane" Doe Admission – provider will need to submit a copy of the admission sheet or other supporting records documenting that the coverage was not known
- The service is directly related to another service for which prior approval has already been obtained and has already been performed
- The new service was not a known need at the time the original authorization was obtained

Please note: Post-service appeal requests that do not meet the above circumstances will not be medically reviewed and will be denied due to the facility's failure to obtain prior authorization. Additionally, post-service appeals received more than 60 days from the date of the Explanation of Payment (EOP) will be denied as untimely.

Non-hospital providers are expected to submit a pre-service authorization request to MCC of AZ (HMO SNP) prior to providing the service or care and cannot be accepted as a retrospective review. However, providers who had an authorization denied or voided for the following reason may request a medical necessity review via the post-service provider appeal (i.e. claim appeal) process within 60 days of the date of the Explanation of Payment (EOP) denial:

- The authorization was voided due to the member's eligibility reflecting primary insurance through another provider at the time the authorization was requested, resulting in the authorization being voided.

Please note that regardless of the outcome of the post-service appeal, members are held harmless and have no financial liability for the services rendered.

4.7 Inpatient authorizations

Authorization numbers require clinical information. Authorization will be denied if clinical information is not received from the provider. Clinical information is required within one day for urgent and non-urgent pre-service inpatient admissions, medical admissions and urgent pre-service outpatient services. Information can be called in to 1-800-424-4509 for medical requests. When leaving a recorded message, please include your name and phone number, the member's name and MCC of AZ (HMO SNP) ID number, and the date of admission so that a clinical staff member can return your call.

For behavioral health inpatient requests, please call 1-800-424-4509. Alternatively, please fill out the Medicare Behavioral Health Authorization Request Form and fax it along with all relevant clinical information to 1-888-656-2598.

Section 4—Referrals & Authorizations

4.8 Pharmacy authorizations

A small number of drugs require prior authorization. Other exceptions to the standard formulary require specific documentation. Refer to Section 7 (Pharmacy: Requesting an exception) for instructions specific to the situation.

Section 5—Claims

5.1 Billing procedures

The information provided here enables providers to comply with the policies and procedures governing MCC of AZ (HMO SNP).

MCC of AZ (HMO SNP) pays clean claims submitted for covered services provided to eligible members. In most cases, we pay clean claims within 30 days.

A remittance advice is provided for all claims payments. The remittance advice addresses paid and denied, but not pended, claims. We accept both electronic and paper claims.

All claims received must comply with the Health Information Portability and Accountability Act (HIPAA). Industry-standard diagnosis codes and procedure codes are required.

A clean claim must be submitted within 90 days of the date of service or discharge and/or within your specific contract terms. When a member's care is ongoing, a claim must be submitted within 90 days of the last day of the month. We request that providers bill every 30 days. The final bill must be received within 90 days of the last date of service.

Interim billing may be used for inpatient hospital admissions, skilled nursing facility admissions, hospice admissions and other types of ongoing care.

Claims should be billed in accordance with CMS' Correct Coding Initiative (CCI) guidelines. MCC of AZ (HMO SNP) processes claims utilizing CCI-based claims editing software and may deny services that do not conform to CCI guidelines. MCC of AZ (HMO SNP) coverage includes only Medicare services. Medicaid services should be billed to the member's Medicaid plan.

When modifiers are utilized in billing and effect pricing, it is important to place those pricing modifiers in the 1st and 2nd modifier positions on the claims (paper and EDI transactions). All other modifiers can follow thereafter. When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe (untimed CPT/HCPCS), the provider enters '1' in the field labeled units.

For untimed codes, units are reported based on the number of times the procedure is performed as described in the CPT/HCPCS code definition (often once per day).

Example: A beneficiary received a speech-language pathology evaluation represented by HCPCS - untimely code 92506. Regardless of the number of minutes spent providing this service, only one unit of service is appropriately billed on the same day.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one-on-one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on any single calendar day using CPT codes and the appropriate number of 15-minute units of service.

Example: A beneficiary received occupational therapy (HCPCS - timely code 97530 which is defined in 15-minute units).

5.2 Clean claims

Unless otherwise stated in the provider contract, all providers must submit clean claims, both initial and corrected, to MCC of AZ (HMO SNP). The start date for determining the timely filing period is as follows:

- CMS-1500/837P claims: measured by the 'from' date of service
- UB-04/837I claims: measured by the 'thru' date of service

Unless prohibited by federal law or CMS, MCC of AZ (HMO SNP) may deny payment of any claims that fail to meet the submission requirement for a clean claim or failure to submit timely.

MCC of AZ (HMO SNP) defines a clean claim as a claim that has no defect, impropriety or lack of substantiating documentation, complies with standard CMS coding guidelines and/or other government program requirements, where applicable, and requires no further documentation, information or alteration in order to be processed and paid timely.

To be considered a clean claim, claim must be submitted on the appropriate claim form, either in electronic format or CMS-1500/UB-04 (or alternative), and have the required fields completed. Electronically submitted claims must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions.

The following information is required for all claims.

- Member name
- Member date of birth
- Member MCC of AZ (HMO SNP) member ID number

Section 5—Claims

Provider information

- Servicing provider name
- Servicing provider address
- Servicing provider NPI number
- Billing provider group name and address, if applicable
- Billing provider NPI number
- Billing provider federal tax identification number (TIN)
    - TIN/NPI number combination must match the W-9 information on file with MCC of AZ (HMO SNP)

Service level information

- Date of service (from and to)
- Valid diagnosis codes (ICD-9 or ICD-10 as of 10/1/15)
- Place of service/bill type
- Procedure code (CPT-4, HCPCS or successors) and/or revenue code
- Modifier, as required
- Units, properly measured (per visit, per minute, etc.)
- Total billed charge

5.3 Non-clean claims

A non-clean claim is a claim that requires corrected data, additional information or further investigation in order for it to be processed.

The following are considered non-clean claims:

- Claims to be investigated for coordination of benefits, subrogation or worker's compensation
- Claims that require medical records for processing
- Claims that include billing for non-covered services
- Claims that include billing for unlisted procedures
- Claims lacking any of the required element of a clean claim

Section 5—Claims

5.4 Electronic Data Interchange (EDI) claims

Independence Care Systems accepts electronic claims through EDI as its preferred method of claim submission. All files submitted to MCC of AZ (HMO SNP) must be in the ANSI ASC X12N format, version 5010A or its successor version.

Claims submitted via EDI must comply with HIPAA transaction requirements. EDI claims are to be sent via clearing house. We work with Change Healthcare and Ability Network.

For claims to be routed to Independence Care Systems, please be sure to include our payer ID number — MCC01. This pin is the identifier at the clearinghouse to route claims directly to the Claims Operations Department.

Type	Format	Submit to
EDI – Institutional claims	HIPAA compliant 837-i format	EDI Payer ID MCC01
EDI – Professional claims	HIPAA compliant 837-p format	EDI Payer ID MCC01
Paper and correct claims	CMS-1500 or UB-04	MCC of AZ (HMO SNP) Claims Department P.O. Box 1105 Elk Grove Village, IL 60009-1105
Appeals	Claims appeal form and any additional documentation	MCC of AZ (HMO SNP) Claims Department 1075 Main Street, Suite 400 Waltham, MA 02451
EDI Support: If you are currently submitting via Change Healthcare, you should have a login for the ON 24/7 website. ON 24/7 is a web-based system that allows customers to submit service requests and check on the state of those requests 24 hours a day, 7 days a week. Please contact Change Healthcare directly at 1-888-363-3361 or visit the ON 24/7 website at http://clientsupport.emdeon.com/login.aspx.		

The bill frequency in CLMO5-3 indicates the claim is an original, replacement or void. For example, a value of ‘7’ represents a replacement claim and a value of ‘8’ represents a void claim.

1	Indicates the claim is an original claim
7	Indicates the new claim is a replacement or corrected claim. The information present on this claim represents a complete replacement of the previously issued claim.
8	Indicates the claim is a voided/canceled claim.

For a replacement or a void, the payer assigned claim number for the last known claim being replaced is sent in Loop 2300, REF02 where REF01 is equal to F8.

5.5 Paper claims submissions

MCC of AZ (HMO SNP) accepts submissions of properly coded claims from providers by Electronic Data Interchange (EDI) or standard paper claims. The provider acknowledges and agrees that each claim submitted for reimbursement reflects the performance of a covered service that is fully and accurately documented in the member's medical record prior to the initial submission of any claim. No reimbursement or compensation is due should there be a failure in such documentation.

We encourage all providers to submit electronic claims whenever possible. We recognize, however, that some providers may choose to submit for reimbursement using industry-standard paper claim forms. If the provider does submit paper claim forms, both CMS 1500 and UB 04 are acceptable.

All paper claims must be submitted on original claim forms (red ink on white paper). Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.

All information must be aligned with the data fields and must:

- Be typed (do not print, hand write or stamp any extraneous data on the form)
- Be in black ink
- Be in a large dark font, such as Pica or Arial, size 10, 11 or 12 point
- Be in capital letters
- Have all required fields populated in order to be considered a clean claim
- Have all fields completed entirely and accurately
- Be submitted in a 9" x 12" or larger envelope
- Include the correct NPI
- Include the correct member ID number

The typed information must not have:

- Broken characters
- Incorrect NPI
- Incorrect member ID number

5.6 Replacement submissions

Replacement and void claims should be submitted electronically using industry-standard claim frequency codes. Providers may submit corrected claims via EDI to correct both paid and denied claims that were previously submitted and processed.

Corrected claims must include:

- The original or last paid claim number
- An indication of these item(s) needing correction
- Submission within 30 days of the original claims Remittance Advice (RA) date

Corrected claims must not include:

- Handwritten changes
- Correction fluid

A replacement is sent when an element of data on the claim was either not previously sent or needs correction. Examples include incorrect dates of service or units.

To qualify for a replacement, certain identifying information must remain the same. If these values change, the prior claim must be voided and a new claim sent with the appropriate frequency.

- Provider (2010AA Loop)
- Patient (either 2010BA or 2010CA Loop)
- Payer (2010BB Loop)
- Subscriber (2010BB Loop)
- Institutional statement period (2300, DTP Segment)

*Enter claim frequency type code (billing code) in the 2300 loop in the CLM*05 03.*
*Enter the original or last paid claim number in the 2300 loop in the REF*F8*.*

Section 5—Claims

5.7 Void submissions

When identifying elements change, a void submission is required to eliminate the previously submitted claim. The entire claim must match the original with the exception of the claim frequency code, condition code and payer assigned claim number.

> Example: Incorrect provider, patient, payer, insured and statement period on an institutional claim or patient did not want insurer to be billed for services.

There is no need to send negative values on a void claim. The claim frequency code indicates that the values are negated. If a new original is required after the void, you should verify the void is finalized prior to sending a new one to avoid duplication.

5.8 Correcting/void — paper HCFA 1500 claims

For profession claims, the provider must include the original or last paid claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified.

Claim form:	CMS 1500
Box number:	22. Medicaid Resubmission and/or Original Reference Number
Instructions:	When resubmitting a claim, enter the appropriate claim frequency code left justified in the left-hand side of the field: 7- Replacement of prior claim 8- Void/cancellation of prior claim

Example:

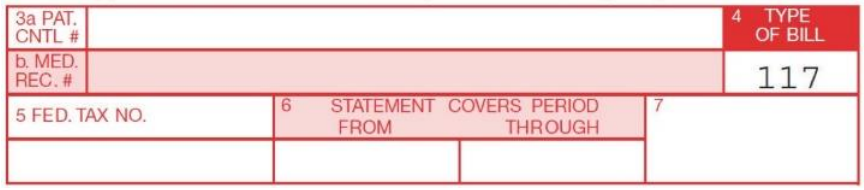
5.9 Correcting/void — paper UB04 claim

For institutional claims, the provider must include the original or last paid claim number and bill frequency code per industry standards.

Section 5—Claims

Example:

Box 4 – Type of Bill: the third character represents the "Frequency Code"



5.10 Claims appeals

A claim appeal is a provider's written notice to MCC of AZ (HMO SNP) challenging, contesting, appealing or requesting reconsideration of a claim or a bundled group of substantially similar claims that are individually numbered and have been denied or adjusted. Claims appeals must be submitted in writing to the MCC of AZ (HMO SNP) Claims Department. Appeals must be submitted on the Provider Payment Dispute and Adjustment Form found on the MCC of AZ (HMO SNP) website.

The appeal must include:

- Provider's tax ID number
- Provider's contact information (an individual person's name and phone number)
- Claim number(s)
- MCC of AZ (HMO SNP) member's ID number
- Date of service
- CPT or HCPCS codes
- Authorization number (if authorization was required)
- A clear explanation of basis upon which the provider believes the payment amount (denial or adjustment), the request for additional information, the request for reimbursement for the underpayment of the claim or other MCC of AZ (HMO SNP) action is incorrect.

When submitting multiple batches of claim appeals:

- Sort appeals by similar issue or by individual member name
- Provide a Provider Payment Dispute and Adjustment form for each batch that gives a summary description of all the batches
- Number each Provider Payment Dispute and Adjustment form

Mail via U.S. Mail to:

MCC of AZ (HMO SNP)
Attn: Claims Operations Department
1075 Main Street, Suite 400
Waltham, MA 02451

5.11 Incomplete provider claim appeals

Provider appeals that do not include all required information as listed above will be returned to the submitter for completion. Appeals will be closed if complete information, as requested, is not received within 30 days of the request for additional information.

Payment disputes include those:

- Seeking resolution of billing determination (adjusted, denied, paid incorrectly or overpaid)
- Disputing a request for recovery of overpayments
- Seeking resolution of a contractual issue

If you believe MCC of AZ (HMO SNP) is paying an amount different than was contractually agreed upon, please direct your dispute to Member Services at 1-800-424-4509.

Member appeals are appeals made by a provider on behalf of a specific member. Please direct member claim appeals to the MCC of AZ (HMO SNP) Quality Department at 1-617-494-5353. See Section 7—Membership and eligibility for more information on filing member appeals.

Incomplete or incorrect claims

If a claim is found to be incomplete or incorrect, the claim will be denied and an appropriate reason code will appear on the remittance advice. For example, an NPI number and provider name may not match or a quantity may not have been specified when one was required. The claim may be resubmitted with the requested information.

MCC of AZ (HMO SNP) does not discriminate or retaliate against providers due to appeals.

Section 6—Membership & Eligibility

6.1 Eligibility inquiry

MCC of AZ (HMO SNP) strongly recommends that providers confirm member eligibility prior to every scheduled service. For emergency services, please verify eligibility as soon as possible following provision of the service. We provide a number of tools for checking eligibility but prefer that providers use online tools. Please visit the MCC of AZ (HMO SNP) Provider Portal at https://www.mccofazprovider.com/providerportalaz/.

6.2 Filing an appeal or grievance on behalf of a member

A physician may, when acting on behalf of a member, file an appeal or grievance. You must have the member's written consent to do so. To be appointed as a member's representative, both the member making the appointment and the representative accepting the appointment must sign, date and complete an Appointment of Representation form. A non-clinical representative may also complete and sign the form with the member's consent. Call Member Services at 1-800-424-4509 to request a form.

To file an appeal or grievance on behalf of a member, call or write to us at:

Appeals	Grievances
MCC of AZ (HMO SNP) Quality Department – Appeals 1075 Main Street, Suite 400 Waltham, MA 02451 Phone: 1-617-551-5053 Fax: 1-855-838-7998	MCC of AZ (HMO SNP) Member Services -- Grievances 1075 Main Street, Suite 400 Waltham, MA 02451 Phone: 1-617-551-5053 Fax: 1-855-838-7998

Appeals

MCC of AZ (HMO SNP) members have the right to appeal a service decision made by us that terminates, suspends or reduces a previously authorized service; denies a requested service or delays providing or arranging for a service.

Section 6—Membership & Eligibility

Appeals procedure

Appeals will be answered in writing within 30 days of the date of receipt. If a delay is in the interest of the member, we may request a fourteen (14) calendar-day extension.

If information from the physician or other sources indicate that waiting the 30 days could jeopardize the member's life, health or ability to regain maximum function, the appeal will be expedited. Expedited appeals must be resolved within 72 hours.

Grievances

A grievance is any member complaint or dispute expressing dissatisfaction with any aspect of the operations, activities or behavior of a plan sponsor, regardless of whether remedial action is requested. Grievances also include complaints regarding the timeliness, appropriateness of, access to and setting of a provided services, procedure or item.

A provider, when assigned by the member, may file a grievance on behalf of a member within 60 days of the event precipitating the grievance. Grievances regarding quality of care may be filed beyond the 60-day time frame, but no later than 180 days following the event.

Grievance procedure

Typically, MCC of AZ (HMO SNP) Member Services handles routine matters and attempts to resolve problems immediately. If the grievance can't be immediately resolved or is more complicated, we may ask you to submit additional information.

Grievances regarding quality of care will be investigated by the quality department. MCC of AZ (HMO SNP) will notify the member and/or the member's designated representative of our findings in writing within 30 days of filing the grievance or 44 days if an extension was granted.

We will send a Notice of Plan's Decision Regarding a Grievance for all quality of care grievances and for other types of grievances as applicable.

6.3 Referring a prospective member (patient)

MCC of AZ (HMO SNP) offers many options to providers to help them inform patients of the opportunity to join our plan. If you wish to refer prospective members, please note we will not reach out to prospective members without a direct request from that patient or the patient's designated representative. We operate a telephone line dedicated to taking prospective member inquiries. The line is staffed by trained and licensed representatives. Patients should call 1-800-424-4505.

Section 6—Membership & Eligibility

Business reply cards

We also offer informational brochures and office displays that are available in several languages. These brochures contain a business reply card. A patient may request a call from an MCC of AZ (HMO SNP) outreach representative for more information or to schedule an appointment by completing the requested information on the card and sending it to MCC of AZ (HMO SNP). Please call 1-800-424-4505 for details.

We can also work with you to facilitate and develop a mailing to potential members. Providers may send a CMS-approved letter to patients to inform them of the opportunity to join our plan. Please call 1-800-424-4505 for information.

On-site outreach

Your practice may arrange to have an MCC of AZ (HMO SNP) representative on-site for informational sessions for potential members. Please call 1-800-424-4505 to schedule.

6.4 Who is eligible to become a member of MCC of AZ (HMO SNP)

Individuals may join MCC of AZ (HMO SNP) if they:

- Are a United States citizen or are lawfully present in the United States
- Live in Maricopa, Gila or Pinal counties
- Have both Medicare Parts A and B
- Are eligible for full Medicaid benefits
- Do not have end stage renal disease (ESRD)

Exclusions include:

- Those diagnosed with end stage renal disease

An MCC of AZ (HMO SNP) outreach representative will further assess eligibility and assist the applicant with enrollment.

6.5 Members who want to change PCPs

MCC of AZ (HMO SNP) members may change their PCP at any time for any reason. If you become aware of a member's desire to change their PCP, please advise them to call Member Services at 1-800-424-4509.

Section 6—Membership & Eligibility

6.6 Member benefits

MCC of AZ (HMO SNP) members receive all the Medicare and Part D Prescription Drug Program benefits. They also receive Medicaid benefits either through MCC of AZ or another managed care organization.

A full description of MCC of AZ (HMO SNP) benefits is available in the annual Summary of Benefits and the annual Evidence of Coverage. To request paper copies, call Member Services at 1-800-424-4509 or download these documents from www.mccofaz.com/dsnp.

6.7 Copays, coinsurance and deductibles

MCC of AZ (HMO SNP) members receive covered services paid in full:

- No deductibles
- No coinsurance

Depending on a member's LIS level, they may be responsible for a prescription drug copay.

6.8 Additional benefits

MCC of AZ (HMO SNP) members receive additional health and wellness benefits not covered by traditional Medicare or AHCCCS. You may encourage your patients to take advantage of these:

- Annual vision exam and $200 every 2 years for eyeglasses
- Annual hearing exam and $1,250 every 3 years for hearing aids

Preventive health and disease management programs

We offer the following programs designed to help members and their caregivers better understand chronic conditions or prevent falls. These programs use population-based interventions to help members develop self-management skills that may improve health outcomes, or to assist caregivers in improving outcomes for the member. Programs include:

- Cardiovascular disease (CVD)
- Diabetes
- Fall prevention
- Congestive heart failure (CHF)

Health and disease management program components can include:

- Educational materials that can assist your patients with nutrition, fitness, medication compliance, fall prevention or disease facts
- In-person educational interventions by a visiting MCC of AZ (HMO SNP) care coordinator
- Appointment reminder and access to PCPs if needed
- Coordination of home health and durable medical equipment (DME)
- Coordination with Medicaid benefits

Physicians may refer members or members may self-refer. Caregivers may also refer members. Members are automatically opted in to a management program if referred or assigned based on diagnosis; however, members may opt out at any time.

We may inform you about gaps in care related to these programs.

Transitions of care

MCC of AZ (HMO SNP) promotes continuity of care between care settings to assist member transitions and to reduce the potential for hospital/facility readmission during periods of high vulnerability. Our care coordinators actively engage in transition planning and follow-up including facilitating physician communication and follow-up visits, as well as medication management. Services are provided for all members; no requests are necessary. For more information on transitions of care, see Section 12—MCC of AZ (HMO SNP) Care Model, Transitions of Care.

6.9 Enrollment & Disenrollment

Enrollment

New MCC of AZ (HMO SNP) members are enrolled effective on the first day of the month. Upon enrollment, all members are assigned a risk level. New members will receive a telephonic triage assessment. Those who are deemed high are assessed by a care coordinator in their homes. Those deemed to be low risk receive a telephonic assessment. For more information on these procedures, see the care coordination section.

All new members receive a welcome call from Member Services in their own language.

Section 6—Membership & Eligibility

Disenrollment -- voluntary

Members with Medicare can only change health plans at certain times during the year. An individual can enroll in, or disenroll from, MCC of AZ (HMO SNP) once per quarter during the first nine months of the calendar year. From October 15 to December 7, a member can join, switch or drop a Medicare health or drug plan for an effective date of January 1 of the following year.

There are other Medicare special election periods (SEPs) that would allow members to change plans, that are independent of the above guidelines.

A provider who becomes aware of a member's wish to disenroll should advise the member or the member's representative to contact MCC of AZ (HMO SNP) at 1-800-424-4509. Members with Medicare Part D Prescription Drug coverage will need assistance with the transition. The Member Services team will be able to determine if the member is eligible to make a change in accordance with the Medicare enrollment regulations.

MCC of AZ (HMO SNP) will ensure the member understands when their disenrollment becomes effective. We advise members about the transition back to Medicare and Medicare Part D or another health plan.

Disenrollment -- involuntary

MCC of AZ (HMO SNP) may disenroll a member involuntarily for a number of reasons. The most common reason for involuntary disenrollment is loss of AHCCCS eligibility. We regularly monitor members' AHCCCS eligibility. If a member needs to complete a redetermination application for AHCCCS, we will attempt to assist the member in order to meet the deadline and avoid disruption of service.

If an enrollee loses their Medicaid eligibility, but can reasonably be expected to regain eligibility within one month, the enrollee is still eligible for membership in our plan during a period of deemed continued eligibility. The period of deemed continued eligibility begins the first of the month following the month in which information regarding the loss of Medicaid is available to the organization and communicated to the enrollee. MCC of AZ (HMO SNP) must continue to provide care for one full calendar month, as long as the plan can provide appropriate care.

Examples of voluntary disenrollment	Examples of involuntary disenrollment
• Member wishes to change plans • Member wishes to return to fee-for-service Medicare or AHCCCS coverage • Member wishes to see an out-of-network PCP	• Member loses AHCCCS eligibility • Member stayed outside the plan service area for more than 6 consecutive months • Member permanently relocated outside the service area • Fraud or abuse

Disenrollment – Retroactive

A small percent of MCC of AZ (HMO SNP) members are retroactively disenrolled from the plan. The typical reason for retroactive disenrollment is a determination by AHCCCS that the member lost eligibility. AHCCCS makes these determinations.

Please refer to the Section 5—Claims for information on the financial implications of retroactive disenrollment.

6.10 MCC of AZ (HMO SNP) member ID card

MCC of AZ (HMO SNP) member ID cards list the member's name and date of birth, the plan ID number, the plan membership effective date and MCC of AZ (HMO SNP) contact information. See the Appendix for a sample ID card.

6.11 Member rights and responsibilities

Member rights

MCC of AZ (HMO SNP) is dedicated to providing quality health care services for our members and to treating each member with dignity and respect. Member rights include the right to:

- Receive information about MCC of AZ (HMO SNP) services, practitioners and providers, enrollment, informational or instructional materials, grievance and appeal rights, and the member's rights and responsibilities annually in a manner appropriate to their condition and ability to understand;
- Receive reasonable accommodations if required;
- Be treated with respect and recognition of their dignity and their right to privacy;
- Participate with practitioners in making decisions about their health care, including the right to refuse treatment;

- Have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Voice complaints or appeals about MCC of AZ (HMO SNP) or the care provided;
- Make recommendations regarding MCC of AZ (HMO SNP)'s member rights and responsibilities policy;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Request and receive a copy of their medical records and request that the record by amended or corrected;
- Not to be balanced billed by a provider for any service;
- Receive updates and/or changes to the rights and responsibilities at least annually;
- Receive access to the Evidence of Coverage annually; and
- Exercise their member rights without negative consequences.

Member responsibilities

MCC of AZ (HMO SNP) defines basic member responsibilities to include the following:

- Provide, to the extent possible, information MCC of AZ (HMO SNP) and its practitioners and providers need in order to care for a member;
- Follow the agreed upon plans and instructions for care;
- Be familiar with covered services and the rules the member must follow to obtain the covered services;
- Inform MCC of AZ (HMO SNP) if there is any other health insurance coverage or prescription drug coverage in addition to the MCC of AZ (HMO SNP) plan;
- Tell their doctors and other health care providers they are enrolled in MCC of AZ (HMO SNP);
- Help doctors and other providers help the member by giving the doctors and providers information, asking questions and following through on the care plan;
- Be considerate by respecting the rights of other patients and acting in a way that is respectful of a health care practitioner or provider and staff;
- Pay any health care bills owed;
- Tell MCC of AZ (HMO SNP) if there is a change of residence; and
- Call Member Services for help when there are questions or concerns.

Section 6—Membership & Eligibility

6.12 Member complaints about office settings

MCC of AZ (HMO SNP) will conduct a site visit if we receive three (3) or more member complaints in a 12-month period about an office site (including cleanliness or access); or if a practice-specific survey detects a deficiency; or if an unfavorable report is received as a result of a provider relations site visit.

- MCC of AZ (HMO SNP) Network and Quality will schedule an on-site office review within 60 days of receipt of the third member complaint or detection of a deficiency.
- If requested by the practice, the MCC of AZ (HMO SNP) representative will sign an appropriate confidentially agreement provided by the practice.
- Site reviews shall be conducted during normal business hours at a time acceptable to the practice and in a manner so as not to unreasonably interfere with practice operations.
- A trained MCC of AZ (HMO SNP) Quality staff person will conduct the site review using the MCC of AZ (HMO SNP) Office Site Visit Checklist — Office Evaluation Survey Tool. A member of the office practice staff may accompany the MCC of AZ (HMO SNP) reviewer during the entire site review.
- Results of the office visit evaluation will be provided to the practitioner with any corrective action plan required.
- If deficiencies are noted, the site must develop and submit a corrective action plan for improvement within 30 days of notification of the office visit results.
- Once an action plan has been submitted and approved by MCC of AZ (HMO SNP), an MCC of AZ (HMO SNP) site representative shall evaluate the site at least every six (6) months and shall reassess each area where a deficiency is noted until the performance standard for that area has been met.

Section 7—Pharmacy

7.1 Contact information

MCC of AZ (HMO SNP) pharmacy technicians and clinical pharmacists are available via phone to review Medicare Part D medication coverage requests, discuss coverage denials, review complex medication regimens or answer any pharmaceutical questions you may have. Please use the contact information below to make any request.

Phone:	1-617-252-6366
Toll free:	1-855-818-4876
Hours of operation:	Monday – Friday, 8 a.m. to 8 p.m. ET
After hours:	1-855-818-4876 A pharmacist is on call from 8 a.m. to 8 p.m. EST on weekends and holidays
Fax:	1-844-810-2659
Email:	swhpharmacy@magellanhealth.com
Pharmacy prior authorization and coverage determination requests fax number:	1-888-251-7823

7.2 Resources

The following resource materials are located on our website at www.mccofaz.com/dsnp:

- Comprehensive Formulary
- Prior authorization criteria
- Prior authorization forms
- Step therapy criteria
- Information about quantity level limits
- Transition fill policy
- Medication Therapy Management program
- Recent drug recalls

Section 7—Pharmacy

The most up-to-date documents are posted on our website the same day changes take effect. We will also remind you of recent formulary changes in your quarterly Provider Newsletter.

7.3 MCC of AZ (HMO SNP) pharmacy benefits

MCC of AZ (HMO SNP) pharmacy benefits include medications in two benefit categories:

1. **Medicare Part D-eligible formulary:** MCC of AZ (HMO SNP) reviews and updates an extensive formulary on an ongoing basis. Members may have a copay for Part D formulary drugs or drugs approved by us, depending on their LIS level.
2. **Medicare Part B drugs provided at the pharmacy:** Some oral, injectable or inhaled prescription drugs may be eligible for payment under either Part B or Part D. When the claim is submitted by a pharmacy, MCC of AZ (HMO SNP) pharmacy will determine the correct benefit and pay the claim. Members will have no cost share for Part B drugs. See Section 5 for physician billing instructions for Part B claims submitted by a prescriber or a provider.

Vaccines

- MCC of AZ (HMO SNP) provides coverage for Part B and Part D covered vaccines for our members.
- Vaccines can be administered and billed by a provider or a pharmacy.
- Claims processors and plan sponsors must provide a method for physicians and pharmacists to be able to bill for vaccines and the administration of vaccines regardless of whether the vaccine is covered under Medicare Part B or Part D.
- Physicians that purchase and administer Part D covered vaccines in their office must bill for the vaccine and administration through an intermediary such as TransactRX.
  - To enroll in Transact Vaccine Manager, visit https://www.mytransactrx.com
  - Please contact TransactRX directly at 1-866-522-EDVM (386) to submit Part D-covered vaccine claims or visit https://www.mytransactrx.com
- When billing Transact Vaccine Manager for Part D vaccines, you must also submit the administration code.
- Do not bill the member for administration of Part D vaccines. Transact Vaccine Manager will reimburse you directly for both the vaccine and its administration costs. Part D-covered vaccines must be submitted within 30 days of administration.

When you are administering a vaccine that has been provided by the member or their pharmacy, you may submit the administration code directly to MCC of AZ (HMO SNP), regardless of whether the vaccine is a Part B or a Part D vaccine. Never charge a member for the cost of administering a vaccine.

The chart below provides a list of common Part B and Part D vaccines.

Section 7—Pharmacy

Part B	Part D	
INFLUENZA: AFLURIA EZ FLU FLUARIX FLUBLOK FLUCELVAX FLULAVAL FLUMIST FLUVIRIN FLUZONE PHYSICIANS EZ USE FLU **PNEUMOCOCCAL:** PNEUMOVAX PREVNAR 13 SINGLE USE EZ FLU **HEPATITIS B SINGLE:** ENERGIX-B*	ACTHIB ADACEL BCG VACCINE BEXSERO BOOSTRIX CERVARIX COMVAX DAPTACEL DTAP DIPHTHERIA-TETANUS ENGERIX-B* GARDASIL HAVRIX HIBERIX IMOVAX RABIES INFANRIX DTAP IPOL IXIARO KINRIX M-M-R II MENACTRA MENHIBRIX	MENOMUNE-A-C-Y-W-135 MENVEO A-C-Y-W-135-DIP MUMPSVAX PEDIARIX PEDVAXHIB PENTACEL PROQUAD QUADRACEL DTAP-IPV RABAVERT RECOMBIVAX-HB SHINGRIX TENIVAC TETANUS-DIPH TETANUS-TOXOID TRUMENBA TWINRIX TYPHIM VI VAQTA VARIVAX YF-VAX ZOSTAVAX

Drugs excluded from the benefit

In general, drugs not covered by Medicare are not covered by MCC of AZ (HMO SNP).

7.4 Drugs with special requirements or restrictions

Drugs requiring an exception

Certain drugs and certain situations require a pharmacist review for coverage. All drugs requiring review are noted in the formulary as having a restriction (e.g. prior authorization) or are not listed in the formulary.

Our formulary is updated monthly. For the most up-to-date formulary, visit our website at www.mccofaz.com/dsnp.

Process for a formulary exception

Providers may request coverage from MCC of AZ (HMO SNP) by:

- Using our website at https://dsnp.mccofaz.com/documents/rx-coverage-determination-form.pdf/

Section 7—Pharmacy

- Sending an email to swhpharmacy@magellanhealth.com
- Faxing us at 1-888-251-7823
- Calling 1-855-818-4876

If you need clarification regarding special requirements or restrictions, please call us at 1-855-818-4876. For immediate resolution, please call us.

MCC of AZ (HMO SNP) sends all approval and denial notifications to the requesting provider's office via fax. If fax is unavailable, we will provide either verbal or written (mailed) notification with required timeframes. All exception request decisions are made within 72 hours of receipt of a complete supporting statement. A prescriber can request an expedited exception decision, which will be made within 24 hours of receipt of the complete supporting statement. Most decisions, both standard and expedited, are made sooner than the required turnaround time. Prior authorization expedited decisions are made within 24 hours of receipt of the request.

Beginning March 1, 2020

Certain Medicare Part B medications administered in an outpatient or office setting (typically billed with an HCPCS J code and NDC number) will require prior authorization for payment. A list of these drugs is available in the Appendix. Since changes may occur from time to time, please check the list on our website at www.mccofaz.com/dsnp.

To obtain prior authorization, please do the following:

- Fax the prior authorization request to the Clinical Utilization Management team at 1-888-656-2389
- Include supporting clinical documentation
- Provide any previous treatment history information
- Recommendation: include the Medicare Medical Prior Authorization Request Form as a header for all prior authorization requests, using service type Ambulatory/Outpatient, Infusion or Oncology Drugs
- Forms are available at www.mccofaz.com/dsnp

Prior authorization (PA)

Drugs requiring prior authorization require clinical information from your office. Use the PA form available on our website. The form is referenced in the Appendix.

Section 7—Pharmacy

Step therapy (ST)

Certain drugs require that a member try one drug or group of drugs before going to the next drug or group of drugs. If the member has tried the pre-required drugs within the specified timeframe, the next step will be processed without office intervention. If step therapy is not appropriate for the patient, call the MCC of AZ (HMO SNP) prior authorization team for an exception. Criteria are available on our website.

Quantity limits (QLL)

For certain drugs, MCC of AZ (HMO SNP) limits the quantity that can be prescribed per time period. Quantity limits are specified for clinical and/or cost reasons. We do not require tablet splitting; however, dosage consolidation is required. A pharmacy or the plan Pharmacy Department may call to suggest alternative quantities of the same drug. Exceptions are granted when titrating a drug dosage up or down. A list is available on the MCC of AZ (HMO SNP) website.

Medicare Part B vs. Medicare Part D

Medications may be covered by different parts of Medicare depending on the diagnosis. For example, anti-emetics, when used in conjunction with chemotherapy, are covered under part B. Whereas, they are typically covered under Medicare part D. Both Part B and Part D drugs are covered by MCC of AZ (HMO SNP). A diagnosis is needed in order to categorize medications for specific members. Include the diagnosis when writing prescriptions.

7.5 Quantity supply per prescription

30- or 90-day supplies

Pharmacies are contracted to provide either a 30-day or 90-day supply of medications per prescription. Prescribers are encouraged to write 90-day prescriptions, as appropriate, as many network pharmacies will provide a 90-day supply of medications. Members may also order 90-day supplies from MRx Mail Order Pharmacy. Physicians may advise members to call MCC of AZ (HMO SNP) Member Services to find the most convenient 90-day pharmacy.

Vacation supplies

90-day supplies mitigate the need for special vacation prescriptions. We grant vacation overrides as needed (refills ahead of schedule and/or larger-than-usual quantities). Supplies of greater than 90 days require special authorization by MCC of AZ (HMO SNP).

Section 7—Pharmacy

Lost medications

There is no need for authorization for your office unless a pattern is detected. A member, physician or pharmacist may call for an override if a medication was lost or left behind.

7.6 Medication Therapy Management (MTM)

Managing medications appropriately keeps our members out of hospitals and nursing homes. MTM is available to all members. We contract with a vendor that uses both retail and consultant pharmacists to meet with and counsel patients about their medication use. Providers can make special requests for these services. Call our Pharmacy Department at 1-855-818-4876 to refer a patient.

7.7 Medication Recall Notifications

MCC of AZ (HMO SNP) pharmacists monitor FDA notifications for drug recalls. All recent drug recalls are listed on our website with a link to the FDA recall notice.

FDA definitions

Class I recall: A situation in which there is a reasonable probability that the use of or exposure to a violative product will cause serious adverse health consequences or death.

Class II recall: A situation in which use or exposure to a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.

Class II recall: A situation in which use of or exposure to a violative product is not likely to cause adverse health consequences.

Please contact our Pharmacy Department at 1-855-818-4876 with any questions about drug recalls.

Section 8—Primary Care Providers

8.1 Interdisciplinary care team (ICT) and responsibilities

MCC of AZ (HMO SNP) forms an interdisciplinary care team (ICT) for certain members. The ICT is designed to assist providers with management of members with complex care needs by offering resources to coordinate medical and non-medical services, such as transportation, personal care, homemaking and medication management.

The ICT is comprised of the member, caregivers, primary care provider (PCP) or clinical designee at the practice, plan care coordinator, Behavioral Health provider if applicable, pharmacist and other team members as required to meet the member's needs. The PCP or practice designee provides clinical direction and oversight. If needed, other professionals and support disciplines may be invited to participate in evaluation and planning services.

MCC of AZ (HMO SNP) reimburses the PCP for participation in the ICT. ICT meetings range from a brief telephonic discussion to face-to-face meetings. The purpose is to review complex care members and identify those who need care coordinator assessments.

8.2 Member initial assessment

Initial assessments are critical in that they allow the member's care coordinator to understand the key issues facing the member.

MCC of AZ (HMO SNP) combines information from the PCP completing the assessment with the information gathered during the home-based assessment to more easily and quickly identify a new member's health and functional status.

Providers may download the Initial Assessment Form from our website.

Providers with an EMR (Electronic Medical Record) may pull the required data from the EMR and send to us in lieu of our form. Chart summaries from the EMR with an e-signature are acceptable. Please note: assessments must include the member's:

- Clinical and non-clinical assessment
- Current diagnoses
- Medications
- Allergies
- Advance directives
- Health care proxy
- Any other pertinent information
- PCP signature (may be electronic)

Notes pertaining to a specific visit or notes limited to a prescription change are not adequate.

When should assessment forms be completed?

1. Whenever a new member joins; this is critical to implementing timely treatment and other interventions.
2. When significant health changes occur, including when a member enters a nursing facility, has a new diagnosis or there is a change in his or her ability to complete an ADL.
3. Annually, even if no significant health changes occur.

Send completed forms to:

MCC of AZ (HMO SNP)
Attn: Clinical Services PCP Assessments
5055 Washington St., Suite 210
Phoenix, AZ 85034

8.3 Opening and closing a member panel

MCC of AZ (HMO SNP) defines the following panel statuses:

- New: PCP will accept members as new patients
- Existing: PCP will only accept those patients currently in their practice who choose to join MCC of AZ (HMO SNP)

All panel status changes require written notice to our Network Department; please email written notice to MCCAZProvider@magellanhealth.com. We require that providers give 90 days' prior notice for changes to the PCP panel.

8.4 Removing members from provider practices

MCC of AZ (HMO SNP) views decisions to terminate a physician-patient relationship very seriously. We are available to assist providers with difficult patient situations. You may seek assistance from Member Services by contacting 1-800-424-4509. You must send the member a written notification clearly stating the reason(s) for the termination and the effective date with a reference to the PCP's internal policy by certified mail, return receipt. You must also forward the same correspondence to us at the following address:

MCC of AZ (HMO SNP)
Attn: Member Services Director
1075 Main Street, Suite 400
Waltham, MA 02451

Section 8—Primary Care Providers

You must continue to provide care to the member for at least 30 days after the termination date. We will assist the member in selecting another PCP and will notify you if the transition occurs in less than 30 days.

8.5 Visit and access requirements

All urgent care and symptomatic office visits must be available to members within 48 hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention.

All non-symptomatic office visits must be available to members within 21 calendar days of the member's request for PCP services and 45 days for specialty services. Examples of non-symptomatic visits include well and preventive-care visits for covered services, such as annual physical examinations and immunizations.

Maternity providers must be available within 14 calendar days for member's in their first trimester, 7 calendar days for member's in their second trimester and 3 business days for members in their third trimester.

PCPs must ensure 24/7 access to physician consultation (at least by telephone). PCPs must also have arrangements with covering health care providers to provide for the provisions of medically necessary services when the PCP is not available.

You are required to maintain records for seven (7) years after termination of your agreement with MCC of AZ (HMO SNP) and for the period of time required by federal and state law and membership contracts, including the period required by CMS and NCQA.

8.6 Medical Records

Each primary care office is responsible for maintaining adequate (paper or electronic) medical records of patient care. Records should be maintained in accordance with applicable federal and state privacy laws. MCC of AZ (HMO SNP) has the right to review your records for claims authorization and service authorization. All medical records should be maintained in a manner consistent with professional practices and prevailing community standards.

You are required to maintain records for seven (7) years after termination of your agreement with MCC of AZ (HMO SNP) and for the period of time required by federal and state law and membership contracts, including the period required by CMS and NCQA.

Section 8—Primary Care Providers

Access to and copies of records

Our Member Services, Clinical Services, UM, Quality and/or Compliance Department staff may request records from your office for one of our covered members for several reasons, including:

- Quality of care measures (HEDIS)
- HCC risk adjustment
- Authorization requests
- Claims payment issues
- Assistance with case coordination
- Determination of requests to term member from provider panel status
- Follow up to a member complaint

Confidentiality of information

Providers are responsible for ensuring and maintaining the confidentiality of information about members and their medical records in accordance with applicable federal and state laws. The names of any member receiving public social services must be kept confidential and protected from unauthorized disclosure. This includes all information, records and data collected and maintained for the operation of the agreement. Providers may not use any such information for any purpose other than carrying out the terms of the agreement. In compliance with the Health Insurance Portability and Accountability Act (HIPAA), members are entitled to an accounting of any disclosure of information.

8.7 Nurse Practitioners (NPs) as PCPs

MCC of AZ (HMO SNP) allows NPs to practice as PCPs and hold their own panels. In order to qualify for this status, the following conditions must be met:

- The NP must be delivering care in a practice contracted with MCC of AZ (HMO SNP) for primary care services
- The NP must be delivering care under a supervising MD, who must be credentialed with MCC of AZ (HMO SNP)
- The NP must have arrangements for admitting at a contracted hospital
- The NP must be credentialed with MCC of AZ (HMO SNP)
- The NP must notify MCC of AZ (HMO SNP) of the desire to act as a PCP by contacting the Network Development Department at MCCAZProvider@magellanhealth.com.

Section 8—Primary Care Providers

When the status is changed to PCP-NP, the NP's name will appear in our provider and pharmacy directory as a PCP-NP; and the practice can inform current patients of the opportunity to select the NP as a PCP.

(NB: Providers on older contracts may require a simple contract amendment. Call Provider Relations with questions.)

Billing for NPs as PCPs

All nurse practitioners, both PCP and non-PCP, should bill using their own NPI number. Do not bill "incident to".

Section 9—Specialty Care Providers

9.1 Referrals

Specialists who are participating with MCC of AZ (HMO SNP) do not need to obtain an authorization for professional services rendered in an office or outpatient setting.

Elective hospital admissions do require prior authorization.

Referrals to non-participating specialists must come from the member's PCP and be authorized by MCC of AZ (HMO SNP). See Appendix for a copy of the Authorization Request Form.

If a specialist feels that additional treatment is required and he or she cannot provide these services, the specialist is responsible for contacting the member's PCP and suggesting the PCP provide the member with an additional referral.

Section 10—Quality Improvement Program

10.1 Introduction

The MCC of AZ (HMO SNP) Quality Improvement Program (QIP) is an ongoing, systematic, interdisciplinary program designed to measure, assess and improve the quality of care and services provided by MCC of AZ (HMO SNP) to its members, and to support the mission of MCC of AZ (HMO SNP) to "maximize the quality of life, health, security and independence of members." The QIP includes medical and behavioral health aspects of care as well as issues related to patient safety. The program description includes the scope of the program and the processes and information used to assist in identifying opportunities for improvement in care and services. Annually, we select specific quality improvement initiatives to focus on in our Quality Work Plan. When the year is over, we conduct a full program evaluation. A complete copy of the QIP Description can be obtained by contacting Member Services at 1-800-424-4509.

10.2 Participating providers

As part of their commitment to the Quality Improvement Program, MCC of AZ (HMO SNP)'s contracted providers are expected to:

- Abide by the policies and procedures set forth by MCC of AZ (HMO SNP)
- Actively take part in the plan's care management process, serving as vital participants of the member's Primary Care Team and working to ensure optimal delivery of care and services
- Participate in relevant quality improvement initiatives
- Cooperate with medical chart review activities and audits
- Provide member information in support of state and federal regulations and accreditation standards.

10.3 Quality model

The purpose of the QIP is to assess the quality and appropriateness of care and services members receive. The program assists our Board of Directors in developing strategies to maintain and improve quality within the organization as a whole. The board has ultimate authority and responsibility for quality of care and services provided to MCC of AZ (HMO SNP) members. The board delegates its quality improvement responsibilities to the National Quality Improvement Committee (QIC) and Chief Medical Officer. The plan's Risk Committee chaired by the Medical Director, provides advice and consultation on clinical quality of care issues.

Quality improvement activities focus on member satisfaction, complaints and appeals, contract services and credentialing, clinical services, utilization management and clinical program initiatives, outreach activities, education and reporting compliance.

The QIP's major function is assessment of the quality of care provided to members as well as the overall efficacy of MCC of AZ (HMO SNP) health care initiatives.

Section 11—Care Model

11.1 Program and philosophy

MCC of AZ (HMO SNP)'s Care Model reflects its mission to maximize members' quality of life, health, security and independence. With its unique capacity to integrate all Medicare Parts A and B, and Medicare Part D, and coordinate AHCCCS benefits, the care model mitigates fragmented care, promotes extended community care tailored to individual needs, and supports members and providers through care coordination to avoid acute care episodes and unnecessary long-term placement.

The MCC of AZ (HMO SNP) Care Model is grounded in the philosophy that:

- Care should remain local and aligned with the providers and community with whom the elder is familiar.
- Member choice is care setting, planning and services is fundamental.
- Coordination and advocacy across time, change in health and functional status, and care setting is the optimal way to provide care.
- Care is holistic, including psychosocial, behavioral and spiritual needs as well as physical needs.
- Cultural and linguistic competency is critical to access and quality of care.

The core elements of a patient-centered medical home are fundamental to the MCC of AZ (HMO SNP) Care Model. The member is at the nucleus of a care system and the PCP is the "medical home" providing medical oversight in care planning and delivery. MCC of AZ (HMO SNP) supports the PCP with care coordinators who focus on care coordination. Assessment and screening for both medical and psychosocial needs, risk identification, care planning, and ongoing monitoring and reassessment are supported by the MCC of AZ (HMO SNP) care coordinator and other care team participants. MCC of AZ (HMO SNP) offers preventive services and other benefits to promote the health and well-being of the member and caregiver, all of which are incorporated into the care planning process.

The wide array of community support services available to MCC of AZ (HMO SNP) members promotes independence and options for individuals to remain in the community while also recognizing and supporting the need for institutional care as the right choice for some members.

11.2 Interdisciplinary Care Team and responsibilities

The MCC of AZ (HMO SNP) Care Model is supported by MCC of AZ (HMO SNP) staff that actively assist with care planning, advocacy and care coordination along with the PCP. Care plans tailored to individual needs and services are evidenced-based and quality driven. To ensure a comprehensive, holistic approach to meeting members' needs, a primary care team of professionals and paraprofessionals is used for assessment, coordination and monitoring. The interactions may be telephonic, written or in-person. The PCP may invite other professional

and persons critical to meeting the care needs of the member to participate in evaluating and planning services. The member and his or her designated representative are active participants in care plan decisions.

Interdisciplinary Care Team (ICT) participants include:

- Member and caregiver(s)
- Primary care provider (PCP)
- MCC of AZ (HMO SNP) care coordinator
- MCC of AZ (HMO SNP) pharmacy consultant
- Member support representative (MST)
- Behavioral health consultants
- Others as needed

11.3 Primacy care provider (PCP)

Each MCC of AZ (HMO SNP) member is required to select an in-network PCP at the time of enrollment. The PCP is the team leader and provides overall clinical direction to the ICT and serves as the "medical home" for the member. The PCP:

- Provides medical oversight
- Provides primary care services
- Assesses the member initially and ongoing as needed
- Collaborates in Individual Care Plan development and reinforces care plan compliance
- Works with MCC of AZ (HMO SNP) to identify changes in member status

11.4 Role of the Care Coordinator

MCC of AZ (HMO SNP) care coordinators are RNs or LCSWs. They do not provide direct care. The responsibilities of the care coordinator include assessment, authorization, and coordination of services through home visits, telephonic calls and letters, development of the Individual care plan (ICP), as well as facilitating communication with the ICT.

The care coordinator is the single point of contact for providers. Their role is to foster clear and consistent communication among the PCP, member and other providers.

Ongoing communication and collaboration between the PCP and care coordinator is essential for care plan development and implementation. Interaction with the PCP may be telephonic, written or in person. An MCC of AZ (HMO SNP) care coordinator is available telephonically 24 hours a day, 7 days a week.

Section 11—Care Model (cont.)

If a member is deemed high complex, a care coordinator will perform an in-home assessment of the member every six months and meet directly with family and caregivers. The care coordinator oversees with development of the members individualized care plan with input from the ICT and reviews and monitors that care plan along with the PCP, ICT and Member. The care coordinator arranges, and coordinates services identified in the care plan and coordinates care across care settings

11.5 Role of the plan Pharmacy Department

MCC of AZ (HMO SNP)'s Pharmacy Department works closely with our care coordinators and providers to assist in the management of care for members. Goals of Pharmacy Care Management are safety, access, compliance, education and optimization of therapy. As a provider, you can request a medication review for your patients. In addition, the Pharmacy Department is actively engaged in programs related to medication management and medication reconciliation.

11.6 Role of plan Member Support Representatives (MSR) and Health guides/Care workers

MCC of AZ (HMO SNP) has incorporated Member Services into the clinical arena with multi-lingual staff representing major language groups. Member Support Representatives have a role that goes beyond traditional Member Services by providing personal, high-touch telephonic communication. MSRs are available to respond quickly to questions and concerns. They educate members upon enrollment and have a roster of members they contact on a regular basis to identify changing needs or confirm health status.

Care workers/health guides integrate non-medical support services into the member's plan of care. They assist members to navigate the network of community support and information services. They serve as a liaison between community service providers (non-clinical).

11.7 Care management process

MCC of AZ (HMO SNP) is committed to empowering our members and their families to participate in short- and long-term planning to support community living as long and as safely as possible. The health status and care needs of individuals are fluid. We incorporate systems to ensure ongoing re-evaluation and restructuring of care services to respond to changing needs.

Assessment categories

MCC of AZ (HMO SNP) conducts multidimensional assessments of our members in order to:

- Have baseline information about the member's health status, services and unmet needs
- Stratify for risk in order to ensure adequate care management oversight
- Ensure continuity of existing services upon enrollment in MCC of AZ (HMO SNP)
- Develop appropriate individual care plans

Section 11—Care Model (cont.)

- Enable ongoing monitoring and rapid identification of status changes

Assessments include appraisals of:

- Diagnostic conditions
- Functional status Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)
- Psychosocial status
- Informal and formal support systems

Risk categories

Based on assessment, members are stratified into risk categories aligned with the intensity of care management needs.

Category	Risk	Definition	Care Manager
Non-complex care needs	Low risk	Members living in the community with limited or no ADL deficits; high social, cognitive, and physical functioning with medical conditions meeting treatment goals	Care worker/health guide and care coordinator
Complex care needs	High risk	Members with conditions or situations requiring expert coordination of multiple services this includes members whose complex needs are driven by SMI and/or Alzheimer's/dementia and/or substance use disorder.	Care coordinator

These categories are identified on monthly PCP Panel Reports with members' names.

11.8 Features of the MCC of AZ (HMO SNP) care model

To promote health and prevent unnecessary illness, all facets of an individual's life must be addressed. Preventing acute episodes of illness and supporting members in the homes when necessary, leads to a healthier, more independent individual.

This holistic approach incorporates the following steps:

- Intake and initial assessment
- Individualized care plans (ICP)
- Coordinated, integrated care delivery
- Monitoring and continuous reassessment

Section 11—Care Model (cont.)

Intake and initial assessment

Information gathering about the new member's health status and existing services begins as soon as possible after CMS acceptance of an enrollment application in order to ensure:

- Existing services continue without disruption
- Continuity of care with existing providers and appointments
- Transition of existing medications
- Early identification of risk factors to ensure rapid implementation of needed services and stabilization of the member

An initial assessment is a comprehensive assessment that serves as the basis for the Individual Care Plan and includes an evaluation of clinical status, functional status, nutritional status and physical well-being; the medical history, including relevant family members and illnesses; screenings for mental-health status and tobacco, alcohol and drug use; and an assessment of need for long-term care services including the availability of informal support.

Initial assessments for members include:

Phone triage	We use a phone triaging process for members new to MCC of AZ (HMO SNP) to identify whether an in-home or telephonic assessment should be conducted by a plan care coordinator.
In-home assessment for at-risk populations	If a member is at risk, an MCC of AZ (HMO SNP) care coordinator is assigned to meet with the member at home. Care coordinators use a standardized assessment tool that identifies: diagnoses, medications, ADL status, IADL status, support systems, mental health status and nutritional status.
Welcome calls	MSRs conduct welcome calls to all new members within the first month of enrollment. During that call, MSRs may obtain information about the needs of the member. The MSR will forward this information to the care coordinator for follow up.
Telephonic assessment	Using a standardized assessment poll MCC of AZ (HMO SNP) care workers/health guides conduct this assessment telephonically for all community based low-risk members. The assessment is used to identify demographic information, health status, medical/social resources, cognitive and functional patterns, sensory and communications, social functioning, caregiver supports, functional status, identification of diagnoses, etc.
PCP assessment	We request that PCPs submit an annual assessment either on an MCC of AZ (HMO SNP) PCP Assessment form or using the summary of the providers EMR to help the care coordinator identify diagnoses, medications, preventive services, special needs and the PCP's priorities for the member.

Section 11—Care Model (cont.)

Individual care plan (ICP)

Each member gets an individual care plan based on:

- Their PCP and care coordinator assessments along with other assessments and service recommendations
- The member's functional, physical, behavioral and psychosocial needs
- The member's self-management goals and objectives (to the extent possible)
- Services tailored to the beneficiary's needs
- Health promotion and preventive services

Members with complex care needs (high risk members) receive in-depth care plans drafted by the MCC of AZ (HMO SNP) care coordinator and based on assessments and meetings with members and their families. Members with non-complex needs (low risk) receive care plans based on the telephonic assessment. All care plans incorporate recommendations of the PCP assessment and other assessments. MCC of AZ (HMO SNP) care coordinators confer with PCPs to determine whether further evaluation and care planning is needed, arrange referrals if necessary and authorize services. Member concurrence with the ICP is a necessary component of care planning.

Coordinated, integrated care delivery

The MCC of AZ (HMO SNP) care coordinator oversees implementation of ICP services and ongoing care needs through communication with the PCP, utilization management, the member and his or her caregivers, and other ICT members. Contractual relationships with providers across care settings including home, hospital, outpatient, rehabilitation, DME, SNFs and behavioral health allow care coordinators to coordinate care in a meaningful way that fosters a virtual "medical home" for the member. This ensures timely and effective delivery of services without fragmentation and disruption. If a member has unique needs, care coordinators will consult the PCP to determine whether a new approach or exception to benefit is needed. PCPs should contact the care coordinator at 1-800-424-4509.

Monitoring and ongoing assessments

The MCC of AZ (HMO SNP) members of the ICT all have a role in monitoring the member and his or her services to assure services are delivered according to quality standards and the member is satisfied. Care coordinators conduct in-home reassessments at scheduled intervals based on risk category as well as any timer there is a suspected change in status, or an issue identified. CSCs maintain close telephonic contact with members to determine needs and issues. PCPs are involved when changes and potential problems surface.

Section 11—Care Model (cont.)

Reassessments are as follows:

Category	Risk	Reassessment Schedule	Conducted by
Non-complex	Low risk	Annually telephonically	Care worker/health guide
Complex care needs	High risk	Every six months face-to-face	Care coordinator

11.9 Centralized enrollee record (CER)

MCC of AZ (HMO SNP) uses an electronic member record to communicate information about the member among internal staff, including MSRs, CSCs, care coordinators and with GSSC. This is not an Electronic Health Record (EHR), but a repository of information collected through assessments, claims (medical and pharmacy), case management notes, telephonic communication with providers and members, ICPs, referrals and authorizations, demographic information, etc. The information is real-time and web-based, allowing care coordinators access to up-to-date information 24 hours a day, 7 days a week. This is a tool to facilitate care planning and communication.

11.10 Transitions of care

MCC of AZ (HMO SNP) promotes continuity of care between care settings to assist member transitions of care and reduce the potential for hospital/facility readmission. Care coordinators actively engage in transition planning and follow-up including facilitation of physician communication and follow-up visits as well as medication management.

The MCC of AZ (HMO SNP) care coordinator:

- Works with the member, his or her caregivers and the ICT to plan, review and agree on the care plan and transfer arrangements
- Collaborates with the ICT to arrange services prescribed in the care plan, including the members Medicaid plan. This might include transportation, home care, nursing, physical therapy, personal care, etc. and ensures services are in place and staff is notified as appropriate
- Phones staff in the new care setting to determine status of member and services
- Schedules reassessments for ICT review of member care plan following the transfer.

Section 11—Care Model (cont.)

The following table describes the transitions of care responsibilities for different care settings.

Transition of Care	Tasks/Responsibilities
Hospital to SNF/LTAC/Rehab	MCC of AZ (HMO SNP) UM Professional : • Identifies participating nursing home providers, directs hospital discharge planner to participating facility • Notifies MCC of AZ (HMO SNP) care coordinator of impending transition • Establishes admission level of care and services with facility • Enters authorization into the authorization application
SNF/LTAC/Rehab to Hospital	SNF Staff: • Contacts PCP when member condition changes • Transfers member, in an emergency situation, to nearest facility as appropriate • Contacts care coordinator to report transfer MCC of AZ (HMO SNP) UM Professional: • Monitors inpatient admission • Coordinates discharge planning with hospital and nursing facility staff • Enters authorization into Care Management system
Hospital/SNF to Home	MCC of AZ (HMO SNP) UM professional: • Coordinates post discharge care plan with hospital/SNF discharge planner and ICT • Authorizes needed services • Enters authorization into care management system MCC of AZ (HMO SNP) UM professional: • Coordinates post discharge care plan with hospital/SNF discharge planner and ICT • Authorizes needed services • Enters authorization into care management system

Section 11—Care Model (cont.)

Transition of Care	Tasks/Responsibilities
Hospital/SNF to Home	MCC of AZ (HMO SNP) care coordinator: • Schedules assessments, drafts care plan and coordinates an ICT review when change in status has occurred • Conducts telephonic care transition assessment call to member to manage transition • Provides PCP with update on hospital stay as necessary
Home to Hospital (non-elective)	MCC of AZ (HMO SNP) UM professional: • Reviews preadmission status and care plan with care coordinator and shares with hospital care manager (review may include factors which effect hospital course and optimal discharge) • Contacts admitting facility to perform medical necessity review of admission and procedure • Enters authorization into the care management system • Monitors progress of inpatient stay • Coordinates discharge plan with hospital staff with a focus on alignment of post-acute needs (i.e. advocacy for SNF placement, proximity to member's community, CLAS) • Communicates transition with care coordinator

Home to Hospital (elective)	Facility, member/caregiver, home care nurse of PCP contacts MCC of AZ (HMO SNP) care coordinator-UM/Community
	MCC of AZ (HMO SNP) UM professional:
	• Contacts admitting facility to perform medical necessity review of admission and procedure
	• Enters authorization into care management system
	• Monitors progress of inpatient stay
	• Coordinates discharge plan with hospital staff Forwards member information to admitting facility
	MCC of AZ (HMO SNP) care coordinator:
	• Arranges, as appropriate:
	  ○ Pre procedure conditioning program
	  ○ Nursing facility site visits

Transition of Care	Tasks/Responsibilities
	○ Home evaluation for DME ○ Skilled service needs in the home ○ Support in home post discharge
Home to SNF	MCC of AZ (HMO SNP) care coordinator and UM professional: • Coordinates nursing facility admission with PCP, facility, member and ICT • Establishes level of care and services required with nursing home staff • Reviews care needs and health status, and arranges transportation and admission • Enters authorization into care management system

11.11 Utilization management (UM)

MCC of AZ (HMO SNP) adopts evidence-based clinical practice guidelines to assist practitioners in making decisions about appropriate care for specific clinical issues.

The clinical practice guidelines address preventive medical services, acute or chronic medical services and behavioral health services. Specific clinical practice guidelines form the clinical basis for MCC of AZ (HMO SNP) disease management programs. The guidelines are reviewed at least every two years. When guidelines are updated, practitioners are notified. Clinical practice guidelines can be found on MCC of AZ (HMO SNP)'s website at www.mccofaz.com/dsnp.

MCC of AZ (HMO SNP) applies objective and evidence-based criteria, taking into account individual circumstances and the local delivery system, when determining medical appropriateness of health care services during the utilization management process. Criteria are stated in Notices of Denial of Medical Coverage. Criteria can be obtained upon request by contacting Utilization Management staff within Clinical Services at 1-800-424-4509.

MCC of AZ (HMO SNP) clinical staff who make UM decisions annually affirm that:

- UM decisions made are based only on appropriateness of care and services and existence of coverage
- Individuals are not rewarded for issuing denials of coverage
- Financial incentives do not encourage decisions that result in underutilization

You can obtain information about the UM process and the authorization of care by calling toll free 1-800-424-4509. After hours, for standard medical authorizations, send a fax to 1-888-656-2390. For behavioral health, please fax to 1-888-656-2598.

Section 11—Care Model (cont.)

We will respond the following business day. For expedited/urgent requests after hours and on weekends, please call 1-800-424-4509.

Section 12—Credentialing

12.1 Credentialing a new medical doctor (MD) provider

Credentialing a new provider is a simple process. Providers may only become credentialed if they are directly contracted with MCC of AZ (HMO SNP) or are part of a larger entity that is contracted with MCC of AZ (HMO SNP).

MCC of AZ (HMO SNP) requires that new providers submit:

- Completed MCC of AZ (HMO SNP) AHP Form, available on website
- Federally required disclosure forms
- W-9s

MCC of AZ (HMO SNP) requires you to enable us to access your records through CAQH.

The provider data form is available on our website at www.mccofaz.com/dsnp or may be requested via email to MCCAZProvider@magellanhealth.com.

MCC of AZ (HMO SNP) may follow up with providers to gather more complete or up-to-date information than what is available in CAQH. This includes office hours, languages spoken and more. We will notify providers in writing once you have been approved.

12.2 Credentialing a new non-MD provider

In addition to physicians, MCC of AZ (HMO SNP) also credentials licensed health professionals such as Nurse Practitioners; physical, occupational and speech therapists; dieticians; podiatrists and chiropractors. NPs must meet standard credentialing criteria.

For NPs interested in participating as PCPs, addition criteria must be met including:

- You must be delivering care in a practice contracted with MCC of AZ (HMO SNP) for primary care services
- You must be delivering care under a supervising MD who must be MCC of AZ (HMO SNP) credentialed or meet credentialing criteria
- You must have arrangements for admitting to a hospital contracted with MCC of AZ (HMO SNP)

You must notify us of your desire to act as a PCP when completing your AZ AHP practitioner credentialing form. Please contact our network at MCCAZProvider@magellanhealth.com.

Section 12—Credentialing

12.3 Delegated credentialing

MCC of AZ (HMO SNP) may delegate credentialing to practitioner groups, ancillary facilities, NCQA-certified credentialing vendors or NCQA-accredited managed behavioral health care organizations. Delegates must follow the individual state law for recredentialing time frames.

12.4 Facility credentialing

MCC of AZ (HMO SNP) credentials and recredentials ancillary facilities. An ancillary facility is an institution or organization that provides services, such as a hospital, residential treatment center, and home health agency or rehabilitation facility.

Medical ancillary facilities include hospitals, home health agencies, skilled nursing facilities and free-standing surgical centers. Behavioral health ancillary facilities include inpatient, residential and ambulatory facilities.

12.5 Recredentialing providers

MCC of AZ (HMO SNP) recredentials providers in accordance with Arizona regulations. We make an effort to begin the process two (2) months in advance of the recredentialing due date and notify providers at least twice in writing if information is missing or needs updating. Timely provider assistance with this process helps avoid potential patient care disruptions.

12.6 Provider demographic changes

Change	Action	Notice Period
Providers new to a practice	Submit provider data form & federally required disclosure form	90 days prior to joining practice
Providers leaving a practice	Written notice	60 days prior to last day
Change of address, phone, panel status, etc.	Written notice	30 days prior to effective date
New Tax ID number	New W-9 form	30 days prior to effective date

Section 12—Credentialing

Written notification should be emailed to MCCAZProvider@magellanhealth.com.

12.7 Notice requirements for providers' termination from groups

Provider groups shall provide MCC of AZ (HMO SNP) written notice when a credentialed PCP or SCP terminates their group affiliation at least sixty 60 days prior to termination. In the event the PCP or SCP's termination is effective in a time period less than sixty 60 days, the group shall provide MCC of AZ (HMO SNP) written notice immediately. This will allow us at least 30 days to notify members.

12.8 Ongoing monitoring and appeal process

MCC of AZ (HMO SNP) monitors, on an on-going basis, Medicare and Medicaid sanctions and sanctions or limitation on licensure. We also review complaints and adverse events that involve providers. If we receive information about a sanction, limitation or specific reportable incident that involves an MCC of AZ (HMO SNP) provider, we will report it to the appropriate authority when required. This includes the National Practitioner Database, Medicare or AHCCCS. If we suspend or terminate a provider for quality reasons, we will also report it to the appropriate authority.

If we suspend or terminate a practitioner from our network, they may appeal the suspension or termination. We will provide written notice along with an explanation of the action we've taken. We will also include information on appeal rights and the appeal process.

12.9 Provider rights

MCC of AZ (HMO SNP) does not make credentialing or recredentialing decisions based on practitioner's race, ethnicity, national identity, gender, age, sexual orientation or the types of procedures or types of patients treated.

Providers' rights in the credentialing and recredentialing process include:

- The right to correct erroneous information
- The right to review information submitted to support their credentialing application (except National Practitioner Data Bank (NPDB) reports, as required by law)
- The right to be informed of the status of their credentialing or recredentialing application upon request
- The right to confidentiality

Section 13—Directory

13.1 The MCC of AZ (HMO SNP) Provider and Pharmacy Directory

MCC of AZ (HMO SNP) publishes a downloadable Provider and Pharmacy Directory for members and will provide copies of these directories to any participating provider upon request. We include contracted providers and pharmacies in directories on the same basis as other similar participating providers.

13.2 Directory on demand

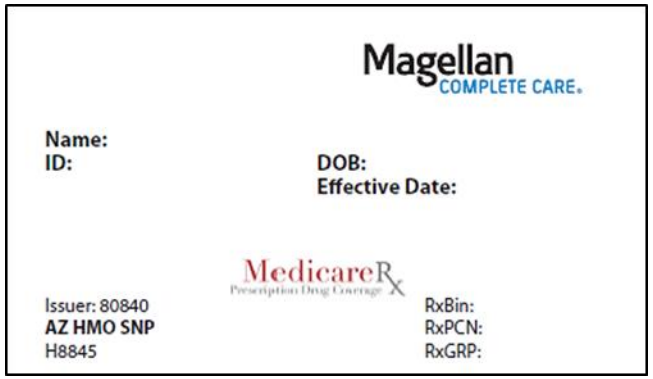
We maintain a searchable online directory that be accessed via the web at www.mccofaz.com/dsnp.

13.3 Updates and corrections

If any provider listing information is incorrect or needs to be modified, please contact the Network Department at MCCAZProvider@magellanhealth.com. Refer to the Notice Provisions in the Provider Credentialing and Provider Changes section of this handbook.

Section 14—Appendix

Sample Member ID Card for MCC of AZ (HMO SNP)



To access the following materials, click on the links below or visit our website at https://dsnp.mccofaz.com/providers/provider-materials/.

Information

MCCAZProvider@magellanhealth.com

https://www.mccofazprovider.com/providerportalaz/

Claims

http://clientsupport.emdeon.com/login.aspx

https://abilitynetwork.com/

https://www.changehealthcare.com/provider-solutions#sort=relevancy

Section 14—Appendix

Compliance

Download two training courses: *Combatting Medicare Parts C and D Fraud, Waste & Abuse Training* and *Medicare Parts C and D General Compliance Training*.

Documents

Medicare Behavioral Health Authorization Request Form

Medicare Medical Prior Authorization Request Form

Medicare Part B Drugs Requiring Prior Authorization

MCC of AZ (HMO SNP) Evidence of Coverage

MCC of AZ (HMO SNP) Model Formulary

MCC of AZ (HMO SNP) Provider and Pharmacy Directory

MCC of AZ (HMO SNP) Quality Improvement Program (QIP)

MCC of AZ (HMO SNP) Summary of Benefits

Prescription Drug Coverage Determination Form

Request for Medicare Part D Prescription Drug Coverage

Pharmacy

swhpharmacy@magellanhealth.com

https://www.mytransactrx.com