

CAPSTONE HEALTH PLAN
A Special Plan for Special Needs

PROVIDER MANUAL

Revised October 1, 2010

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1 Introduction

Welcome to Capstone Health Plan, Inc.

Capstone would like to welcome you, as a provider of health care, to the organization. This manual will help you gain a better understanding of how the Capstone organization works and how members receive services through the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) and Capstone Health Plan, Inc. Capstone is a locally administered **non-profit** health plan that is sub-contracted with DES/DDD to provide acute health care services to eligible DES Arizona Long Term Care (ALTCS) members.

Capstone and their providers shall deliver quality health care services that equal or exceed current professional practice and community standards. Capstone shall pursue the program objective to integrate acute care services in the least restrictive setting consistent with personal health, safety, cultural beliefs and within the benefit structure of the Capstone plan.

Our goals are achieved through **physician input, support and participation** in the program's daily operations and working committees. As the gatekeeper of medical care, the Primary Care Physician controls and orchestrates the appropriate medical care of our members through the referral process. These factors make our organization a viable and dynamic health plan in the eyes of our contracted provider network, as well as our regulator, DES/DDD.

Mission Statement

"Capstone is dedicated to providing quality, cost effective health care to our members. Equally important is the assurance of equitable and timely compensation to our physicians and other providers. The organization will work to meet the unique service needs and potential of each developmentally disabled member, while promoting optimum health care outcomes within a managed care setting."

Telephone & Fax Numbers

Local Telephone (928) 779-2113		Toll Free Telephone (800) 336-3874	
✓ Claims Department	x3493 x3483	Fax (928) 779-5108	
✓ Finance Department	x3492	Fax (928) 779-5108	
✓ Health Services Department	x3484	Fax (888) 779-3251	
✓ Prior Authorization	x3487 x3488	Fax (928) 779-3234 Fax (928) 214-3497	
✓ Medical Director	x3486	Fax (928) 214-3497	
✓ Member Services	x3585	Fax (928) 779-5108	
✓ Provider Services	x3481	Fax (928) 779-5108	

2 Organization and Administrative Structure

Developmentally Disabled (DD) Program

The Department of Economic Security receives Title XIX (Medicaid) funding through AHCCCS Administration to provide long-term care and acute health care services to persons with developmental disabilities who are eligible for ALTCS benefits. The ALTCS program is for persons who are at risk for institutionalization due to their need for services. AHCCCS contracts with DES/DDD to provide services to persons who qualify for DDD and ALTCS services. DES/DDD provides long-term care services and contracts with Capstone to provide acute health care services to eligible and enrolled DES/DDD members.

Persons with developmental disabilities are eligible for certain services provided through the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). ARS Section 36-551 and the DES/DDD Policy and Procedures Manual define developmental disability as a severe chronic disability which:

1. Is attributed to: mental retardation, cerebral palsy, epilepsy, autism or developmental delay at six (6) years of age or older, or is “at risk” for one of the above if under six (6) years of age.
2. Is manifested before the person attains age eighteen (18).
3. Without appropriate intervention, is likely to continue indefinitely.
4. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency; and reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services which are lifelong or of extended duration.

Demographics

The population served by DES/DDD is greater than 14,600 persons statewide, as of August 2003.

- Approximately 76% of these individuals live in their natural home or foster home and are provided Home and Community Based Services (HCBS) by DES/DDD.
- Approximately 22% of these individuals live in a group home or adult developmental home, and are provided HCBS by DES/DDD.
- Approximately 2% reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

Capstone Service Areas

The service areas include Coconino, Yavapai, Mohave, Navajo and Apache Counties. The provider network extends beyond the service areas to include border communities in Utah, New Mexico and California.

Provider Services

The Provider Services Department is responsible for developing and maintaining Capstone Health Plan's provider network of PCP's, dentists, specialists, hospitals and ancillary providers. The Capstone Provider Services representative serves as a link to all other departments within the health plan. Provider Services also conducts training activities and keeps the provider informed of their responsibilities as a contracted provider. The Provider Services representative can help in resolving many administrative issues or concerns and should always be your first contact at Capstone Health Plan.

Role of Provider Services Representative

The role of the Provider Service representative is to serve as the primary contact between the health plan and the provider for administrative concerns. The representative provides initial and follow-up staff training and conducts on-site visits to ensure compliance with policies and procedures. Your Provider Services representative can answer many of your questions directly, research your problem or help direct you to the proper information source. Capstone specific supplies such as, EPSDT forms, referral forms, provider manuals and formularies can be obtained by contacting your Provider Services representative.

Provider Communication

Capstone Health Plan will keep providers informed of any health plan changes via the Provider Newsletter, the Dental Newsletter and information specific correspondence. Updates to the Provider Manual and Health Plan Formulary will be provided as changes and revisions occur.

Capstone conducts annual provider and member surveys to solicit information to help us improve our services. Capstone is interest in your opinions and any suggestions you may have. We encourage you to take the time to complete the provider survey. Results of the provider and member survey will be published in the newsletters.

Professional Staff Changes

Any changes in the professional staff in your office, including physicians, physician assistants and nurse practitioners must be reported to Capstone Health Plan immediately. Prior notification of any changes to address, tax identification numbers, telephone numbers or professional staffing is necessary to ensure continuity of care and correct claims payment.

All physicians, med-level professionals and dentists are credentialed prior to participation in the Capstone network. Any changes in licensure, accreditation, liability coverage or DEA registration must be reported to Capstone immediately. Copies of renewed information should be faxed to the Capstone office as soon as received by the practitioner.

Administrative changes in your office staff may result in the need for training. Contact the Capstone Provider Services representative to schedule any needed staff training.

Network Management

Capstone's Provider Services representative routinely reviews information about the plans network to identify potential areas for expansion or modification. Continual monitoring of services provided by the network allows Capstone to determine the need for potential provider types. Capstone works with local organizations, contracted providers and other health plan associates to secure new contracts within the service areas.

Capstone Health Plan contracts with providers based on their geographical location including all bordering areas of each county. The network need is based on current and projected membership, member utilization and existing coverage within an area. Changes in the location of your office may result in contract termination if the new location is not within an area served by Capstone Health Plan. Capstone requests notification of any changes to office information or professional staff in advance to assist us in better serving our members and providers.

3 Member Services / Eligibility

Verifying Member Enrollment

Providers can contact Capstone Health Plan to verify a member's eligibility by calling:

Office - (928) 779-2113 or (800) 336-3874 / Hours – 8:00 a.m. to 5:00 p.m.

Pager - (928) 779-8920 After Hours Staff On-Call Pager - leave a detailed message and a representative will return your call with eligibility information.

Providers should verify eligibility prior to providing services. PCP's can consult their member roster to determine if a member has been assigned to them. The Capstone Member Services Representative should be contacted if a member indicates that they are assigned to the PCP, but are not listed on the roster.

Member Enrollment Rosters

Capstone Health Plan will provide monthly enrollment rosters to all PCPs within the first five business days of the month.

Rosters do not serve as a definitive confirmation of a member's enrollment in Capstone. Providers are required to verify member eligibility for each date of service.

Notification will be faxed to the PCP office immediately following the assignment of a new member.

Member ID Card

Capstone Health Plan issues an identification (ID) card to each member that is approved by AHCCCS for enrollment with Capstone Health Plan. A current Capstone ID card should be presented by the member each time services are provided.

Medicare Eligibility

Each Developmentally Disabled (DD) member is assigned a 4-digit rate code defining the member's current Medicare status. The member's rate code can be found on the Capstone roster distributed on the first of the month.

- If the last two digits of the rate code end with the numbers "10", the member is ***not*** Medicare eligible.
- If the last two digits of the rate code end with the numbers "00 or 20", the member is Medicare eligible. Please be sure to contact Medicare, if a members' eligibility is in question.
- Be sure you identify Medicare members for proper billing to avoid delays in claims payment.

Private Insurance

Members who are eligible for enrollment with Capstone may also have other insurance coverage.

- Always double check with the member to determine if they have primary insurance coverage.

Member Rights

Access to Care. Capstone members shall be accorded impartial access to treatment or accommodation that is available or medically indicated, regardless of age, race, creed, sex, sexual preference, national origin or religion.

Respect and Dignity. Capstone members have the right to considerate, respectful care at all times and under all circumstances.

Privacy and Confidentiality. Capstone members have the right, within the law, to personal and informational privacy, including:

- All interviews and examinations shall be conducted in surroundings designed to ensure reasonable audio/visual privacy.
- Any discussion or consultation involving care shall be conducted discreetly. Individuals not directly involved in the member's care shall not be present without permission.
- The member's medical record shall be read only by individuals directly involved in the treatment or monitoring of quality, and by others only upon authorization.
- All communications and records pertaining to member care, including the source of payment for treatment, shall be treated as confidential.

Communication. Capstone members have the right to elect to bring an interpreter with them to appointments when the provider does not speak or understand the member's primary language. If the member so chooses, this interpreter may be present during all communications, including during examinations. Capstone members have the right to obtain from their PCP, all current information about their diagnosis, medical care and any known possible outcome. Members also have the right to ask Capstone for information regarding whether or not the health plan has physician incentive plans that affect the use of referral services, the types of compensation arrangements the plan uses, summary of member survey results.

Consent. Capstone members have the right to reasonable information and participation involving their health care. No member shall be subjected to any procedure without the voluntary, competent and knowledgeable consent of the member or that of a legally authorized representative.

Identity. Capstone members have the right to know the identity and professional status of individuals providing services, and to know which physician is primarily responsible for their care.

Refusal of Treatment. Capstone members may refuse treatment to the extent permitted by law. Members are responsible for their actions if treatment is refused or if the instructions of the PCP or clinic are not followed.

Grievances. Capstone members shall be informed of their grievance rights via the Capstone Member Handbook.

Medical Information. Capstone members have the right to obtain from the PCP complete and current information concerning diagnosis (to the degree known), treatment and any known prognosis.

- Information shall be communicated in terms that members can reasonably be expected to understand.
- When it is not medically advisable to give such information to the patient, it should be made available to a legally authorized representative.

Policy Information. Capstone members have the right to be kept informed of covered and excluded services, PCP assignment, Advance Directive information, and other pertinent Health Plan rules and guidelines.

Member Responsibilities

Provision of Information. Capstone members and/or their legal representative have the responsibility to provide, to the best of their knowledge, accurate and complete information as requested.

- Members shall release all information about present conditions, past illnesses, hospitalization, medication and other matters relating to their health at the time of enrollment and/or upon request.
- At the time of the eligibility determination and subsequent enrollment with Capstone, member must provide all pertinent information relative to other medical insurance coverage that they have available.
- If at any time, the Capstone member received medical coverage beyond his/her AHCCCS coverage, the member is obligated to report this information to his/her AHCCCS enrollment office and to Capstone Health Plan.
- Failure to fully disclose requested information will result in denial of claims and possible disenrollment.

Primary Care Physician (PCP). Capstone members have the responsibility to elect a PCP upon enrollment from available PCPs in the Provider Directory. If a PCP is not elected in the required timeframe, one will be assigned. The member is responsible for knowing the name of his /her assigned PCP.

Appointments. Capstone members are responsible for keeping appointments, or if unable to do so, notifying their provider's office prior to the time of the appointment. Members are responsible for scheduling an appointment during office hours, whenever possible, rather than using urgent or emergency care facilities. Unnecessary use of these facilities may result in a refusal of the claim.

Notification to Providers of Eligibility. Capstone members, or their caregiver, have the responsibility to inform the attending physician that they are covered by AHCCCS.

Immunization Records. Capstone members, or their caregiver, have the responsibility to provide accurate and complete immunization information, and to bring immunization records to appointments for members 18 years and younger.

Compliance with Instructions and Refusal of Treatment. Capstone members are responsible for following the treatment plan(s) recommended by all providers of medical care. If a member chooses to ignore or refuse treatment plans, he/she assumes full responsibility for the results of this action.

Member Reimbursement

Capstone Health Plan will reimburse members when they have personally incurred expenses in order to obtain medically necessary services that are covered benefits. Reimbursement is limited to travel, meals, lodging and pharmacy expenses incurred while obtaining covered medical services.

Transportation and/or Travel

In order to receive reimbursement for transportation and/or travel expenses a member must:

- Notify Capstone 24 hours in advance of the appointment.
- Complete a Travel Reimbursement Form for the entire period of travel.
- Submit the Travel Reimbursement Form along with all receipts for expenses to Capstone Member Services Department.
- Include proof of appointment from the provider or clinic where services were obtained.

Pharmacy

Capstone provides medication through Partners Rx Pharmacy Benefit Management network. There is no co-payment for medication dispensed through Capstone pharmacy benefits. If the medication is covered by the member's other insurance, Capstone will reimburse the co-payment via Partners Rx.

In order to receive reimbursement for co-payment on other insurance, the member must:

- Complete a Direct Member Reimbursement Form, and
- Forward proof of payment to Partners Rx (original receipt).

Member Assignment

Primary Care Physician (PCP) Assignment

Upon initial enrollment with Capstone Health Plan the member is automatically assigned to an age appropriate PCP in their geographic service area.

Capstone offers members the opportunity to select a Capstone contracted PCP within the member's geographic service area within 10 days of enrollment. If the member fails to elect a PCP within the required timeframe, one will be assigned. After final PCP assignment the Member is notified via mail. The member is responsible for knowing the name of his/her assigned PCP.

Reassignment of a Member to another PCP

PCPs may request a member reassignment to another PCP. All requests must be submitted by the PCP in writing to the Capstone Member Services Department and include the specific reason(s) for requesting reassignment.

Upon receipt of a valid request, member will be reassigned to a contracted PCP that can meet their medical needs. The physician will be obligated to provide covered services to the member until notified by Capstone that the transition to another PCP has been completed.

Additionally, it is the PCP's responsibility to inform the member of their request for reassignment. It must be emphasized that a PCP's request to have a member choose another PCP should be based on inability to establish a satisfactory physician/patient relationship and not on patterns of utilization or diagnosis.

Dentist Selection

Eligible Capstone members have direct access to the dentist of their choice and are encouraged to select a dentist within their geographical service area. A list of Dental providers is included in the Provider Directory distributed to all Capstone members when enrolled.

All eligible members are sent a reminder notice every six (6) months informing them it is time for a routine dental exam. Pediatric dentists are available and recommended by Capstone for those meeting the age requirements of the dental specialist. If unsure where to go, Capstone recommends that the member's contact the Member Services representative for assistance in selecting a dentist in their area. The Capstone dental network also includes dental providers specializing in sedation for those members who require sedation for routine cleaning or other treatment.

It is the Dental provider's responsibility to notify Capstone when a member has scheduled an appointment and obtain appropriate authorization prior to providing services.

4 Provider Responsibilities

Responsibilities and Expectations

The responsibilities and expectations of Capstone contracted providers are as follows:

1. Follow the terms and conditions of the signed agreement with Capstone Health Plan.
2. Comply with the terms and conditions of the AHCCCS Minimum Subcontract Provisions attached to every Capstone provider agreement.
3. Maintain a current AHCCCS Provider Identification Number.
4. Submit full and complete credentialing and re-credentialing applications and supporting information to Capstone as requested.
5. Maintain all required professional licenses and certifications.
6. Deliver services to Capstone members in a non-discriminatory manner without regard to race, color, creed, religion, sex, sexual preference, national origin, health status, income level, or on the basis that persons are Capstone members enrolled in the ALTCS/DDD program.
7. Verify members' eligibility and obtain any necessary authorization prior to initiation of services.
8. Comply with the Americans with Disabilities Act (ADA) and provide reasonable accommodations to members.
9. Report any known or suspected cases of fraud and abuse to Capstone Health Plan (see section 16 of this manual).
10. Notify Capstone of any factor affecting the agreement with Capstone, such as change in licensure or credentialing status, change of address or change in insurance coverage.
11. Submit claims and encounter documents to Capstone in a timely and complete manner.
12. Provide services and maintain records for the EPSDT program as established by AHCCCS and Capstone; maintain patient medical records and other record keeping systems in a complete and legible manner, in accordance with applicable laws, regulations and rules, and retain such records for the duration established in the Capstone agreement.
13. Cooperate with Capstone and any authorized regulatory agency regarding quality management and utilization management programs.
14. If provider is an Emergency Services Facility, services must be available on a 24-hour, 7-days a week basis. If provider is a Primary Care Physician, he or she or an appropriate on-call physician must be available for services, consultation or prior approval activities on a 24-hour, 7-days a week basis.
15. Comply with all applicable federal, state and local laws, rules and regulations, including anti-kickback and self-referral laws and implementing regulations.

16. Maintain all insurance coverage required by the Capstone agreement.
17. Comply with federal and state laws regarding Advance Directives.
18. Recognize that Medicaid/AHCCCS/ALTCS and Capstone are usually, by law, the payor of last resort. Assist Capstone in the identification and primary billing of other third party payers including, but not limited to, the federal Medicare program.
19. Comply with the Drug Formulary established by Capstone and follow Capstone's prior authorization guidelines for dispensing of drugs not included in the formulary.

Americans with Disabilities Act (ADA)

Under Title III of the ADA, requirements for public accommodations such as a physician's office mandate that they must be accessible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

Physicians should ensure that their offices are as accessible as possible to persons with disabilities, and should make efforts to provide appropriate accommodations such as large print materials or easily accessible doorways for those with disabilities. To assist in meeting these requirements, Capstone Health Plan offers over the phone interpreter services at no cost to the provider or member.

For more information pertaining to available ADA resources offered through Capstone Health Plan, please call your Provider Services Representative.

Appointment Standards

Contracted providers are expected to adhere to patient appointment standards and waiting times established by the DD/ALTCS program and Capstone. The appointment standards are as follows:

Primary Care Physician (PCP)

1. Emergency appointments the same day or within 24 hours of the member's telephone call or other notification, or as medically appropriate.
2. Urgent care appointments within 2 days.
3. Routine care appointments within 21 days.
4. Routine dental care appointments within 30 days.

Specialty Referrals

1. Emergency appointments within 24 hours of referral.
2. Urgent care appointments within 3 days of referral.
3. Routine care appointments within 30 days of referral.

Waiting Times

Physician Services

1. Waiting times should not exceed **45** minutes except when physician is not available due to emergency circumstances.

Primary Care Physician (PCP) Responsibilities

The responsibilities of the Capstone contracted Primary Care Physician (PCP) are as follows:

1. Deliver and/or arrange for timely, high quality, cost-effective covered services consistent with accepted professional standards, understanding that it may take more time and care for the diagnosis and treatment of persons with chronic diseases/disabilities, as well as, additional time and interaction with their families.
2. Manage the member's care to ensure continuity of care.
3. Utilize the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program for all members from birth through 20 years of age.
4. Capstone encourages primary care physicians to perform an annual health screening for adult members. Generally accepted screening diagnostic tests recommended by recognized professional associations are covered.
5. Participate in the Individual Service Plan (ISP) process when PCP expertise is needed to ensure most appropriate placement and plan of care.
6. Review the ISP submitted by the DES/DDD Support Coordinator to become familiar with the member's needs and requirements.
7. Maintain the unit medical record for the member, (i.e., documentation in accordance with the medical records standards included in this manual).

Medical Records

As a condition of participation, a provider must maintain and make available all records and information including, but not limited to, medical and financial records, relating to the AHCCCS program.

Capstone member medical records must be maintained in a current, detailed, organized, and comprehensive manner that permits effective review. Records must be legible and reflect all aspects of care, including ancillary services.

Written approval from the member is not required:

1. Before transmitting member records to a physician/provider when services are rendered to the member through referral to a health plan or program subcontracted provider.
2. For the PCP to share treatment or diagnostic information such as laboratory test results with the member's Regional Behavioral Health Authority (RBHA), Children's Rehabilitative Services (CRS), or their contracted providers, if the member is receiving services through these facilities.
3. When medical records are requested for quality or utilization review purposes, a release signed by the member is not needed for Capstone, DES/DDD, or PCP requests for records in accordance with Arizona Administrative Code R-9-22-512 and in compliance with all other federal and state laws regarding protected information. Information related to fraud and abuse may be released so long as protected HIV-related information is not disclosed.

Member medical records must be available and accessible to health care practitioners at the time of service, and to appropriate AHCCCS, Capstone and/or HCFA agents for quality review purposes.

Capstone will assess the content of medical records to ensure standards are met during on-site office audits.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 has many provisions impacting the health care industry, including transaction code sets, privacy, and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers who transmit health care information electronically, health plans and health care clearing houses.

Capstone Health Plan makes every effort to comply with the provisions of this federal mandate and encourages providers to contact available sources or their own legal counsel for guidance in implementing HIPAA requirements.

5 Covered Services

Below is a listing and description of covered and non-covered health care services, requirements and limitations. Further explanation of services can be found in the following sections:

- Behavioral Health Services
- Family Planning
- Prior Authorization

Acute Care Health Services

1. Hospital services (inpatient and outpatient).
2. Emergency Medical Services.
3. Physician Services.
4. Services that may be provided in Rural Health Clinic or Federally Qualified Health Center.
5. Lab, x-rays, and medical imaging services.
6. Pharmacy Services.
7. Medical Supplies, durable medical equipment, orthotic and prosthetic devices.
8. Emergency and Medically necessary transportation services.
9. Family planning to include birth control pills; supplies and devices; surgical procedures to cause sterility, delay or prevent pregnancy.
10. Therapies including occupational therapy, physical therapy, respiratory therapy and speech therapy.
11. Podiatry Services.
12. Home Health / Private duty nurse.
13. EPSDT Services.
14. Medically necessary organ transplants limited to: kidney, pancreas, kidney-pancreas, cornea, bone, heart, lung, heart-lung, liver and certain bone marrow transplants.
15. Vision:
 - Children under 21 may receive an annual eye exam and one pair of corrective lenses.
 - Adults 21 and older may receive corrective lenses if medically required after cataract removal.

16. Dental:
 - Children under 21 are allowed a routine check-up every 6 months.
 - Adults 21 and older may receive emergency dental care and medically necessary dentures.
17. Behavioral Health Services for emergency/crisis stabilization.

Non-Covered Services

1. Hearing aids, eye exams for glasses/lenses, and non-emergency dental services for persons 21 or older.
2. Physical therapy prescribed for maintenance reasons only.
3. Treatment of the basic conditions of alcoholism and drug addiction.
4. Services provided in an institution for the treatment of tuberculosis or mental disorders.
5. Sex change operations or the reversal of voluntarily induced sterilization.
6. Services determined by AHCCCS to be experimental or provided primarily for the purpose of research.
7. Personal care items (i.e. toothbrushes).
8. Services or items furnished solely for beauty or cosmetic reasons.
9. Routine podiatry (foot and ankle) services.
10. Orthognathic (jaw) surgery for members age 21 years and older.
11. Most over the counter items unless they are in place of a prescription item.
12. Abortions (unless the mother is pregnant through rape or incest or an abortion is needed to save the life of the mother).
13. Abortion counseling (except in above cases).
14. Organ transplants except for kidney, pancreas, kidney-pancreas, cornea, bone, heart, lung, heart-lung, liver and certain bone marrow transplants.
15. Durable medical equipment not deemed medically necessary (i.e. wheelchair ramps and lifts, exercise equipment, items for the caregiver's convenience, hygiene and comfort items).
16. Medical services provided to a person who is an inmate of a public institution or who is in the custody of a state mental health facility.

Emergency Department Utilization

All Capstone members are issued a Member Handbook at the time of enrollment. Capstone Health Plan advises members to contact their PCP's office when at all possible before going to the Emergency Department. However, if they believe it is a life threatening emergency, they are advised to call 911 or visit the nearest emergency facility.

Emergency services are those health services that are required for the relief of severe pain or treatment of a sudden medical condition which, if not immediately treated could result in disability or death.

Providers may not refer members to the Emergency Room due to non-availability of a same day appointment. All assigned members are considered **active** patients. Every effort should be made to meet the appointment availability standards.

Please assist Capstone in educating your patients on the appropriate use of emergency services as indicated below:

Appropriate for ED

Sever pain: chest or stomach
 Difficulty breathing
 Deep cut w/bleeding that cannot be stopped
 Poisoning or overdose
 New or severe seizure
 Major car accident
 Broken bones
 Stab wound
 Gunshot wound
 Pregnant with pain or bleeding

Non-Appropriate for ED

Earache, Toothache,
 Allergies or sinus problems
 Colds, cough, sore throat, flu
 Rash
 Sunburn or minor burns
 Chronic back pain or lumbago
 Minor headache
 Broken cast, removal of stitches
 Teething
 Strain or sprain

Health care services for member traveling or temporarily living outside the country is restricted to emergency services only.

6 Behavioral Health Services

Capstone is contracted with DES/DDD to provide limited acute behavioral health services as indicated below. DES/DDD is contracted with the Department of Health Services, who in turn contracts with Regional Behavioral Health Authority (RBHA) to provide other behavioral health services.

Capstone will facilitate the referral of members of any age to receive behavioral health services, including drug and alcohol abuse treatment, to the RBHA in the member's area. The RBHA for Coconino, Yavapai, Mohave, Apache, and Navajo Counties is *Northern AZ Regional Behavioral Health Authority (NARBHA)*.

Role of Primary Care Physician

Referral Request

1. The PCP initiates referrals to the Regional Behavioral Health Agency (RBHA) in the community and documents the referral in the member's medical record.
2. In a crisis or emergency, the PCP or designee will call the RBHA and make the appointment for the patient.
 - In non-emergency situations, the PCP will instruct the member, parent or guardian to call and schedule their own appointment.
3. The Regional Behavioral Health Authority (RBHA) will send all Individual Service Plans (ISP) to the PCP, to be included in the member's medical record.
4. The PCP is to share information relevant to the member's treatment. Treatment data to be shared with the PCP will be required in the following circumstances:
 - Medication adjustment and monitoring
 - Laboratory and radiology services
 - Emergency/crisis admissions or events
 - Events requiring medical consultation with the PCP
 - Upon discharge from an inpatient setting or from the Behavioral Health Organization
 - The PCP, the RBHA and Capstone will share information following AHCCCS' confidentiality guidelines. It is not necessary to obtain a signed release of information in these instances.
 - AHCCCS Registration R9-22-51-C states, "Medical record information may be disclosed without the consent of an applicant, member or eligible person for the purpose related to administration of the plan."

5. Members who are referred for substance abuse treatment only, will need a signed release of information under the guideline of 42 CFR Part 2 governing Confidentiality of Alcohol and Drug Patient Records.
6. As of October 1, 1999, PCPs are able to treat and medicate members for the following Behavioral Health Disorders:
 - Depression
 - Anxiety
 - Attention Deficit Disorder (ADD)
7. PCPs are responsible for ensuring members receive medication either from the contracted pharmacies or RBHA.
8. Problems or suspected problems detected upon EPSDT screening must be further evaluated and treated or referred for treatment using a RBHA *Behavioral Health Services Referral*.

Emergency Crisis Services

- Coverage is limited emergency services only.

PCP Questions Regarding Psychiatric Issues

RBHA has made arrangements to have a psychiatrist available by telephone to answer questions of a general nature. For telephonic and/or one time “Face-to-Face” psychiatric consultations, call the RBHA Service Area Agency closest to the member’s place of residence, then ask to speak to the physician on call.

RBHA Service Area Agency Information

(928) 774-2070

(800) 640-2123

<http://www.hs.state.az.us/bhs>

<http://www.narbha.org/services.htm>

7 Children's Rehabilitative Services (CRS)

CRS is a program administered by the Arizona Department of Health Services (ADHS) that is designed to provide specialty medical and surgical care of a comprehensive and habilitative nature to children who meet CRS financial and medical eligibility criteria.

1. The CRS program provides a comprehensive multi-disciplinary approach to management of CRS covered conditions, but does not provide primary care. Capstone remains responsible for provisions of primary care.
2. CRS is not an emergency service program. CRS administrators will attempt to accommodate emergency referrals.
3. Capstone will remain responsible for the provision of all covered services to members until CRS eligibility is confirmed.

CRS Eligibility

- Child has a CRS-covered condition as defined in the CRS Policy and Procedure Manual.
- Child requires comprehensive multi-disciplinary care.
- Child has a reasonable potential for habilitation.

CRS covered services will ordinarily include the planned management of the covered condition, including inpatient care, surgery, therapy, prescription drugs, limited DME and home health care, and social and educational services, as well as periodic follow-up.

Member Is Currently Enrolled In CRS

- Schedule appointments through the CRS clinic in which the member is eligible.
- Educate the member or caregiver to obtain medications through the CRS pharmacy program for prescriptions written by a CRS physician.

Emergency Services

Emergency services are not ordinarily covered by CRS, nor is the initial care of newborn infants. Retinopathy of Prematurity (ROP) may be an exception. To expedite the CRS application process for these cases, contact the CRS Patient Advocate at the appropriate clinic listed below.

Flagstaff (928) 773-2054
Tucson (928) 324-3220

Phoenix (602) 406-6416 or (602) 406-6440
Yuma (928) 344-7294

Capstone members with CRS covered conditions should be referred to CRS. The member has a responsibility to pursue enrollment in CRS. Capstone can provide your office with an application form for the member to complete. Call Capstone Member Services if an application is needed.

8 Family Planning Services

Capstone provides Family Planning Services to eligible members who voluntarily choose to delay or prevent pregnancy. Below is a listing and description of covered and non-covered family planning services.

Covered Services

1. Contraceptive counseling, medication, supplies and associated medical and laboratory examinations including, but not limited to, oral and injectable contraceptives, Norplant, intrauterine devices, diaphragms, condoms, foams, suppositories and sponges. (Norplant insertion requires Prior Authorization)
2. Associated medical and laboratory examinations including ultrasound studies related to family planning.
3. Treatment of complication resulting from contraceptive use, including emergency treatment.
4. Natural family planning education or referral to qualified health professionals.
5. Sterilization (male and female). Follow AHCCCS Rules and Regulations regarding required documentation.
6. Abortion, when essential to protect the life of the mother or when the pregnancy is the result of rape or incest.
7. Pregnancy Screening
8. Screening and treatment for sexually transmitted diseases

Non-Covered Services

1. Infertility services including diagnostic testing, treatment services or reversal of surgically induced infertility.
2. Abortion counseling, except as indicated above.
3. Abortions except as noted above.
4. Hysterectomies that are not medically necessary.

Sterilization

Federal consent requirements for voluntary sterilization require:

1. The member must be at least 21 years of age at the time consent is signed.
2. The member is mentally competent.
3. Consent must be voluntary and obtained without duress.
4. Thirty (30) days, but no more than 180 days, have passed between the date the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.
5. Members may be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since the member gave informed consent for the sterilization.
6. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
7. The person securing the informed consent and the physician performing the sterilization procedure must sign and date the consent form.
8. A copy of the signed Federal Consent Form must be submitted by *each provider* involved with the hospitalization and/or the sterilization procedure.

Sterilization Consent

Consent for sterilization may **not** be obtained when a Capstone member:

- Is in labor or childbirth.
- Is seeking to obtain or obtaining an abortion.
- Is under the influence of alcohol or substances that affect that member's state of awareness.

Elective Sterilization

All requests for elective sterilization must have the approval of both the Capstone Medical Director and the DES/DDD Medical Director. The following documentation is required at time of request for prior authorization:

- Current physical exam.
- Birth control method(s) previously used.
- Gynecological, sexual, and reproductive history.
- Associated medical conditions.

- Description of the procedure to be performed including any special considerations needed.
- Documentation of guardianship.
- A Federal Consent Form signed by the client and/or guardian.
- Physician statement of medical necessity.

Emergency Sterilization

In the event an emergency sterilization procedure is performed due to a life-threatening situation, Capstone must be notified within 2 working days.

9 Prior Authorization

Overview

The Capstone Prior Authorization process is designed to provide the process necessary to support the prospective review of medical services.

Capstone contracted Primary Care Physicians are the gatekeepers of Prior Authorization Requests. Requests received by non-PCP providers will be redirected by Capstone to the PCP. The following providers may request an authorization for necessary medical services:

- Dental providers requesting specialty dental services
- Attending physician at time of hospital discharge
- Specialist with current consult & treat authorization
- Medically necessary transportation may be requested by member or member's guardian.

Who to Contact for Prior Authorization

Prior authorization for services must be obtained from the Capstone Prior Authorization Department.

Prior authorization for a non-formulary medication must be obtained from Partners Rx.

Where to Direct Prior Authorization Requests

Capstone Health Plan Prior Authorization Department:

Telephone: **(928) 779-2113** or **(800) 336-3874** extension **3487** or **3488**

Fax: **(928) 779-3234** or **(928) 214-3497** or toll free **(888) 779-3251**

Partners Rx Authorization for Non-Formulary Medications:

Help Desk: **(800) 364-8865**

Fax: **(602) 678-0941** or **(866) 563-9220**

Services that Require Prior Authorization

Certain medical services require authorization from Capstone Health Plan prior to services being rendered. Please refer to the list below.

1. Referrals to Specialists
2. Podiatry Services
3. Chiropractic Services
4. Incontinence products
5. Dental services for children under age 21 costing >\$3,000
6. Ophthalmology Services for members age 21 and older
7. Elective Hospitalizations
8. Admission to Skilled Nursing or Rehabilitation Facilities
9. Home Health Care
10. Elective Surgical or Outpatient Facility Procedures
11. Non-Formulary Medications and Formulary Medications designated "PA Required"
12. Rehabilitative Therapies (respiratory, physical, occupational, speech)
13. Durable Medical Equipment, Prosthetics, Orthotics, Adaptive Aids, Oxygen
14. Medical Supplies
15. Commercial Oral and Enteral Nutritional products
16. Infusion Therapy (outpatient)
17. Colonoscopies
18. Esophagoduodenoscopy (EGD)
19. Electromyography (EMG)
20. CT Directed Biopsies and Injections
21. Cardiac Stress Testing, Including Stress Echocardiograms
22. Behavioral Health Services
23. Non-Emergent Medically Necessary Transportation
24. General Anesthesia for dental work or other procedures
25. Non-emergent lumbar punctures

Services that Require Prior-Authorization from the Capstone Medical Director

1. Dialysis
2. Growth hormone and Synagis
3. Consultations with developmental pediatricians
4. High-frequency chest wall oscillation (HFCWO) vests
5. Bone Marrow Biopsy and Aspiration
6. Sleep Studies
7. 24 hr EEG Video Monitoring
8. PET Scans
9. Neuropsychological Evaluations
10. Genetic Testing
11. Allergy Testing
12. Chemotherapy and Radiation Therapy

Services that Require Prior-Authorization from the DDD Medical Director

1. Transplant (heart, heart-lung, liver)
2. Hospice
3. Total Parenteral Nutrition (TPN) longer than 6 months in duration
4. Sterilization
5. Hysterectomy
6. Termination of pregnancy
7. Foster care member denials

Services That Do Not Require Prior-Authorization

1. Services provided by the Primary Care Provider (PCP), including Well Child visits (EPSDT)
2. Routine Outpatient Diagnostic Testing, including, but not limited to, MRI and CT scans, X-rays, EEG, audiogram
3. Dental services for children under the age of 21 that are preventive or that cost less than \$3,000 (must be covered services under AHCCCS/Capstone Policy)
4. Emergency Dental Services: limited for adults to treatment of acute pain, infection (medications but not tooth extractions), or fracture of the jaw
5. Eye Exams and one (1) pair of glasses per year for members under 21 years of age
6. Prescription Medications listed on the Capstone Formulary.

Services that Require Notification to Capstone within 72 hours:

1. Emergency Department Visits
2. Emergency Transportation
3. Emergency Hospitalizations Provider **must notify** Capstone Health Plan **no later than 72 hours after a member presents to a hospital**, including receiving emergency medical services. Capstone **will deny payment** for failure to provide timely notice of admission. The notification may be made by faxing (928) 779-3234.

How to Complete an Authorization Request

Providers are requested to submit a Capstone Authorization Request Form for all authorization requests. You may download a copy of the Authorization Request form at: <http://www.nazcap.com/providers>. Providers are also encouraged to submit any pertinent medical documentation in support of the request. Failure to submit sufficient justification information may cause the authorization request to be denied. Pertinent documentation includes the following:

- Description of requested service
- Reason for recommendation
- Name of specialist or facility to which the patient is being referred
- Specialty of person/place to which the patient is being referred
- Address, phone number and fax number for referred specialist or facility

Deadlines for Requesting Authorization

It is Capstone Health Plans policy that all requests for authorization must be made prior to the service being rendered.

However, emergency services, such as ER admissions must be reported to Capstone Health Plan within 24 hours of admission. Emergency transportation providers must notify Capstone within ten (10) business days from the date of service.

Time Frames for Providing Authorizations

It is the policy of Capstone to respond to an authorization request with an Approved, Medical Review or Denied status within two (2) business days of receipt.

- Elective service requests will be decided within two (2) business days after receipt of the clinical information needed for Capstone staff to render an appropriate decision. The PCP will be notified by fax of approval or denial
- Urgent service requests will be decided within one (1) business day after receipt of the clinical information needed for Capstone staff to render an appropriate decision. The PCP will be notified by fax of approval or denial of urgent requests within the same business day of decision being made.
- For denials, the PCP and Capstone member will be sent written notification of the decision within two (2) business days of denial.
- Capstone will make every attempt necessary to meet the above listed time frames for authorization requests.

Approved Requests

Approved Requests are faxed back to the PCP and to the service provider with an authorization number.

- The authorization number must appear on all claim forms submitted to Capstone for payment.
- The authorization will remain effective for 60 days from the date of issue unless otherwise indicated.
- All authorizations are contingent upon the member's eligibility status on the date the service is provided.
- For services not included under the approved request, the PCP must contact Capstone to amend the original request and receive a new authorization. Claims submitted without an amended authorization number may be denied.

Medical Review

If a referral request requires additional information, clarification and/or documentation before a decision can be made, the request will be placed in Medical Review. The referral request will be faxed back to the requesting office for any required information. Requests placed in Medical Review will be directed to the Medical Management Department. A final decision will be made when the appropriate information is received. If the information is not received within the requested time period, the request may be denied.

- Prior authorization requests placed in Medical Review will be acted upon within fourteen (14) working days of receipt.
- Prior authorization requests directed to the Medical Management Committee will be acted upon within (60) days.

Denied Requests

Denied Requests will generate Denial Notifications to be sent to both the PCP and the Capstone Member.

- A denial indicates that the request clearly does NOT meet Capstone approval criteria (i.e., member not eligible, service requested not medically necessary/appropriate/covered, requested provider is not a registered AHCCCS provider.)
- The Capstone Medical Director makes all final denial decisions. Notification of denials and appeal rights is performed per AHCCCS policy based on Perry vs. Kelly.
- Denial notification for services not yet rendered will be sent to the member in writing within two (2) business days of the decision. Denial notification will be faxed to the PCP. Appeal and grievance rights, including denial rule references, are included with the denial notification.
- Denial notification for services already provided or currently being provided will be sent to the PCP and member within two (2) days of the decision, along with a Notice of Intended Action specifying a 10 day period prior to the reduction, suspension, or termination of the service.

Appeal and grievance rights, as well as denial rule references, will be included in the notice. If the member files a written request for an appeal within 15 days of the date of notice, Capstone will continue to provide the current level of services during the appeal.

10 EPSDT / Prevention

Definition

Chapter 1 EPSDT is a federally mandated program specifying medical standards of care for preventive efforts of children. EPSDT Services is defined as Early and Periodic Screening, Diagnosis and Treatment services for members under the age of 21 years.

Early means as early as possible in the child's life, or as soon after the member's eligibility with Capstone has been established.

Periodic means at intervals established by the AHCCCS Administration for screening to assure that a condition, illness, or injury is not incipient or present.

Screening means regularly scheduled exams and evaluation of the general physical and mental health, growth, development and nutritional status of infants, children and youth. Also, the identification of those in need of more definitive study. Screening and diagnosis are not synonymous.

Diagnosis means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory test, and X-rays, when appropriate.

Treatment means any type of health care or services recognized to prevent or ameliorate a condition, illness, and injury or to prevent or correct abnormalities detected by screening or diagnostic procedures.

EPSDT Screening Components

Capstone EPSDT requirements will be conducted according to the time frame identified in the EPSDT periodicity schedule and inter-periodic screenings as appropriate for all members under the age of 21 years. The provider shall perform the following:

- A comprehensive health and developmental history (including physical, nutritional and behavioral health assessment);
- A comprehensive unclothed physical exam;
- Appropriate immunizations according to age and health history;
- Laboratory tests (including blood lead screening assessment appropriate to age and risk, tuberculosis screening appropriate to age and risk, anemia testing, and if appropriate, diagnostic testing for sickle cell trait);
- Health education;
- Appropriate dental screening;
- Appropriate vision, hearing and speech testing.

Physical Exam

1. EPSDT services will be provided according to community standards of practice and the EPSDT periodicity schedule. Capstone EPSDT tracking forms will be used to document services provided and compliance with standards.
2. Physical Examination – A comprehensive, unclothed physical examination performed according to acceptable medical practice.
3. The purpose of the EPSDT physical examination is to:
 - Evaluate the form, structure, and function of particular body region and systems;
 - Determine if these region(s) and systems are normal for the child's age and background;
 - Discover those diseases and health problems for which no standard screening test has been developed, including evidence of child abuse and/or neglect.
4. The physical examination serves as a general health evaluation and provides important information for other components of the EPSDT screening. The PCPs consider age of the member when conducting the physical examination. The PCPs will initiate appropriate referrals according to their findings.

Developmental Assessment

The developmental assessment is designed to determine whether a child's developmental process falls within a normal range of achievement according to age and cultural background. Screening for developmental assessment will be done at each EPSDT visit. The assessment will include obtaining a relevant developmental history, assuring accurate and informative observation of members and attending to parental concerns. Emphasis will be placed on monitoring development within the context of the member's overall well being, rather than viewing development within isolation during a testing session. An objective developmental test must be administered as a 'second stage' screening instrument when the history and/or physical examination is suspicious. The following elements will be assessed:

- Gross motor development, focusing on strength, balance, locomotion;
- Fine motor development, focusing on eye-hand coordination;
- Communication skills or language development, focusing on expression, comprehension and speech articulation;
- Self-help and self-care skills;
- Social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents and other adults;
- Cognitive skills, focusing on problem solving or reasoning.

Throughout school age, focus on:

- Visual-motor integration;
- Visual-spatial organization, visual sequential memory;
- Attention skills and auditory processing skills;
- Auditory sequential memory.

For adolescents, focus on:

- Potential presence of learning disabilities;
- Peer relationships;
- Psychological/psychiatric problems;
- Vocational skills.

Anytime the member's assessment falls out of the normal range of achievement according to age and cultural background the PCP will refer the member to appropriate specialist, state program or community resource for follow up evaluation, diagnosis and treatment.

Nutritional Assessment

Nutritional Assessment and Supplemental Nutritional Feedings (these services must be Prior Authorized) – EPSDT covers assessment of nutritional status as specified in the EPSDT periodicity schedule. Nutritional assessment will be accomplished through questions regarding dietary practices to identify unusual eating habits or diets at each EPSDT visit.

The complete physical exam will include a dental screening examination with further guidance on obtaining necessary dental care, accurate measurement of height and weight and appropriate lab tests according to age and risk. Use of a growth chart developed by the National Center of Health Statistics (NCHS) is recommended for each EPSDT member.

Capstone covers supplemental nutritional feedings, provided on either an internal or oral basis, when determined medically necessary.

Tuberculin Testing

Tuberculin testing recommended for children in a high-risk population includes:

- Any child born outside the United States in developing countries;
- Any child with any medical condition which would increase the incidence of TB infection such as HIV infection, chemotherapy treatment, diabetes, renal disease or treatment which suppresses the immune system;
- Any child living in a household with anyone who has TB, anyone with HIV infection, anyone who has a positive PPD test and/or anyone identified as an alcoholic or as an IV drug abuser.

Blood Lead Screening

EPSDT covers blood lead screening as appropriate to age according to the EPSDT periodicity schedule. All children ages 6 months to 72 months are considered at risk and must be screened for lead poisoning and a verbal risk assessment must be completed at each EPSDT visit to determine risk category.

Immunizations

EPSDT covers all child and adolescent immunizations as specified in the EPSDT periodicity schedule. The appropriate immunization must be provided to maintain an “up to date” status for each EPSDT member. Capstone providers coordinate with the ADHS Vaccine for Children program in the delivery of immunization services. Immunizations are provided according to the Advisory Committee on Immunizations Practices (ACIP) schedule.

Vision Screening

The PCP will assess vision screening at each EPSDT visit as appropriate to age according to the EPSDT periodicity schedule and as medically necessary. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered under the EPSDT screening process. The PCP will initiate appropriate referrals to an Ophthalmologist for further evaluation when an EPSDT member fails the vision screening.

Hearing/Speech Screening

The PCP according to the periodicity schedule will assess hearing screening at each EPSDT visit. Further necessary evaluations, such as impedance testing, are referred to an Ear, Nose and Throat (ENT) Specialist as needed. Speech screening for language development will also be assessed at each EPSDT visit. Medically necessary and appropriate speech therapy is a covered service.

Behavioral Health Screening

Screening for mental health and substance abuse is assessed at each EPSDT visit. The PCP may refer to AHCCCS Behavioral Health Screening Guidelines. For further details on Behavioral Health Services refer to the Behavioral Health Services section.

Dental Screening

Dental screening is provided according to the EPSDT periodicity schedule. Members are allowed self-referral to a dentist.

Health Education

Health counseling and education is provided at each EPSDT visit through the anticipatory guidance section of the EPSDT tracking form. The anticipatory guidance is to assist parents and guardians in what to expect in terms of the member’s development and information about the benefits of healthy lifestyles, accident and disease preventions.

EPSDT Forms

Use of the age appropriate standardized EPSDT Tracking Form is required to document the EPSDT screening evaluation. All sections of the EPSDT form must be completed. EPSDT forms can be found on the Capstone Health Plan website or the AHCCCS website.

A completed copy of the EPSDT form must be submitted to the claims department when billing for EPSDT encounters.

EPSDT Dental Services

Capstone members age 0 to 20 years are entitled to receive routine dental care services that include emergency, preventative and therapeutic dental services through the federally funded EPSDT program. Authorization or Primary Care Provider (PCP) referrals for routine, usual and customary services for this age group are not required. However, it is expected that the PCP will initiate and encourage appropriate individual member referrals to contracted providers in addition to self-referral.

- Capstone members within this age group are advised that they may call the dentist directly to schedule an appointment. All PCPs and members are informed of participating dental providers in their area.
- The following EPSDT dental services are covered:

Emergency Dental

1. Emergency dental services are a covered benefit for all Capstone members and do not require prior authorization. A retrospective review of emergency services is performed to determine the medical necessity and appropriateness of the service. Capstone requests notification from provider for tracking purposes.
2. Emergency services include, but are not limited to, the following:
 - Relief of sever pain accompanying an oral or maxillofacial condition, limited to immediate palliative treatment, but including extractions when professionally indicated;
 - Initial treatment for acute infections;
 - Immediate and palliative procedures for acute cranio-mandibular problems and for traumatic injuries to teeth, bone, and soft tissue;
 - Laboratory and preoperative procedures, including examination and radiographs;
 - Appropriate anesthesia for optimal patient management;
3. Treatment for pain, infection, swelling or injury.
4. Extraction of symptomatic, infected and non-restorable primary and permanent teeth, and retained primary teeth.
5. General anesthesia or conscious sedation when local anesthesia is contraindicated or when management of the patient require it.
6. Preventative dental services as specified in the EPSDT periodicity schedule.

Routine Dental

Capstone encourages eligible members to obtain a routine dental examination every six (6) months. The examination includes the following:

1. Instruction in self-care oral hygiene procedures;
2. Complete intraoral examinations;
3. Diagnostic radiology procedures, including panograph or full-mouth x-rays: supplemental bitewing x-rays; and occlusal or periapical films;
4. Oral prophylaxis performed by the dentist or a dental hygienist;
5. Application of topical fluorides;
6. Dental sealants on all non-carious permanent first molars.

Therapeutic Dental

Services are covered when medically necessary. These services include:

1. Periodontal procedures, scaling/root planning, curette, gingivectomy, osseous surgery;
2. Space maintainer when posterior primary teeth are lost prematurely;
3. Stainless steel crowns for both primary and permanent teeth;
4. Composite crowns for only anterior primary teeth;
5. Plastic or acrylic crowns for anterior primary teeth;
6. Plastic or acrylic crowns for permanent teeth;
7. Pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing molar;
8. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations;
9. Dentures, orthodontics and orthognathic surgery when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan agreed upon by the PCP and the dentist.

Effective 10/1/09, the following limitations apply:

- The minimum age for complete x-ray series, including bitewings (D0210) increased to 6 years.
- The minimum age for panoramic x-rays (D0330) increased to 5 years.
- The minimum age for bitewing x-rays, two films (D0272)-increased to 2 years.
- The minimum age for bitewing x-rays, three or four films (D0273, D0274) increased to 10 years.
- The maximum age for dental sealants (D1351) lowered to age 15 years.
- Behavior management by report (D9920) is eliminated as a covered benefit.

EPSDT Immunizations

A comprehensive periodic immunization compliance shall be addressed at each EPSDT visit. The immunization compliance will be conducted according to the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practice (ACIP).

All Capstone providers of EPSDT services shall meet the following immunization conditions:

1. Provide immunization services at no charge to the Capstone members.
2. Utilize all clinical encounters with members to screen, and when indicated immunize, as per ACIP schedule.
3. Ensure members receive the following required immunizations in the appropriate time frame:
 - DTP – diphtheria, tetanus and pertussis
 - TD – tetanus and diphtheria toxoids
 - IPV – inactivated polio virus vaccine (or) OPV – oral polio virus vaccine
 - MMR – measles, mumps and rubella
 - HIB – haemophilus B conjugate vaccine
 - HBV – hepatitis B vaccine
 - VZV – varicella zoster virus vaccine
4. Educate parents and/or caregivers about immunizations at each EPSDT visit. This includes explaining the importance of immunizations, the true contraindications of vaccines, and the risks and benefits of the immunization.
5. Adhere to only true contraindications to vaccine, as specified in the ACIP recommended Standards for Pediatric Immunization Practices.
6. Simultaneously administer to members all vaccine doses needed according the ACIP Schedule.
7. Record the following, as required by Arizona Revised Statute:
 - Vaccine and dosage given
 - Date the vaccine was given (month/day/year)
 - Name of the manufacturer of the vaccine
 - Lot number of the vaccine
 - Signature of the person administering the vaccine

This information shall be kept in the child's medical record at the PCP's office.

8. Encourage parents and/or caregivers to maintain a copy of their child's personal immunization record. The provider's office will update this record at each EPSDT visit, documenting what vaccine was given, the date (month/day/year) of the vaccine, and who administered the vaccine.
9. If a member receives their immunization from the county health department, Capstone will provide this record to the PCP for inclusion in the chart.

Exemptions from Immunization

Capstone Health Plan and State regulations allow for exception based on medical or personal beliefs. However, such exemptions are not intended to be used to achieve compliance. Claiming exemptions is not a substitute for protection that can only be gained from immunization. Documentation of exemption for personal or medical reasons may be written in the PCP's progress notes on the members chart.

1. Medical Exemption: An Arizona Department of Health Services (ADHS) approved form must be signed by the child's PCP stating that the child has a medical condition such that the required immunizations would seriously endanger his/her well-being. This statement must be disease specific, states whether the condition is permanent or temporary, and include the date.
2. Personal Exemption: The parent or guardian must submit a signed statement using an approved ADHS form, stating that he/she has read and understands the risks and benefits of the disease(s) and immunization(s) and refuses consent for the immunization of the child.

State Required Immunization Reporting

All immunizations administered to children 18 years of age and under must be reported to the State Health Department, Arizona State Immunization Information System (ASIIIS). As stated in the A.R.S. § 36-135 and AAC R9-6-706 & 707, reporting of immunizations administered to children within the state of Arizona is mandatory. The reporting of all such data on children, from birth to 18 years, is the only way to assure that the state's central database has the complete record of every child. With complete reporting, providers will no longer have to reconstruct the record from previous providers.

For additional information you can call ADHS at: (602) 230-5894 or (877) 491-5741 or visit their web site at: <http://www.hs.state.az.us/phs/asiis>.

EPSDT Program Compliance

It is the goal of Capstone Health Plan to maintain a minimum 90% compliance rating for completed EPSDT examinations of Capstone members. Capstone Health Plan and the PCP shall work together to achieve this goal by adhering to the following responsibilities:

Responsibilities of Capstone

1. Educate Capstone members and providers regarding services available.
2. Send monthly notification to members and PCP's according to Periodicity Schedule.
3. Assist the PCP by providing information and facilitating referrals as needed.
4. Perform on site office and chart reviews to assure compliance with EPSDT requirements.
5. Monitor, track and report EPSDT program compliance to DES/DDD Managed Care.

Responsibilities of PCP

1. Perform EPSDT services according to Periodicity Schedule. Use acute care visits to address missed screenings, when necessary.
2. Properly use and complete the EPSDT Tracking Form (completion of **all** sections is required).
3. Submit a copy of the completed EPSDT Tracking Form with the EPSDT encounter.
4. Refer Capstone members for initial treatment and follow-up care for conditions detected during the EPSDT screening.
5. Participate in Capstone on site office visits and chart reviews as requested by Capstone.



Capstone Health Plan encourages primary care providers to refer eligible members to the WIC program. The following information is for your reference and may be obtained at the Arizona Department of Health Services website: <http://www.hs.state.az.us>

Arizona Women, Infants, and Children

Arizona WIC is a federally funded program which provides Arizona residents with nourishing supplemental foods, nutrition education, and referrals. The participants of WIC are either pregnant, breastfeeding, or postpartum women, and infants and children who have nutritional needs and meet income guidelines.

How to Become a Client

- Call 1-800-2525-WIC to set up an appointment with your local WIC agency.
- Find a WIC Clinic near you by searching the internet at :
http://www.hs.state.az.us/phs/oncdps/wic/wic_clinics.htm
- Bring proof of income. One of the following for everyone who works:
 - Paycheck
 - Tax return
 - Letter from employer
- Individuals with proof of AHCCCS, TANF, or Food Stamps meet WIC income eligibility.
- Bring proof of residence or identity. One of the following:
 - Driver's License
 - Utility bill
 - Official identification
- Undergo a simple health screening to determine nutritional risk.

Eligibility Guidelines

1. Must be in one of the following categories
 - Pregnant woman
 - Breastfeeding woman
 - Postpartum woman to 12 months (if she's breastfeeding)
 - Infants
 - Child under 5 years of age
2. Meet income guidelines
3. Must be at nutritional risk
4. Must be a resident of Arizona

Participant Benefits

- WIC foods
- Health Screening
- Nutrition Education
- Breastfeeding Support
- Premature births are reduced
- Low birth rates are reduced
- Long term medical expenses reduced
- Immunization referrals

Nutrition Education

Nutrition Education is provided to all WIC participants. Nutrition education stresses the relationship between proper nutrition and good health. Special emphasis is placed on the nutritional needs of the client. Nutrition education assists the client in achieving a positive change in food habits to result in improved nutritional status. Use of supplemental foods and other nutritious foods enables the client to prevent nutrition-related problems.

Each WIC clinic provides appropriate nutrition education to all participants using at least two nutrition contacts within a six month certification period. The nutrition education contacts come in the form of individual counseling, group classes, and a wide variety of nutrition education materials.

Breastfeeding

The goal of breastfeeding services is to ensure that all pregnant WIC participants be encouraged to breastfeed unless it is contraindicated for health reasons. Benefits may include individual breastfeeding counseling or group educational classes, educational materials, provision of additional foods for breastfeeding women and the distribution of breast pumps for breastfeeding women to encourage breastfeeding through times of separation from their infants.

11 Adult Dental Services

Overview

Capstone covers dental services provided by a licensed dentist or dental hygienist to members within certain limits based on member age and eligibility category. The dental services described in this section apply to members age 21 years and older. **All dental services for members age 21 and older require prior authorization.** Please refer to the EPSDT/Preventive section of this manual for benefits available to member's age 20 years and younger.

Adult Dental Benefits

In accordance with AHCCCS Policy 310-D Capstone covers medical and surgical services furnished by a dentist only to the extent that such services may be performed under State law by either a physician or by a dentist, and the services would be considered physician services if furnished by a physician.

Adult covered dental services must be related to the treatment of a medical condition such as acute pain, excluding temporomandibular joint (TMJ) pain; infection; or fracture of the jaw. Covered services include a limited problem focused examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.

Exception for Transplant and Cancer Cases

Adult dental services provided as a pre-requisite to AHCCCS covered organ or tissue transplantation are limited to the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations (silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns). Capstone covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered.

Limitations

Except for limited dental services covered for pre-transplant candidates and for members with cancer of the jaw, neck or head described above, covered services furnished by dentists to members 21 years of age and older do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. These services are not an AHCCCS covered service for adults even though they are rendered by a dentist.

12 Pharmacy Services

Overview

Capstone Health Plan contracts with Partners Rx for pharmacy benefit management services. The Partners Rx network is comprehensive and additional information may be found at: www.partnersrx.com. A listing of all participating pharmacies and the Capstone Formulary can be found at www.nazcap.com/pharmacy.

Please be sure to refer to the formulary prior to writing a member's prescription. ***Whenever possible, prescriptions should be written for the generic equivalent per the formulary.***

To avoid the member experiencing delays at the pharmacy, please contact Partners Rx to obtain a prior authorization when a non-formulary medication is prescribed.

Non-Formulary Prior Authorization

All non-formulary medications require a prior authorization to be obtained through Partners Rx using the proper authorization request form included in this section. Complete the entire request form and fax to the following number:

Partners Rx Fax Number: (800)-527-0531

You may also contact the Partners Rx Help Desk if you need further assistance at:

Partners Rx Help Desk: (800) 711-4555

Please obtain prior authorization approval before the patient goes to the pharmacy.

Pharmacy Limitations

- Capstone does not cover medications that are covered by Children's Rehabilitative Services (CRS). Prescriptions written by a CRS physician for a member enrolled in CRS are to be filled at the CRS pharmacy. CRS has a mail delivery service for members who cannot pick up the medications at the pharmacy. CRS covered medications are **excluded** from Capstone coverage, this includes prescriptions written for these medications by any physician, including the PCP. Please notify members to obtain their CRS covered medications from CRS.
- Thirty (30) day limitation on coverage of psychotropic medications prescribed that is not covered by Capstone. Please see the Behavioral Health section of this manual for additional information regarding Capstone coverage of these medications.

13 Durable Medical Equipment (DME)

Overview

Durable Medical Equipment (DME) and medical supplies are items ordered by the PCP for the exclusive use of the patient as a treatment for illness, disease, or accidental injury.

Medical supplies, durable equipment, orthotic and prosthetic devices prescribed by the PCP, a practitioner or by a specialty physician, qualify as covered services when they are medically necessary and not excluded by rules quoted in Arizona Administrative Code R9-22-208.

Durable Medical Equipment Benefits

Durable means the item is able to exist for an extended period without significant deterioration. The item may be rented or purchased, depending on the following:

1. Medical necessity and diagnosis.
2. Regulations of primary member's insurers, such as Medicare.

Repairs to equipment, which a member already owns prior to Capstone enrollment as well as equipment purchased by Capstone are covered in order to make the equipment serviceable.

Consumable DME

- Diabetic supplies
- Feeding supplies
- General medical supplies
- Ostomy supplies
- Respiratory supplies
- Splints – medically necessary
- Surgical supplies
- Urinary supplies

Standard DME (rental or purchase)

- Canes, crutches, walkers
- Manual hospital beds and accessories
- Manual wheelchairs and accessories
- Oxygen & related respiratory equipment
- Patient lifts
- Shower chairs
- Suction machines
- Other equipment deemed medically necessary by PCP

Orthotics and Prosthetics

Capstone covers orthotic and prosthetic devices that meet the following criteria:

- Orthotics determined to be medically necessary to prevent or correct a deformity.
- Prosthetic devices and supplies determined to be medically necessary for post amputation.

As of 10/1/2010 per A.R.S. 36-2907, all orthotics and the following prosthetics are not covered for Non-QMB members 21 years of age and older:

1. Bone Anchored Hearing Aids (BAHA), also known as osseointegrated implants
2. Cochlear implants
3. Insulin pumps
4. Percussive vests

Adaptive Aides

- Feeding aids (including trays for wheelchair)
- Helmets
- Traction equipment
- Transfer aides
- Wedges for positioning
- Car Seats: Based on Medical Necessity. Documentation needed includes: Height and Weight, Head and Trunk Control, Air Way Obstruction potential (per physician), Presence or Absence of a potential for scoliosis, Presence or absence of seizure activity and frequency.

Customized or Special Order DME

- Electric or semi electric beds
- Power wheelchairs (see guidelines)
- Special order or custom commode chairs
- Special order or custom shower chairs
- Standers (prone and upright)
- Other equipment that must be specially modified or made for an individual member

DME Requests

- All DME requires a referral for prior authorization.
- Consumable DME will be limited to a one-month supply.
- Authorization number(s) for consumable DME and the rental of standardized DME will be issued for the length of the PCP's referral.
- Standard DME will not be replaced or repaired more often than one time per year without extenuating circumstances.

Authorization Process

- Fax a completed Authorization Request Form to Capstone with a pertinent diagnosis along with the estimated length of use.
- Monthly consumable DME requests: PCP initiates a referral to a Capstone DME provider, the DME provider will fax in Authorization Request.

Customized or Special Order Requests

- Customized or Special Order DME requires approval by the Medical Director.

PCP Responsibility

- Send a written prescription to Capstone describing the item(s) requested and length of time of use, if applicable.
- Provide medical necessity, in writing, for equipment requested. Include all pertinent documentation at time of request.

Therapist Responsibility

- Provide evaluation for equipment.
- Provide progress notes.
- Provide care plan using equipment with goals stated.
- Sign ISPP requesting equipment.
- Provide post equipment receipt evaluation.

DDD Support Coordinator Responsibility

- Provide ISPP which mentions equipment as objective. Identify goals associated with equipment.
- Responsible for following usage and appropriateness of equipment.

If there is not a recent physical therapy evaluation on the client, Capstone will initiate a referral to a physical therapy specialist to provide an evaluation which includes; reason for the equipment request along with goals and objectives. Capstone reserves the right to have a DME specialist of our choice present for the physical therapy evaluation, and to make a home visit, if necessary, to assess the appropriateness of the equipment in the member's home environment. When Capstone has received and reviewed all the documents requested, the information will be presented to the Medical Director for decision. The Medical Director may choose to have a second opinion by a rehabilitative doctor to evaluate all the records and give a recommendation before his final decision is made.

Exclusions of Coverage

- Air purifiers*
- Comfort items
- DME items for family or care taker convenience
- Equipment not needed for medical necessity
- Exercise equipment
- Humidifiers*
- Hygiene items
- Wheelchair lifts
- Wheelchair ramps

**Under certain conditions these items may be covered by the health plan when determined medically necessary and approved by the Medical Director.*

14 Claims / Billing

Acceptable Claim Formats

Providers may submit their claims in one of the following formats:

- CMS 1500
- UB04
- ADA Dental Claim Form

AHCCCS Provider Identification Number

All claims submitted to Capstone Health Plan must include the provider's AHCCCS Provider Identification Number. Claims submitted without the correct or current AHCCCS ID number will be denied.

Providers may register with AHCCCS by contacting the AHCCCS Provider Registration office at (602) 417-7670 or (800) 794-6862 (in Arizona) or (800) 523-0231 (out of State).

National Provider Identifier (NPI)

All claims submitted to Capstone Health Plan must include the provider's NPI as per CMS guidelines. Claims submitted without the correct or current NPI will be denied.

Where to Send Claims

Electronic Claim Submission: Capstone Health Plan accepts CMS1500 claims electronically through Emdeon. For more information you may contact our Claims Department.

Please refer to a current Emdeon Business Services Payer List for a definition. The following information is necessary to submit claims to Capstone Health Plan:

Item Description	Comment	RT/FLD
Claim Status	Level 1	
Payer Contact	Claims Department (928) 779-2113	
Source of Payment Code	Must Contain a Value of "F" edits: Commercial	30-4
Payer ID	86044	30-5
Payer Type	Participating	
Card Status: Blanket No- Card	Yes: Claim Office ID may contain "NOCD".	30-6

If you have any questions regarding electronic claims submission to Capstone Health Plan through Emdeon, please contact Emdeon Business Services Customer Solutions at (800) 845-6592.

Paper Claim Submission: Completed forms should be mailed to the following address:

**Attn: Claims Department
Capstone Health Plan, Inc.
914 N. San Francisco St., Suite A
Flagstaff, AZ 86001**

Claim Submission Time Frames

An initial claim for services provided to a Capstone member must be received by Capstone not later than 180 days from the date of service. For hospital inpatient claims, “date of service” means the date of discharge of the patient. Claims initially received beyond the 180 day time frame will be denied.

If a claim is originally received within the 180 day time frame, the provider has up to 12 months from the date of service to resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, Capstone is not liable for payment and will deny the claim.

Medicare / Other Insurance Liability

Capstone has a liability for payment of benefits after Medicare and all other third party payers. Providers must bill all private insurance carriers and Medicare prior to billing Capstone.

Capstone maintains a record of each member’s coverage by other carriers. If a member’s record indicates third party coverage, but no other insurance payment is indicated on the claim and/or an EOB is not attached to the claim, the claim will be denied.

The initial claim must be submitted to Capstone within 180 days of the date of service, even if payment from Medicare or other insurance has not been received. The claim must also meet the 12 month clean claim time frame.

Providers may not bill Capstone for more than the member’s financial responsibility for the service (e.g. any deductible, coinsurance and/or co-pay).

Resubmitting a Claim

Capstone will deny claims with errors that are identified during the adjudication process. These errors will be reported to the provider on the remittance advice. Providers should correct the claim errors and resubmit the claim for processing within the 12 month clean claim time frame. All claim resubmission should include at a minimum the following information:

1. Corrected claim form including all previously submitted lines.
2. Copy of the remittance advice from the denied claim.
3. Note the reason you are resubmitting the claim and include any corrections you have made.
4. Any additional documentation requested (i.e. third party insurance EOB, inpatient discharge summary etc.).

Claims should be resubmitted to the Capstone Claims Department at the address above.

Pharmacy Claims

Capstone has a pharmacy management services contract with Partners Rx for all pharmacy services. All pharmacy claims are processed by Partners Rx. Claims are submitted electronically by the dispensing pharmacy, specialty pharmacy or home health care agency. Claims for co-payments may be submitted on the Universal Pharmacy Claim Form to:

**Attn: Help Desk
Partners Rx
15950 North 76th Street, Suite 200
Scottsdale, AZ 85260**

Claims Research / Informal Issue Resolution

The Capstone Health Plan Claims Department is available to assist providers in resolving issues. Providers may contact the Claims Department for questions about status or questions regarding previously processed claims.

**(928) 779-2113 or (800) 336-3874 x3481
8:00 a.m. to 5:00 p.m. Monday – Friday**

Items for research may also be faxed to the Claims Department at: **(928) 779-5108**. Providers may also mail to the Capstone Claims Department.

Please include all pertinent information that you believe can assist the Claims Department in resolving your issues.

Claims Disputes and Appeals

Providers may appeal any claim decisions made by Capstone Health Plan. Providers are encouraged to try to resolve their claim problems first by contacting the Claims Department or your Provider Representative.

Providers must institute any appeal challenging a claim denial or adjudication within 12 months from the ending date of service, or for a hospital claim, within 12 months from the date of discharge. Please refer the Claim Dispute and Appeal Section of this Provider Manual for details on how to file a claims dispute.

Sample Claims Remittance Advice

A Claims Remittance Advice will be returned for every claim processed. A sample of the Claims Remittance Advice can be found at www.nazcap.com. Please contact the Capstone Claims Representative if you need assistance reading this form.

15 Claim Disputes and Appeals

General Information

Providers should exhaust all processing procedures before filing an appeal. If the provider has exhausted all processing procedures and still has a disputed claim, the provider has the right to file an appeal with the Division of Developmental Disabilities.

We recommend that providers go through the claims research process prior to filing an appeal (see below).

Note: *This process does not take the place of the appeal process nor does it extend the appeal filing deadline.*

Claims Research

The Claims Department will assist providers with problem resolution and resubmission of claims. This department can help providers avoid the claim dispute process.

The Claims Department will also research claims that the provider believes were incorrectly processed and provide clarification and explanation.

If the provider receives a Remittance Advice and believes that a claim was denied inappropriately or paid incorrectly, the provider should contact the Claims Department as soon as possible. The provider must provide the Claims Department with the following information:

- ✓ Provider Name
- ✓ Recipient's AHCCCS ID#
- ✓ Date(s) if service in question
- ✓ Dollar amount

The Claims Department will evaluate the claim data and determine if the denial or payment was appropriate.

A Claims Representative will notify the provider of the action taken and the outcome for the claim in question.

Time Limits for Filing an Appeal

A provider must institute any claim dispute challenging the claim denial or adjudication within 12 months from the ending date of service, or for a hospital claim, within 12 months from the date of discharge. The appeal receipt date will be considered the date the appeal is received by the Division of Developmental Disabilities Office of Compliance and Review.

Appeal Process

An appeal or claim dispute must be submitted in writing to:

**Office of Compliance and Review
Division of Developmental Disabilities
PO Box 6123, Site Code 791A
Phoenix, AZ 85005**

The appeal must state in detail the basis for the appeal and the relief requested. The provider should include any documents, which will support the facts of the case.

The Office of Compliance and Review will send a copy of the appeal to Capstone Health Plan requesting review and comment of the provider's request.

Decisions

The Office of Compliance and Review will make a final decision concerning all appeals within thirty (30) days of filing the appeal. A letter will be mailed to the provider stating the decision, the reason for the decision, and the appeal process.

The provider should inform the Office of Compliance and Review of their decision to appeal within the designated time frame, as stated in the decision letter.

16 Fraud and Abuse

Identification, Reporting and Notifications

Providers are responsible to report suspected provider or member fraud and abuse to Capstone Health Plan. The Arizona Revised Statutes (A.R.S.) and Code of Federal Regulations (CFR) provide the following definitions regarding fraud and abuse:

- Abuse (by member) - Intentional physical harm, injury caused by negligent acts of omissions, unreasonable confinement, sexual abuse or sexual assault (A.R.S. 46-451).
- Abuse (by provider) - Providers practices that are inconsistent with sound fiscal, business, or medical practices, and result in any unnecessary cost to the Medicaid (AHCCCS) program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care (CFR 455.2).
- Exploitation - The illegal or improper use of an incapacitated or vulnerable person or his resources for another's profit or advantage (A.R.S. 46-451).
- Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 DFR 455.2).

Initial Notification

1. If personnel suspect exploitation, fraud, abuse or neglect, as defined herein, by providers, subcontractors, members or employees, this information shall be immediately reported in writing to Capstone Health Plan.
2. Unusual incidents which shall be reported include:
 - Abuse, neglect or exploitation of a member or other person affiliated with the Plan which is receiving or providing services within the Plan.
 - Fraud, including the loss, theft, misappropriation or overpayment of AHCCCS funds.
 - Any other incident that Capstone determines should be reported to AHCCCS.

Reporting to External Agencies

1. If the affected Capstone member is in a skilled nursing facility, assisted living facility, or a home and community based setting (HCBS), the following agencies must be notified of the suspected abuse, fraud, negligence or exploitation.
 - Adult Protective Services / Child Protective Services
 - Arizona Department of Health Services (except for incidents involving financial matters)
 - Arizona Health Care Cost Containment System

- Local Police Department
2. Notification of agencies is not to be considered confirmation of actual abuse, fraud, negligence or exploitation. Capstone is required to notify these agencies to allow them to begin their own investigations of the incident as soon as possible.
 3. Agency reports shall be sealed in a separate confidential file, and maintained in a secure environment.

Reporting to AHCCCS

Capstone Health Plan shall be responsible for reporting all suspected incidents to AHCCCS via the appropriate AHCCCS reporting forms and within the established timeframes.

- Incidents involving providers will be submitted to the AHCCCS Office of Program Integrity.
- Incidents involving members will be submitted to the AHCCCS Member Fraud Investigations and Office of Managed Care.

Notification of Incidents Reported to the Media

1. In addition to the reporting requirements above, every effort will be made to notify AHCCCS of any incident where information may be released to the news media.
2. If notification cannot be made prior to the release, then it shall be made as soon as practicable following the release.
3. Notification will include all information relative to the incident and the content of information released to the news media.

Investigation

1. Once the incident has been reported, a complete and thorough investigation of the incident by Capstone, in conjunction with other notified agencies, will be performed in a timely manner. The results of the investigation shall be filed with AHCCCS and will include the following:
 - A detailed description of the incident under investigation, including the date of the incident and the complete name of all individuals involved in the incident.
 - Initial documentation, including law enforcement reports, if applicable, any information submitted regarding the situation, or any available information regarding previously reported situations, which appear relevant to the current matter.
 - Interview questions, which thoroughly address the unusual incident, and responses of interviewers to those questions.
 - Any administrative actions taken.

17 Contracting

Provider Contract

Capstone Health Plan uses a standard provider agreement when subcontracting with physicians, dentists, and ancillary services. This contractual agreement may be changed from time to time in order to conform to current state and federal policies and trends.

All provider agreements comply with the applicable regulations and policies established by AHCCCS and set forth in the Arizona Administrative Code, Article 4, Contracts, Administration and Standards. Each provider agreement contains the minimum subcontract provisions established by AHCCCS.

All contracted providers must obtain a National Provider Identifier (NPI) as per Centers for Medicare guidelines prior to providing services to a Capstone Member.

Primary Care Providers (PCP)

Capstone Health Plan requires all primary care providers to execute a Provider Service Agreement and complete credentialing prior to providing medically necessary services to Capstone Members.

Specialty and Ancillary Providers

Capstone will solicit a Provider Service Agreement with specialty physicians, dentists and ancillary providers according to the needs of the provider network. A provider possessing a valid AHCCCS Provider Identification Number and a National Provider Identifier may provide medically necessary services to Capstone members without contracting or credentialing.

Questions

Please contact the Provider Network Manager at the telephone number listed in the Introduction section of this Provider Manual for questions about your Capstone Health Plan Provider Services Agreement.

18 Credentialing / Recredentialing

Overview

Before a practitioner or provider is allowed to participate in the Capstone Health Plan provider network, the Capstone Credentialing Committee ensures that the practitioner has the legal authority, professional accreditation, experience and the service facilities necessary to meet the needs of Capstone members. The credentials of each Capstone PCP are reviewed at least every three years.

Capstone practitioner credentialing and recredentialing policies and procedures apply to all licensed, independent practitioners who are qualified to provide medically necessary and other covered services to Capstone members. Practitioners affected by this policy include, but are not limited to, primary care physicians, dentists, nurse practitioners, nurse midwives and physician assistants. This policy does not apply to practitioners whose practices are limited to facility hospital setting.

Applicant Rights

- Each eligible applicant has an equal opportunity to become a participating provider.
- At any time after submitting an application until the denial or approval of the application by the Board, the applicant has the right to review information submitted in support of his or her application, and the right to correct any erroneous information. The applicant will be notified of his or her right to review and correct erroneous information submitted in support of the application.

Capstone Rights

- Capstone reserves the right to deny applications.
- Capstone reserves the right to request information from existing providers during the credentialing period concerning their quality of care or quality of services.
- Capstone has the right to terminate, modify, or suspend existing providers for quality of care or quality of service concerns.
- Capstone has the right to terminate, modify or suspend existing providers during the investigation of alleged incidents of fraud, abuse or exploitation.

Credentialing Process

1. An applicant will not be considered for credentialing or recredentialing unless the application is complete.
2. An applicant for either credentialing or recredentialing must provide the following information, and any further information requested on the application:

- ✓ Current and valid Arizona license or certification to practice;
 - ✓ A valid DEA certificate, where applicable;
 - ✓ Evidence of current and adequate professional liability insurance coverage in the minimum amount of one million (\$1,000,000) dollars combined single limits.
 - ✓ Documentation of good standing and clinical privileges in a hospital or other medical facility designated by the applicant as his or her primary admitting or consulting facility, as applicable; and
 - ✓ Board certification, if the practitioner states that he or she is board certified.
3. An applicant for initial credentialing must also provide the following information:
- ✓ Evidence of graduation from an accredited school, as applicable to the area of practice;
 - ✓ Evidence of completion of residency, other post graduate training, or Board certification training, as applicable;
 - ✓ Professional liability claims history including all malpractice claims and outcomes for the last fifteen years;
 - ✓ Work history, beginning at graduation to the present, explaining any work hiatus of more than two months;
 - ✓ Explanation of all adverse actions by a state or county medical association, state board of nursing, state dental board, specialty board, or other licensing or certification body, including revocation, suspension, modification, probation, or other action against a license or certification;
 - ✓ Explanation of all adverse actions against an applicant's DEA/BNDD number, including revocation, suspension, modification, probation, relinquishment or other action;
 - ✓ Explanation of all restrictions of medical staff privileges, including termination, suspension, or modification;
 - ✓ Explanation of all felony convictions and all felony or misdemeanor convictions related to the delivery or payment of a healthcare services; and
 - ✓ Explanation of all Medicare, Medicaid or AHCCCS sanctions or exclusions.
4. An applicant for recredentialing must also include the following information:
- ✓ Professional liability claims and outcomes since the date of the initial application;
 - ✓ Work history since the date of the initial application;
 - ✓ Explanation of any adverse actions by a state or county medical association, state board of nursing, state dental board, specialty board, or other licensing or certification body, including revocation, suspension, modification, probation, or other action against a license or certification, since the date of the initial application;

- ✓ Explanation of all adverse actions against an applicant's DEA/BNDD number, including revocation, suspension, modification, probation, or other action, since the date of the initial application;
 - ✓ Explanation of all restrictions of medical staff privileges, including termination, suspension, or modification, since the date of the initial application;
 - ✓ Explanation of all Medicare, Medicaid or AHCCCS sanctions or exclusions, since the date of the initial application;
 - ✓ Explanation of all felony convictions and all felony or misdemeanor convictions related to the delivery or payment of a healthcare services, since the date of the initial application;
 - ✓ Any changes to the information contained in the initial application.
5. All applications must include a statement which addresses:
- ✓ The reasons for any inability by the applicant to perform essential functions of the position, with or without accommodation;
 - ✓ The applicant's lack of present illegal drug use;
 - ✓ The applicant's history of any losses of license and felony convictions;
 - ✓ The applicant's attestation to the correctness and completeness of the information.
6. The Committee or its designee will query the National Practitioner Data Bank (NPDB), the Health Integrity and Protection Data Bank (HIPDB), the Board of Medical Examiners or the Board of Osteopathic Physicians, and/or the Office of Inspector General for relevant information. For non-physician practitioners, the Committee or its designee will query the appropriate regulatory board or agency, as applicable.
7. For applicants applying for recredentialing, the Committee or its designee may also review data from:
- ✓ Member complaints and grievances;
 - ✓ Results of quality reviews or quality improvement activities;
 - ✓ Utilization management;
 - ✓ Member satisfaction surveys.
8. The Committee or its designee will request a response from the applicant concerning any missing information, discrepancies found between the application and information obtained through primary source verification, or adverse information revealed by primary source verification. Upon request, the applicant will have one week to respond to the Committee in writing.
9. The Committee or its designee may conduct site visits to the applicant's office or offices.
10. The Committee will make its decision based on the above information. Within 30 days of its decision, the Committee will notify the applicant of its decision, the reasons for its decision, and the applicant's right to appeal its decision to the Board within 30 days of that decision.

11. Within 35 days of the Committee's decision, the applicant may appeal the decision of Committee to the Board. With this appeal, the applicant may submit a written statement and any additional information relevant to the Board's decision.
12. The Board will consider the Committee's decision, along with any statement and additional information submitted by the applicant. The Board will notify the applicant within 30 days of its decision and the reason for its decision.

If at any time during the three year (3) credentialing period, the Committee determines that there is reason for concern regarding the quality of care or quality of services of a provider, the Committee or its designee may notify the provider of these concerns. The provider will have one week to respond to the Committee in writing to address those concerns. The Committee will make a decision regarding the provider's continued participation in the network, and will notify the provider within 30 days of its decision and the reasons for its decision. The provider may appeal the decision of the Committee to the Board within 35 days of the Committee's decision, and may submit a written statement and any additional information relevant to the Board's decision. The Board will consider the Committee's decision, along with any statement and information submitted by the provider. The provider will be notified of the Board's decision and the reasons for its decision within 30 days of that decision.

19 Quality Management

Capstone Health Plan maintains a Quality Management / Utilization Management (QM/UM) Plan for the Developmentally Disabled (DD) care programs that meet AHCCCS requirements. The QM/UM Plan addresses such issues as: the availability of primary care practitioners, accessibility of services, member satisfaction, disease management programs, maternal and child health, clinical practice guidelines, and clinical quality improvement. The QM/UM Plan evaluation is submitted annually to DES/DDD as part of the health plan reporting requirements.

The Board of Directors delegates authority for the operational implementation of the QM/UM Plan to the Medical Management Committee. At its discretion, the Medical Management Committee may institute corrective action and revise Plan policies and procedures with respect to quality management and improvement matters. The Medical Director serves as the Chairperson, attends meetings of the Medical Management Committee as a voting member, and chairs designated subcommittees.

Medical Management Committee

Committee Structure

1. The Medical Management Committee is composed of the Medical Director, Health Services Director, and three (3) participating physicians. The physician membership is given to physicians contracted as primary care physicians with the plan and specialty physicians practicing in the local network. The Committee chair is the Medical Director.
2. The Committee meets once each calendar quarter. Additional ad-hoc meetings may be held to discuss matters of urgency.
3. A simple majority of the Committee voting members constitutes a quorum, which must be present before the Committee conducts its business. Resolution of Committee matters requires a majority vote of the quorum.

Committee Responsibilities

1. The Medical Management Committee is responsible for assessing the status and progress of all quality management and improvement efforts.
2. The Medical Director and Health Services Director are responsible for the overall implementation of the QM/UM Plan.
3. Capstone providers and practitioners are required to participate in QM/UM activities. Every contract established regarding a provider specifies that:
 - The provider or practitioner will comply with all medical policies and procedures set forth in, or referenced by, the QM/UM Plan;

- The provider or practitioner will ensure that all medical records are maintained according to Capstone's requirements, and are accessible to Capstone, its representatives, and the representatives of DES/DDD Managed Care Operations.
 - The provider or practitioner will cooperate fully with Capstone's member complaint and grievance procedures and comply with all final resolutions of member complaints and grievances as may be determined by the Plan or DES/DDD Managed Care Operations.
 - Capstone will review each provider or practitioner participating in the provider network to determine that the provider meets and continues to meet the standards set forth in the credentialing and recredentialing policies.
 - The provider or practitioner will provide information and copies of all documentation required to verify that the provider or practitioner meets prescribed standards, and will notify Capstone's provider network department immediately following the occurrence of any instances affecting the ability of the provider or practitioner to meet the prescribed standards.
 - The provider or practitioner is required to comply with the quality management standards established by Capstone Health Plan.
4. Practitioners may also participate voluntarily in the QM process by becoming members of the Medical Management Committee, completing annual practitioner satisfaction surveys, and submitting any concerns or suggestions regarding quality management issues to the Medical Management Committee.
 5. Health plan staff has an obligation to report quality management and improvement issues. Staff members are trained in the appropriate processes for reporting concerns or recommendations to the QM department.

Work Plans

1. Capstone Work Plans contain specific objectives to be achieved by the QM/UM plan in the designated year, as well as a description of the projects designed to meet those objectives and a QM/UM evaluation plan.
2. Each Work Plan is based on the results of the annual QM/UM plan description evaluation as reviewed by the Office of Managed Care.
3. Each project is submitted to the Medical Management Committee for inclusion in the Capstone QM/UM Plan.
4. The Medical Management Committee reviews and approves all proposed Work Plans to be included in the final QM/UM Plan.

Areas of QM/UM Plan Activity

Availability of Primary Care Practitioners (PCPs)

1. Availability standards, including the number and geographic distribution of PCPs.

2. The Provider Services Department measures Capstone's performance against the availability standards quarterly.

Accessibility of Services

1. Accessibility standards regarding preventive care, routine primary care, urgent care, emergency care, after-hours care, and telephone services are outlined in the Provider Service Medical Office Visit Wait Time / Appointment Availability policy.
2. The Provider Services Department uses standardized tools to measure Capstone's performance against the medical care accessibility standards quarterly.

Member Satisfaction

1. The Member Service Department oversees the administration of member satisfaction surveys, which are conducted at least annually.
2. The Grievance Coordinator undertakes a quarterly analysis of complaint and grievance issues.
3. The Member Service Department conducts a quarterly analysis of the reasons given by members who ask to change primary care practitioners.
4. The Member Services Department establishes a performance goal for each area of member satisfaction measurement, based on current industry best performance or the desired level of improvement over the Plan's previous performance. The Member Services Department uses the data obtained from each measure to identify areas for improvement.
5. Plan practitioners and providers are advised of the outcome of member satisfaction measurement activities through the Provider Newsletter.

Clinical Quality Improvement Activities

1. Assessments of all clinical issues are undertaken by the Medical Management Committee.
 2. Selection of issues for assessment.
 3. Capstone's performance in each area of clinical practice is measured by the Medical Management Committee.
- Interventions to improve Capstone's performance in the selected areas of clinical practice, and in the provision of continuity and coordination of care are developed and undertaken in accordance with Capstone's QM/UM Plan.
 - Individual cases of poor quality of care are addressed using the procedures defined in Capstone's QM/UM Plan.

Provider Profiling

1. Utilization of services and member satisfaction data will be collected, monitored and evaluated for contracting and quality purposes.
2. A review of the profiling file will be included in the recredentialing process, which will allow the Credentialing/Peer Review Committee to make an informed decision regarding the performance of the network providers. The profile may contain data related to:
 - Member Satisfaction Surveys
 - Utilization – Rx, Hospital, ER, DME, and Specialist
 - Members complaints, grievance and appeals data, and quality of care issues
 - Appointment accessibility and availability
 - EPSDT rates
 - Medical record review results
3. A yearly report of data collected and corrective action completed will be presented to the Medical Management Committee for review and further recommendation for quality and contracting purposes.
4. The practitioner's provider profile file will be reviewed concurrently with the recredentialing file.

CULTURALLY COMPETENT PATIENT CARE

A Guide for Providers and Their Staff

Institute for
Health Professions Education

Georgia G. Hall, Ph.D., MPH

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SECTION ONE

INTRODUCTION

This guide is intended to help Providers and their staff meet the challenge of caring for an increasingly diverse patient population, whose culture - which includes language, lifestyle, values, beliefs and attitudes may, differ from those of the dominant society.

Since these and other elements of culture influence the experience of illness, access to care, and the process of getting well, Providers and their staff are compelled to learn about them and incorporate that knowledge into the patient care plan.

Cultural competence can be defined as a combination of knowledge, clinical skills and behaviors that lead to positive outcomes of patient care with ethnically and culturally diverse populations.

Central to cultural competency is the provision of services, education and information in appropriate languages and at appropriate comprehension and literacy levels.

Benefits of a culturally competent approach to care:

- Devise more appropriate plans of care
- Improve quality of patient care and outcomes
- Reduce patient non-compliance
- Improve patient satisfaction
- Provide enhanced individual and family care
- Gain sensitivity to patient needs
- Work more effectively with diverse patient populations
- Adhere to federal and state requirements

SECTION TWO

HEALTH BELIEFS, ATTITUDES, AND BEHAVIORS: IMPLICATIONS FOR CLINICAL CARE

Culturally Competent Healthcare

An understanding of value systems and their influence on health is essential to providing culturally competent healthcare. Every culture has a value system that dictates behavior directly or indirectly by setting and encouraging specific norms. Health beliefs and practices, in particular, reflect that value system.

Providing care for patients from diverse backgrounds requires understanding one's own values as well as the values of other groups. There is a natural tendency for people to be culture bound, that is, to assume that their values, customs, attitudes and behaviors are always appropriate and right.

The following list, comparing dominant Anglo–American values with those of more traditional cultures demonstrates their differing views.

<u>Anglo-American</u>	<u>More traditional cultures</u>
Personal control over environment	Fate
Change	Tradition
Time dominates	Human interaction dominates
Human equality	Hierarchy/rank/status
Individualism/privacy	Group welfare
Self-help	Birthright inheritance
Competition	Cooperation
Future Orientation	Past orientation
Action/goal/work Orientation/informality	“Being” orientation
Directness/openness/honesty	Formality
Practicality/efficiency	Idealism/Spiritualism

Source:

Cross-Cultural Counseling: A guide for Nutrition and Health Counselors, U.S. Department of Agriculture/US Department of Health and Human Services, Nutrition Education Committee for Maternal and Child Nutrition Publications, 1986.

General Beliefs

- Beliefs about the cause, prevention, and treatment of illness vary among cultures. These beliefs dictate the practices used to maintain health. Health practices can be classified as folk, spiritual or psychic healing practices, and conventional medical practices. Patients may follow a specific process in seeking health care. Cultural healers may be used in addition to conventional medical care.

Understanding Your Values and Beliefs

- Cross-cultural healthcare requires Providers and their staff to care for patients without making judgments about the superiority of one set of values over the other.
- Providers are not only influenced by the cultural values they were raised with, but also by the culture of medicine which has its own language and values. The complexity of the health care system today is time oriented, hierarchical and founded on disease management and the preservation of life at any cost. Realizing these values as part of the current medical culture will be useful when dealing with patients with different values.

Knowing Your Patient

- The difference between a Provider who is culturally competent and one who is culturally aware is in the service that person provides. A culturally competent Provider is aware of the cultural differences and even more aware of the individual and his or her personal needs.

Appreciate the Heterogeneity that Exists Within Cultural Groups

- As studies about cultural and ethnic groups demonstrate, there are distinctive characteristics that contribute to their uniqueness. Knowledge about these unique characteristics is important to the development of culturally relevant programs.
- Since significant variability may exist between and among individuals from the same cultural and ethnic group, over-generalization is a danger. Such variability can be due to: age, level of education, family, rural/urban residence, religiosity, level of adherence to traditional customs, and for immigrant patients, degree of assimilation and acculturation.

The Role of Economics

- The culture of poverty is as important as a person's ethnicity, social status and cultural background. Economic status may influence the patient's ability to acquire medical supplies or other resources (such as running water, electricity, adequate space, healthful or specific diet, etc.) needed for continuity of care and wellness. Decisions that are made about lower income patients' care must be sensitive to the differing degrees of access to resources.

The Role of Religious Beliefs

- Religious beliefs can often influence a patient's decision about medical treatment. Because of their religious faiths, patients may request diagnosis but not treatment. If a particular treatment is absolutely necessary, Providers may find it helpful to consult with the patient's spiritual leader. Patients who seek mainstream medical care may also seek treatment from healers in their culture. Rather than discouraging this, especially if the alternative treatment is not harmful, Providers and their staff may want to incorporate traditional healing into the general treatment plan.

The Role of the Family

- Traditional cultures place a greater emphasis on the role of the family. Decision-making about health issues may be a family affair. It can be helpful for Providers and their staff to take this into account as medical decision-making takes place.
- Questions to consider:
 1. How many family members can accompany the patient into the room?
 2. Should friends be allowed in the room?
 3. Who can or should be told about the patient's condition?

SECTION THREE

STRATEGIES AND APPROACHES IN ASSESSING PATIENT'S BELIEFS ABOUT HEALTH AND ILLNESS

Cultural Assessment

Cultural assessment of the patient is an important step in identifying the patient's views and beliefs related to health and illness. Beliefs about the cause, prevention, and treatment of illness vary among cultures. Such beliefs dictate the practices used to maintain health. Studies have classified Health Practices into several categories: **folk practices**, **spiritual** or **psychic healing practices**, and **conventional medical practices**.

In addition to the general data collected from a patient, the following checklist may be helpful in gaining culturally specific information.

- ✓ Where were you born?
- ✓ If you were born outside the USA, how long have you lived in this country?
- ✓ Who are the people you depend upon the most for help? (Family members, friends, community services, church etc.)
- ✓ Are there people who are dependent on you for care? Who are they? What kind of care do you provide?
- ✓ What languages do you speak?
- ✓ Can you read and write in those languages?
- ✓ What is the first thing you do when you feel ill?
- ✓ Do you ever see a native healer or other type of practitioner when you don't feel well?
- ✓ What does that person do for you?
- ✓ Do you ever take any herbs or medicines that are commonly used in your native country or cultural group?
- ✓ What are they, and what do you take them for?
- ✓ What foods do you generally eat? How many times a day do you eat?
- ✓ How do you spend your day?
- ✓ How did you get here today?
- ✓ Do you generally have to arrange for transportation when you have appointments?

Cultural Assessment (continued)

To help Providers and their staff conduct cultural assessments, the questionnaire below will help determine a patient's beliefs about his or her problem:

Tools To Elicit Health Beliefs

1. What do you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your disorder?
7. What are the chief problems that your sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?

Further Questions to Consider

1. Do individuals in this culture feel comfortable answering questions?
2. When the Provider asks questions, does the patient, or family, perceive this as a lack of knowledge?
3. Who should be told about the illness?
4. Does the family need a consensus or can one person make decisions.
5. Does the patient feel uncomfortable due to the gender of the Provider?
6. Does more medicine mean more illness to the patient?
7. Does no medication mean healthy?
8. Does the patient prefer to feel the symptoms, or mask them?
9. Does the patient prefer ONE solution or choices of treatment?
10. Does the patient want to hear about risks?

Source:

Kleinman, Arthur A. Patients and Healers in the Context of Culture. The Regents of the University of California. 1981.

SECTION FOUR

EFFECTIVE PATIENT COMMUNICATION AND EDUCATION STRATEGIES

Communication

Intercultural communication is a key clinical issue in medicine and can determine quality of care. The language barrier is a particularly serious problem for Providers and patients alike. Since effective communication between patients and Providers is necessary for positive outcomes, the use of translators is essential.

Even with English speaking populations, it can be a challenge for the patient to try to understand the medical jargon that is commonplace among professionals in the healthcare setting. For example, words like “diet” have different meanings to professionals than they have in the general public.

Other Factors Influencing Communication:

Conversational style: It may be blunt, loud and to the point – or quiet and indirect.

Personal space: People react to others based on their cultural conceptions of personal space. For example, standing “too close” may be seen as rude in one culture and appropriate in another.

Eye contact: In some cultures, such as Native American and Asian, avoiding direct eye contact may be a sign of respect and represents a way of honoring a person’s privacy.

Touch: A warm handshake may be regarded positively in some cultures, and in others, such as some Native American groups, it is viewed as disrespectful.

Greeting with an embrace or a kiss on the cheek is common among some cultures.

Response to pain: People in pain do not always express the degree of their suffering. Cultural differences exist in patient’s response to pain. In an effort to “be a good patient” some individuals may suffer unnecessarily.

Time orientation: Time is of the essence in today’s medical practice. Some cultural groups are less oriented to “being on time” than others.

Other Factors Influencing Communication (Continued):*What's in a name:*

Some patients do not mind being called by their first name; others resent it. Clarify the patient's preference early on in the patient-Provider relationship.

Nonverbal communication:

Messages are communicated by facial expressions and body movements that are specific to each culture. Be aware of variations in non-verbal communication to avoid misunderstandings.

When English is a second language:

According to the US Census Bureau, 14% of Americans speak a language other than English in their home and 6.7 million people have limited or no English skills. As these numbers continue to grow, the need for multilingual care becomes more significant.

Patients with limited English proficiency may have more difficulty expressing thoughts and concerns in English and may require more time and patience. It is best to use simple vocabulary and speak slowly and clearly. Do not assume that because the patient can speak English that he can read and write in English as well. Remember, just because somebody speaks with a "perfect" American accent, doesn't mean that they will have complete and full mastery of the English language.

Translators:

Often, volunteers from the community or relatives are brought by the patient to help with translation. Since patients may be reluctant to confide personal problems with non-professionals and may leave out important facts, this practice should be discouraged. Realize that it may be difficult for patients to discuss personal issues in front of a third non-professional party. The use of employees as translators (secretaries, house keeping etc.) may not be a better solution.

Translators should understand and speak a language well enough to manage medical terminology. The ideal translator is a professional. If a professional translator is not available, over the phone translation services can be used.

Enhancing cross-cultural communication

Communicate effectively: Allow more time for cross-cultural communication, use translators who are not family members and ask questions about cultural beliefs.

Understand differences: Realize that family integration is more important than individual rights in many cultures. Involve spiritual or religious advisors when appropriate. Be aware of your own cultural beliefs and biases. Be sensitive to your authority as a medical professional.

Identify areas of potential conflict: Determine who is the appropriate person to make decisions and clarify and discuss important ethical disagreements with them.

Compromise: Show respect for beliefs that are different from your own. Be willing to compromise about treatment goals or modalities whenever possible. Remember that taking care of patients from other cultures can be time-consuming and challenging. In almost all instances, however, the extra time and effort expended will result in more satisfied patients, families and professionals.

SECTION FIVE

CULTURAL RESOURCES AND INTERPRETATION/TRANSLATION SERVICES

ALL AHCCCS contracted Health Plans and Program Contractors provide a variety of cultural competency resources, including interpretation/translation services and cultural awareness training. Under the AHCCCS program, these organizations are required to provide interpretation/translation services to Providers and Members free of charge.

If you need interpretation/translation services for patient care or wish to receive more information about available cultural competency resources, please contact the patient's AHCCCS Health Plan or Program Contractor to make the necessary arrangements.

AHCCCS and its participating Health Plans and Program Contractors encourage you to use professional interpretation/translation services. Use of non-professional interpretation/translation services such as by bilingual staff and/or a patient's family member may jeopardize patient outcomes.

Internet Resources

There are many cultural competency resources available on the Internet. The following listing is intended for informational purposes only.

General Reference sites:

- ☞ AMA Cultural Competence Initiative - <http://www.ama-assn.org/ethic/diversity/>
- ☞ National Center for Cultural Competence: Bureau of Primary Health Care Component
<http://www.dml.georgetown.edu/depts/pediatrics/gucdc/nccc.html>. Home page
<http://www.dml.georgetown.edu/depts/pediatrics/gucdc/cultural.html>
- ☞ Ethnomed: University of Washington: cultural profiles, cross cultural topics, patient education
<http://healthlinks.washington.edu/clinical/ethnomed/>
- ☞ http://www.baylor.edu/~Charles_Kemp/hispanic_health.htm Great site for information on Hispanic and other cultures (i.e. Bosnian refugees).
- ☞ Society of Teachers of Family Medicine: Multicultural Health Care and Education
<http://stfm.org/corep.html>. General curriculum information and listings of print, experiential exercises, games, simulations and video resources (not online). STFM homepage <http://stfm.org/index.html>
- ☞ AMSA (American Medical Student Association): <http://www.amsa.org/programs/gpit/cultural.htm>
- ☞ Cross Cultural Health Care Program (CCHCP) Site offers schedules/location/fees of cultural competency training, interpreter training, research projects, community collaboration, and other services. Online registration for training sessions, interpreter and translation services.
<http://www.xculture.org/>

General Reference Sites (continued):

- ☞ Opening Doors: in progress - cultural issues of health care -will contain discussion forum on cultural issues in healthcare, articles, etc. <http://www.opening-doors.org/>
- ☞ Perspective of Difference: an interactive teaching module
<http://medicine.ucsf.edu/divisions/dgim/pods/html/main.html>
- ☞ Bridge to Wellness: Cultural Competency <http://www.serve.com/Wellness/culture.html>. Homepage: www.serve.com/Wellness -Developed for Adult Psychiatry- list of cultural competency principles for health care clinicians.
- ☞ U.S. Department of Health and Human Services: The Initiative to Eliminate Racial and Ethnic Disparities in Health <http://raceandhealth.hhs.gov/>
- ☞ National Institute of Health Office of Research on Minority Health
<http://www1.od.nih.gov/ormh/main.html>
- ☞ Health and Human Services: Health Resources and Services Admin.: news articles
<http://www.hrsa.dhhs.gov/>
- ☞ US Department of Health and Human Services: Office of Public Health and Sciences: Office of Minority Health Resource Center <http://www.omhrc.gov/>
- ☞ Bureau of Primary Health Care Supported Community Health Programs
<http://www.bphc.hrsa.dhhs.gov/databases/fqhc/fqhcquery.cfm>
- ☞ The Center for Cross Cultural Health: (410 Church street, Suite W227, Minneapolis, MN 55455)
<http://www.umn.edu/ccch/>
- ☞ Cross Cultural Health Care Program (Pacific Medical Clinics / 1200 12th Avenue South, Seattle, WA 98144-2790 / Phone: (206) 326-4161) <http://www.xculture.org/>
- ☞ Department of Health and Human Services / Health Resources and Services Administration / Bureau of Primary Health Care (4350 East-West Highway, Bethesda, MD 20814)
- ☞ Interface International: Provides publications and training tools (c/o Suzanne Salimbene, Ph.D. / 3821 East State Street, Suite 197, Rockford, IL 61108 / Phone: (815) 965-7535 / e-mail: IF4YOU@aol.com)
- ☞ Simulation Training System (218 Twelfth Street, Del Mar, CA 92014-0901) / Resources for Cross-cultural Health Care: <http://www.diversityrx.org/>
- ☞ National Urban League (Phone: 212-310-9000) or <http://www.nul.org/>
- ☞ African Community Health and Social League (Phone: (510) 839-7764)
<http://www.progway.org/ACHSS.html>
- ☞ Association of Asian Pacific Community Health Organizations (Phone: (510) 272-9536)
<http://www.aapcho.org>
- ☞ National Coalition of Hispanic Health and Human Services Organizations / Phone: (202) 387-5000
<http://www.cossmho.org>
- ☞ Center for American Indian and Alaskan Native Health Phone: (410) 955-6931 /
<http://ih1.sph.jhu.edu/cnah/>
www.culturalorientation.net or www.erc.msh.org "Providers Guide to Quality and Culture)

Interpretation Services

Capstone Health Plan, Inc. has obtained interpretation services from the company Language Line Services. This service is available to assist providers with members who speak limited or no English. Language Line Services are accessible through a toll free telephone number and provides over the phone interpretation in hundreds of languages.

Capstone encourages providers to use this free service of professional translators to communicate with members. For more information on how to obtain access to Language Line Services, please contact your Provider Service Representative.

21 Provider Directory

A Directory of Providers may be found on our website www.nazcap.com

- **Primary Care Practitioners (PCPs)**
- **Specialty Physicians***
- **Dental Providers***
- **Durable Medical Equipment (DME) & Supplies**
- **Home Health**
- **Hospitals**
- **Laboratory**
- **Pharmacy**
- **Urgent Care**
- **Vision Services**

Specialty Physicians and Dental Providers not listed on the directory may also be available to provide services to Capstone members. You may refer to any provider that is willing to see a Capstone member, so long as they have a valid AHCCCS Provider Identification Number.