arkansas total care™

Provider and Billing Manual

2024

ArkansasTotalCare.com

1-866-282-6280 (TTY: 711)

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Welcome

Thank you for joining the Arkansas Total Care network of healthcare professionals. We are proud to have your partnership and look forward to transforming the health of our community, one person at a time. As a Risk-Based Provider Organization (RBPO), Arkansas Total Care staff work with members and providers to ensure that both parties have the information and resources to help our members reach their health goals.

This manual contains the information you need to understand our benefits, policies, and procedures. It also contains contact information so you can reach our staff with any questions or concerns.

About Us

Arkansas Total Care is a Provider-Led Arkansas Shared Savings Entity (PASSE), a partnership between an insurance payer and several provider groups. We serve participants in the Arkansas Medicaid program as an RBPO.

PASSEs were developed in Arkansas to provide more extensive care coordination to high-need individuals with intellectual or developmental disabilities (IDD), as well as individuals with behavioral health (BH) needs. The goal of partnering with provider groups is to ensure that there is provider oversight of the care and treatment we provide for our members with specialized needs.

Arkansas Total Care empowers our members to achieve their health goals through care coordination, goal setting, and connection to community resources.

About this Manual

This provider manual contains comprehensive information and billing guidelines about Arkansas Total Care operations, benefits, policies, and procedures. The most up-to-date version can be viewed on the “For Providers” section of our website, ArkansasTotalCare.com. You will be notified of updates via notices posted on our website and/or in Explanation of Payment (EOP) notices.

Key Contacts and Important Phone Numbers

The following table includes several important telephone and fax numbers available to providers and their office staff. When calling, it is helpful to have the following information available:

- National Provider Identifier (NPI) number
- Tax Identification Number (TIN)
- Member's Arkansas Total Care and/or Medicaid ID

Health Plan Information		
Website	ArkansasTotalCare.com	
Address	Arkansas Total Care P.O. Box 25010 Little Rock, AR 72221	
Department	**Phone and/or Website**	**Fax and/or Email Address**
Provider Services	1-866-282-6280 (TTY: 711)	N/A
Member Services		N/A
Inpatient and Outpatient Prior Authorization (PA) Requests		1-833-632-6974
Concurrent Review/Clinical Information		1-833-249-2342
Admissions		1-833-632-6934
Medical Management		1-833-513-5041
Behavioral Health		1-833-632-6934
24/7 Nurse Advice Line		N/A
Pharmacy Services for Prior Authorization	1-833-587-2011 CoverMyMeds.com/main/prior-authorization-forms/	1-833-582-2341
TurningPoint	501-263-8850 1-866-619-7054	501-588-0994
Advanced Imaging (MRI, CT, PET) (Evolent Health)	1-866-500-7685 RadMD.com	N/A
Envolve Vision (routine and optometry services only)	1-844-280-6792 VisionBenefits.EnvolveHealth.com	N/A
To report suspected waste, abuse, and fraud	1-866-685-8664	N/A
EDI Claims Assistance	1-800-225-2573 ext. 6075525	EDIBA@centene.com
HHAeXchange	HHAeXchange.com	Support@HHAeXchange.com

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Secure Provider Portal

Arkansas Total Care offers a robust secure provider portal with functionality that is critical to serving members and that helps ease administration for providers. The portal can be accessed at Provider.ArkansasTotalCare.com. All providers and designated office staff have the opportunity to register an account with the secure provider portal.

Once registered, providers will have access to tools that make obtaining and sharing information easy. It's simple and secure.

Functionality

All users of the secure provider portal must complete a registration process. Once registered, providers can:

- Check eligibility and view member rosters.
- View the specific benefits for a member.
- View the status of all claims that have been submitted, regardless of how they were submitted.
- Update provider demographic information, such as address, office hours, etc.
- (For primary care providers) view and print patient lists. The patient list will indicate the member's name, ID number, date of birth, care gaps, disease management enrollment, and product in which they are enrolled.
- Submit authorizations and view the status of authorizations that have been submitted for members.
- View, submit, copy, and correct claims.
- Submit batch claims via an 837 file.
- View and download explanations of payment (EOP).
- View a member's health record, including visits (physician, outpatient hospital, therapy, etc.), medications, and immunizations.
- View gaps in care, including preventive care or services needed for chronic conditions.
- Send and receive secure messages with Arkansas Total Care staff.
- Access both patient and provider analytic tools.

Manage Account access allows you to perform functions as an account manager, such as adding portal accounts needed in your office and managing permissions for those accounts.

Disclaimer

Providers agree that all health information — including that related to patient conditions, medical utilization, and pharmacy utilization — available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

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Credentialing and Recredentialing

The credentialing and recredentialing process verifies that participating practitioners and providers meet the criteria established by Arkansas Total Care, as well as applicable government regulations and standards of accrediting agencies.

If a practitioner or provider already participates with Arkansas Health & Wellness in a Medicaid or Medicare product, then they will **not** be credentialed separately for the Arkansas Total Care product. The practitioner or provider must have an active Arkansas Medicaid number.

Notice: To maintain a current practitioner or provider profile, practitioners or providers are required to notify Arkansas Total Care of any relevant changes to their credentialing information in a timely manner — no later than 10 days from the date of the change.

- Signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence, and ability to perform essential functions with or without accommodation
- Completed ownership and control disclosure form
- Current malpractice insurance policy face sheet, which includes insured dates and the amounts of coverage
- Current controlled substance registration certificate, if applicable
- Current drug enforcement administration (DEA) registration certificate for each state in which the practitioner will see Arkansas Total Care members
- Completed and signed W-9 form
- Current educational commission for foreign medical graduates (ECFMG) certificate, if applicable
- Current unrestricted medical license to practice, or other state license
- Current specialty board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history if work history is not completed on the application with no unexplained gaps of employment over six months for initial applicants
- Signed and dated release of information form not older than 120 days
- Current Clinical Laboratory Improvement Amendments(CLIA) certificate, if applicable

Arkansas Total Care will primary-source verify the following information submitted for credentialing and recredentialing:

- License through appropriate licensing agency
- Board certification, residency training, or professional education, where applicable
- Malpractice claims and license agency actions through the national practitioner data bank (NPDB)
- Federal sanction activity, including Medicare and Medicaid services (OIG: Office of Inspector General)

For providers (hospitals and ancillary facilities), a completed "Facility/Provider – Initial Credentialing" application and all supporting documentation as identified in the application must be received with the signed, completed contract.

For Home and Community Based Services (HCBS) providers, or for providers submitting roster updates for atypical practitioners, a completed Atypical & HCBS Provider application and all supporting documentation as identified in the application must be received with the signed, completed contract.

For non-licensed practitioners, provider groups can use the Personal Care Roster Template located on the Provider Credentialing section of our website to make additions, terminations, and/or updates. To submit additions, terminations, and/or updates, email the completed roster to our credentialing team at ArkCredentialing@centene.com.

Once the application is completed, the credentialing committee usually will render a decision on acceptance following its next regularly scheduled meeting in accordance with state and federal regulations.

Practitioners or providers must be credentialed prior to accepting or treating members. Primary care providers cannot accept member assignments until they are fully credentialed.

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Credentialing Committee

The credentialing committee, including the medical director or their physician designee, is responsible for establishing and adopting necessary criteria for participation, termination, and direction of the credentialing procedures. Committee meetings are typically held on a monthly basis or more often if deemed necessary. Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to the committee's decision.

Recredentialing

Arkansas Total Care conducts practitioner/provider recredentialing at least every 36 months from the date of the initial credentialing decision or most recent recredentialing decision. As of January 1, 2023, recredentialing for HCBS providers occurs every 36 months in accordance with state requirements. The purpose of this process is to identify any changes in the practitioner or provider's licensure, sanctions, certification, competence, or health status that may affect the practitioner or provider's ability to perform services under the contract. This process includes all practitioners, facilities, and ancillary providers previously credentialed and currently participating in the network.

Between credentialing cycles, Arkansas Total Care conducts provider performance monitoring activities on all network practitioners and providers. Arkansas Total Care reviews monthly reports released by both federal and state entities to identify any network practitioners or providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid. Arkansas Total Care also reviews member complaints and grievances against providers on an ongoing basis.

A provider's agreement may be terminated if at any time it is determined by the Arkansas Total Care credentialing committee that credentialing requirements or standards are no longer being met.

Right to Review and Correct Information

All providers participating within the network have the right to review information obtained by Arkansas Total Care to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source, such as the National Practitioner Data Bank, malpractice insurance carriers, and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer-review-protected.

Providers have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer-review-protected) in the event that the provider believes any of the information used in the credentialing or recredentialing process to be incorrect, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner. Arkansas Total Care will inform providers in cases where information obtained from primary sources varies from information provided by the practitioner. To request release of such information, a written request must be submitted to the credentialing department. Upon receipt of this information, the provider will have 14 days from the initial notification to provide a written explanation detailing the error or the difference in information to the credentialing committee.

The Arkansas Total Care credentialing committee will then include this information as part of the credentialing or recredentialing process.

Arkansas Total Care
Attn: Credentialing Department
P.O. Box 25230
Little Rock, AR 72202
ArkCredentialing@centene.com

Right to Be Informed of Application Status

All providers who have submitted an application to join Arkansas Total Care have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the credentialing department at 1-844-263-2437 or ArkCredentialing@centene.com. The credentialing department can also be contacted regarding the status of provider additions, terminations, or changes from providers with an existing provider agreement.

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Right to Appeal or Reconsideration of Adverse Credentialing Decisions

Applicants who are existing providers and who are declined continued participation due to adverse credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within 30 days of the date of the notice.

New applicants who are declined participation may request a reconsideration within 30 days of the date of the notice. All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the credentialing committee at the next regularly scheduled meeting and/or no later than 60 days from the receipt of the additional documentation in accordance with state and federal regulations.

Written requests to appeal or reconsideration of adverse credentialing decisions should be sent to the following address:

Arkansas Total Care
Attn: Credentialing Department
P.O. Box 25230
Little Rock, AR 72202
ArkCredentialing@centene.com

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Provider Administration and Role of the Provider

Primary Care Provider (PCP)

The primary care provider (PCP) is a specific physician or physician group operating under the scope of their licensure, who is responsible for supervising, prescribing, and providing primary care service; locating, coordinating, and monitoring other medical care; rehabilitative service; and maintaining continuity of care on behalf of a member. PCPs are the cornerstone of the Arkansas Total Care service delivery model. The PCP serves as the **Medical Home** for the member. The Medical Home concept assists in establishing a member/provider relationship that supports continuity of care and patient safety. This leads to the elimination of redundant services, more cost-effective care, and better health outcomes.

Arkansas Total Care requires PCPs, dentists, and specialists to conduct reasonable outreach whenever a member misses an appointment, and to document this in the medical record. An effort will be considered reasonable if it includes **three** attempts to contact the member. Attempts may include, but are not limited to, written attempts and/or telephone calls. At least **one** such attempt must be a follow-up telephone call.

Provider Types that May Serve as PCPs

Providers who may serve as PCPs include family medicine; family medicine–adolescent medicine; family medicine–geriatric medicine; family medicine–adult medicine; general practice; pediatrics; pediatrics–adolescent medicine; internal medicine; internal medicine–adolescent medicine; internal medicine–geriatric medicine; obstetrics and gynecology; gynecology; and nurse practitioners who received full independent practice authority or who practice under the supervision of any of the above specialties.

The PCP may practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Department of Health clinic, or similar outpatient clinic. With prior written approval, Arkansas Total Care may allow a specialist provider to serve as a PCP for members with special healthcare needs, multiple disabilities, or acute or chronic conditions as long as the specialist is willing to perform the responsibilities of a PCP as outlined in this manual.

Member Panel Capacity

All PCPs have the right to state the number of members they are willing to accept into their panel. Arkansas Total Care does not and is not permitted to guarantee that any provider will receive a certain number of members.

Notification may be in writing or by calling the provider services department at 1-866-282-6280. A PCP must not refuse new members for addition to their panel unless the PCP has reached their specified capacity limit.

In no event will any established patient who becomes a member be considered a new patient. Providers must not intentionally segregate members from fair treatment and covered services provided to non-members, including hours of operation.

Member Selection or Assignment of PCP

Arkansas Total Care members will be directed to select a participating PCP at the time of their enrollment. In the event that an Arkansas Total Care member does not make a PCP choice, Arkansas Total Care usually will assign the member a PCP using either or both of the following methods:

- The member's Care Coordinator will assist the member in selecting a PCP.
- A PCP will be selected based on the member's previous relationship with a PCP. If a member has not designated a PCP within the first 30–60 days of being enrolled in Arkansas Total Care, Arkansas Total Care may review and assign the member to the most recent PCP who has submitted claims for the member within the last 90 days.

Members are advised to contact the member services department at 1-866-282-6280 if they would like to change their PCP.

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Withdrawing from Caring for a Member

Providers may withdraw from caring for a member. Upon reasonable notice and after stabilization of the member's condition, the provider must send a certified letter to the Arkansas Total Care member services department detailing the intent to withdraw care. The letter must include information on the transfer of medical records as well as emergency and interim care.

A PCP may request that an individual transfer their PCP enrollment to another PCP because the arrangement with that individual is not acceptable to the PCP.

Examples of unacceptable arrangements include, but are not limited to, the following:

- The enrollee fails to appear for two or more appointments without contacting the PCP before the scheduled appointment time.
- The enrollee is abusive to the PCP.
- The enrollee does not comply with the PCP's medical instruction.

At least 30 days in advance of the effective date of the termination, the PCP must give the enrollee written notice to transfer his or her enrollment to another PCP.

- The notice must state that the enrollee has 30 days to enroll with a different PCP.
- The PCP must forward a copy to the enrollee and to the local Department of Human Services (DHS) office in the enrollee's county of residence.
- The PCP must continue as the enrollee's primary care provider during the 30 days or until the individual transfers to another PCP, whichever comes first.

PCP Coordination of Care to Specialists

When medically necessary care is needed beyond the scope of what the PCP can provide, PCPs are encouraged to initiate and coordinate the care members receive from specialist providers. **Paper referrals are not required by Arkansas Total Care; however, they may be required by the referred-to provider.**

In accordance with federal and state law, providers are prohibited from making referrals for designated health services to healthcare providers with whom the provider, the member, or a member of the provider's family or the member's family has a financial relationship.

PCP Responsibilities

Arkansas Total Care will monitor PCP actions for compliance with certain responsibilities. PCP responsibilities include, but are not limited to, the following:

- Providing primary and preventive care and acting as the member's advocate
- Providing, recommending, and arranging for care
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds DHS data specifications
- Maintaining continuity of each member's healthcare
- When needed, effectively communicating with the member by using (free of charge to the member):
  - Sign language interpreters for individuals who are deaf or hard of hearing
  - Oral interpreters for individuals with limited English proficiency (LEP)
- Making referrals for specialty care and other medically necessary services, both covered and non-covered by the plan
- Maintaining a current medical record for the member, including documentation of all service provided to the member by the PCP, as well as any specialty or referral services
- Arranging for specialist services
- Allowing Arkansas Total Care direct access (**not** via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS® and other contractual, regulatory, or other programs

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Specialist Provider Responsibilities

Specialist providers should communicate with the PCP regarding a member's treatment plan and referrals to other specialists. This allows the PCP to better coordinate the member's care and ensures that the PCP is aware of the additional service request.

To ensure continuity and coordination of care for the member, every specialist provider should:

- Maintain contact and open communication with the member's referring PCP.
- If applicable, obtain required authorization from the medical management department before providing services.
- Coordinate the member's care with the referring PCP.
- Provide the referring PCP with consultation reports and other appropriate patient records within five business days of receiving such reports or test results.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of patient medical information.
- Actively participate in and cooperate with all quality initiatives and programs.

Unable to Serve Notifications

HCBS Provider Responsibilities:

- HCBS providers may submit an Unable to Serve notification in situations where they are no longer able to ensure the health and safety or welfare of the member.
- When an HCBS provider is unable to ensure the member's health, safety, or welfare, the provider must notify Arkansas Total Care through the Arkansas Total Care Incident Report Box and DHS by submitting a formal letter outlining the rationale and supporting justification for no longer being able to serve the member.
    - If an HCBS provider is unable to ensure the member's health, safety, or welfare because qualified personnel are unavailable to deliver a CES waiver service that has been authorized by Arkansas Total Care, they must demonstrate and document reasonable efforts to recruit and retain qualified personnel and the results of those efforts.
    - If an HCBS provider is unable to ensure the member's health, safety, or welfare because adequate housing is not available, the provider must propose alternative housing arrangements and locations within the member's available resources. If the member is unwilling to accept any of the proposed alternative housing arrangements, the provider should document that the member has refused available resources.
- When determining a plan for the transition of care, the HCBS provider should ensure the following are taken into consideration:
    - If the member is residing in provider-owned or operated housing, all tenant and lease laws and regulations are being followed.
    - The transition plan allows for adequate time to transfer the member's care to a new provider.
    - The transition plan does not put the member at unnecessary risk.
    - The transition plan addresses all of the member's needs, both service- and non-service-related.

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Hospital Responsibilities

Arkansas Total Care has established a comprehensive network of hospitals to provide services to our members. Hospital services and hospital-based providers must be qualified to provide services under the program. All services must a) be provided in accordance with applicable state and federal laws and regulations, and b) adhere to the requirements set forth by accrediting agencies, if any, and Arkansas Total Care.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit.
- Obtain authorizations for all inpatient and selected outpatient services listed in the Pre-Auth Needed tool available at ArkansasTotalCare.com, except for emergency stabilization services.
- Notify the medical management department of all admissions via the ER within one business day.
- Notify the medical management department of all newborn deliveries within one day of the delivery — notification may occur through our secure provider portal, fax, or by phone.
- Adhere to the standards set in the **Time Frames for Prior Authorization Requests and Notifications** table in the **Medical Management** section of this manual.

Voluntarily Leaving the Network

Providers must give Arkansas Total Care notice of voluntary termination following the terms of their participating agreement with the health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail. Arkansas Total Care will notify affected members, in writing, of a provider's termination 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt of a termination notice.

Appointment Availability and Wait Times

Arkansas Total Care follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Arkansas Total Care monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care, and to reduce inappropriate emergency room utilization.

Appointment access audits:

- Arkansas Total Care may conduct appointment accessibility surveys telephonically and/or on-site or ad hoc for complaint/grievance investigation to determine appointment availability based on requirements outlined in the provider manual and state contract for each line of business.
- Arkansas Total Care may survey their top five specialties to ensure that specialty access standards are being met. The state may determine which specialties are to be audited, and the health plan should comply with those requirements.
- Arkansas Total Care may assess all PCPs and providers in each geographic region and randomly audit to ensure that the below services are available.

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The table below depicts appointment availability for members:

Service Type	Time Frame
Emergency care — medical, behavioral health, substance abuse	24 hours a day, seven days a week
Behavioral health service, developmental disability service, mobile crisis service, mobile crisis response	24 hours a day, seven days a week
Urgent care — medical, behavioral health, substance abuse	Within 24 hours
Primary care — routine, non-urgent symptoms	Within 21 calendar days
Behavioral health, substance abuse care — routine, non-urgent, non-emergency	Within 21 calendar days
Prenatal care	Within 14 calendar days
Primary care access to after-hours care	Office number answered 24/7 by answering service or instructions on how to reach a physician
Preventive visit/well visit	Within 30 calendar days
Specialty care — non-urgent	Within 60 calendar days
HCBS — identified as necessary to project the health and safety of the member	Within 90 calendars of completion of the PCSP

Provider Phone Call Protocol

PCPs and specialist providers must:

- Answer the member's telephone inquiries on a timely basis.
- Schedule appointments in accordance with the appointment standards and guidelines set forth in this manual.
- Schedule a series of appointments and follow-up appointments as appropriate for the member and in accordance with accepted practices for timely occurrence of follow-up appointments for all patients.
- Identify and, when possible, reschedule canceled and/or no-show appointments.
- Identify special member needs while scheduling an appointment, such as wheelchair and interpretive linguistic needs, non-compliant individuals, or persons with cognitive impairments.
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal office hours.
- Have protocols in place to provide coverage in the event of a provider's absence.
- Document after-hours calls in a written format, either in the member's medical record or an after-hours call log, and then transfer to the member's medical record.

Note: If after-hours urgent or emergent care is needed, the PCP, specialist provider, or their designee should contact the urgent care center or emergency department to notify the facility of the patient's impending arrival. Arkansas Total Care does not require prior authorization for emergency care.

Arkansas Total Care will monitor appointment and after-hours availability through its quality improvement program (QIP).

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Provider Data Updates and Validation

Arkansas Total Care believes that providing easy access to care for our members is extremely important. When information — such as address, office hours, specialties, phone number, and hospital affiliations — about your practice, your locations, or your practitioners changes, it is your responsibility to provide timely updates to Arkansas Total Care. Arkansas Total Care will ensure that our systems are updated quickly to provide the most current information to our members. Additionally, Arkansas Total Care and our contracted vendors will perform regular audits of our provider directories.

We need your support and participation in these efforts. The Centers for Medicare & Medicaid Services (CMS) may also audit provider directories throughout the year, and you may be contacted by them as well. Please be sure to notify your office staff so that they may route these inquiries appropriately.

24-Hour Access to Providers

PCPs and specialist providers are required to maintain sufficient access to needed healthcare services on an ongoing basis and must ensure that such services are accessible to members 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.
- A member must be able to access their provider after normal business hours and on weekends. This may be accomplished through the following:
  - A covering physician;
  - An answering service;
  - A triage service or voicemail message that provides a second phone number that is answered; and/or
  - If the provider's practice includes a high population of Spanish-speaking members, it is recommended that the message be recorded in both English and Spanish.
- Examples of unacceptable after-hours coverage include but are not limited to:
  - Calls received after-hours that are answered by a recording telling callers to leave a message.
  - Calls received after-hours that are answered by a recording directing patients to go to an emergency room for any services needed.
  - Not returning calls or responding to messages left by patients after-hours within 30 minutes.

The selected method of 24-hour coverage chosen by the provider must connect the caller to someone who can render a clinical decision or reach the PCP or specialist provider for a clinical decision. Whenever possible, PCPs, specialist providers, or covering professionals must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

In accordance with the Licensure Manual for Community Support System Providers, providers must have a 24-hour emergency telephone number for all members they serve. Providers must also include a summary document in the paient's primary language at the front of all service records. Arkansas Total Care will monitor providers' compliance with these provisions through scheduled and unscheduled visits and audits conducted by Arkansas Total Care staff.

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Confidentiality Requirements

Providers must comply with all federal, state, and local laws and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements. Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential provider/member information, whether oral or written, in any form or medium. The following information is considered confidential:

- All **individually identifiable health information** held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The privacy rule calls this information protected health information (PHI). Individually identifiable health information, including demographic data, is information that relates to:
  - The individual's past, present, or future physical or mental health/condition
  - The provision of healthcare to the individual
  - The past, present, or future payment for the provision of healthcare to the individual
  - Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual
  - Various common identifiers, such as name, address, birth date, or social security number

The privacy rule excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 u.s.c. §1232g.

Provider offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Arkansas Total Care.

Member Privacy Rights

Arkansas Total Care privacy policy assures that all members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, as well as applicable contractual requirements. Arkansas Total Care's privacy policy conforms with 45 CFR parts 160 and 164 — relevant sections of HIPAA that provide member privacy rights and place restrictions on uses and disclosures of PHI (§164.520, 522, 524, 526 and 528).

Use and Disclosure Guidelines

Arkansas Total Care is required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations

A privacy request may be subject to specific limitations or restrictions as required by law. Arkansas Total Care may deny a privacy request under any of the following conditions:

- Arkansas Total Care does not maintain the records containing the PHI.
- The requester is not the member, and Arkansas Total Care is unable to verify the requester's identity or authority to act as the member's authorized representative.
- The documents requested are not part of the designated record set, such as credentialing information.
- Access to the information may endanger the life or physical safety of, or otherwise cause harm to, the member or another person.
- Arkansas Total Care is not required by law to honor the particular request, such as accounting for certain disclosures.
- Accommodating the request would place excessive demands on Arkansas Total Care or our time and resources and be contrary to HIPAA.

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Arkansas Total Care Benefits

Overview

Arkansas Total Care network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this provider manual, please contact the provider services department at 1-866-282-6280. A provider service representative will be happy to assist you.

Arkansas Total Care covers, at minimum, those core benefits and services specified in our agreement with DHS and defined in the **administrative rules and department policies and procedure** handbook.

Covered Services

All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. Arkansas Total Care must make sure that a member has access to all services covered under the Medicaid state plan, the 1915 (I) State Plan, and Community & Employment Support waiver, including therapy services and services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program for children. For services outside of the EPSDT program, members will be considered an adult at the age of 18 unless otherwise specified.

State Plan Services:

- Personal care
- Physician specialists
- Family planning
- Primary care physician
- Pharmacy
- Inpatient psychiatric services and residential for children and youth
- Durable medical equipment
- Hospital services
- Outpatient behavioral health counseling
- Occupational therapy
- Physical therapy
- Health counseling
- Speech therapy
- Nursing services

For a listing of Community & Employment Support waiver services, 1915 (I), and Community Independence waiver services, visit ArkansasTotalCare.com.

Sterilization

Sterilization procedures, such as tubal ligation or vasectomy, are covered when coordinated through a PCP and delivered by a network provider. Providers must counsel members regarding alternative methods of birth control that are available. The sterilization procedure is permanent, and the surgery cannot be 100% guaranteed to make a member sterile. Inform members that the signed consent can be withdrawn at any time and that they will not lose any health services or benefits.

The member must be at least 21 years of age, mentally competent, and not in an institution at the time they voluntarily sign the consent form. The member must give informed consent and sign the Sterilization Consent Form at least 30 days, but no more than 180 days, before the procedure in order to receive coverage. Providers should use the Division of Medical Services Sterilization Consent Form (DMS – 615), which can be found on the Arkansas Medicaid website.

Abortion

Abortions are an excluded service except as allowed by state or federal law.

Hysterectomy

Hysterectomy surgery is covered when it is considered medically necessary and performed by a network provider. The provider and member must complete the Patient Acknowledgment for Hysterectomy form prior to performing the procedure. The consent form must accompany the claim to obtain payment. Providers should use the Division of Medical Services Acknowledgment of Hysterectomy Information (DMS – 2606), which can be found on the Arkansas Medicaid website.

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Non-Covered Services

Non-covered services are services that are not covered by Arkansas Total Care. Authorization does not guarantee payment of claims. Services are reimbursed by Arkansas Total Care only if the service is deemed medically necessary, or if it is a covered service provided to an eligible member.

Please visit ArkansasTotalCare.com or call the provider services department at 1-866-282-6280 for a complete list of these services.

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Vision Benefits

Importance of Verifying Benefits, Eligibility, and Cost Shares

Arkansas Total Care provides covered health services to individuals who have intellectual and developmental disabilities and/or behavioral health needs in the state of Arkansas.

Routine Vision Services

For specific individual member benefits and eligibility, log in to our provider portal, Eye Health Manager (VisionBenefits.EnvolveVision.com/logon), or call our customer service center at 1-844-280-6792.

The Arkansas Medicaid program uses Select Optical to furnish eyeglasses for Arkansas Total Care members.

- Providers should place their eyewear orders directly with Select Optical.
- Providers are to use the Arkansas Medicaid frame kit supplied by Select Optical.

Optical services that are medically necessary and meet Envolve Vision's guidelines are covered and must be billed in accordance with Envolve's guidelines. A copy of Envolve's policies and guidelines may be found by logging in to Envolve's provider portal at VisionBenefits.EnvolveHealth.com/logon. Prior authorization is not required for medically necessary eyewear; however, it is subject to retrospective review. Please maintain documentation in the member's file of the necessity of the eyewear and/or services provided.

Medically necessary eye care services are covered for members of all ages as indicated in the Medicaid State Plan.

- No prior authorization is required for the majority of services; however, it is required for some. Please see the prior authorization section below for more information.
- All claims for medically necessary eye care services and ocular injectable drugs should be directed to Envolve.
- Providers should comply with the Arkansas Total Care preferred drug list when prescribing medications to a member. The preferred drug list can be found at ArkansasTotalCare.com.

Detailed instructions for submitting prior authorization requests can be found on the Eye Health Manager at VisionBenefits.EnvolveVision.com/logon. Select **Online Forms** and then **Prior Authorization Request Form**.

For more information, contact Envolve's utilization management department by phone at 1-800-465-6972 or by fax at 1-877-865-1077.

To access the Eye Health Manager, visit VisionBenefits.EnvolveVision.com/logon. Log in with your username and password. Please contact the network management team if you have misplaced your username or password, or if you need access to the Eye Health Manager.

Medical Vision Services

For specific individual member benefits and eligibility, log in to our provider portal, Arkansas Total Care at ArkansasTotalCare.com, or call our customer service center at 1-866-282-6280.

Medical vision services that are medically necessary and meet Arkansas Total Care's guidelines are covered and must be billed in accordance with Arkansas Total Care guidelines. A copy of Arkansas Total Care's policies and guidelines may be found on the Arkansas Total Care website and provider portal at ArkansasTotalCare.com. Please maintain documentation in the member's file of the necessity of the services provided.

- No prior authorization is required for the majority of services; however, it is required for some. Please see the prior authorization section below for more information.
- All medical and surgical services are subject to Arkansas Total Care's utilization management policies and procedures. Policies and procedures can be found on the Arkansas Total Care website and provider portal at ArkansasTotalCare.com.
- All claims for medically necessary eye care services and ocular injectable drugs should be directed to Envolve.

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- Providers should comply with the Arkansas Total Care preferred drug list when prescribing medications to a member. The preferred drug list can be found at ArkansasTotalCare.com.

Detailed instructions for submitting prior authorization requests can be found on the Arkansas Total Care at ArkansasTotalCare.com. For more information, contact Arkansas Total Care's utilization management department by phone at 1-866-282-6280.

Routine Vision Claims Submission

Eye Health Manager (available 24/7):

- Verify member eligibility and benefits.
- File claims.
- Review claim status.
- Use audit tools.
- Download, research, and reprint EOBs.

Electronic Claims Submission: Change Healthcare Payer ID #56190

Paper Claims Submission:

Envolve Benefit Options
Attn: Claims
P.O. Box 7548
Rocky Mount, NC 27804

Customer Service: Member Eligibility and Claims Inquiries — 1-844-280-6792

Network Management: Provider Participation Inquiries — 1-800-531-2818

Medical Vision Claims Submission

Please see section for claims submission to Arkansas Total Care.

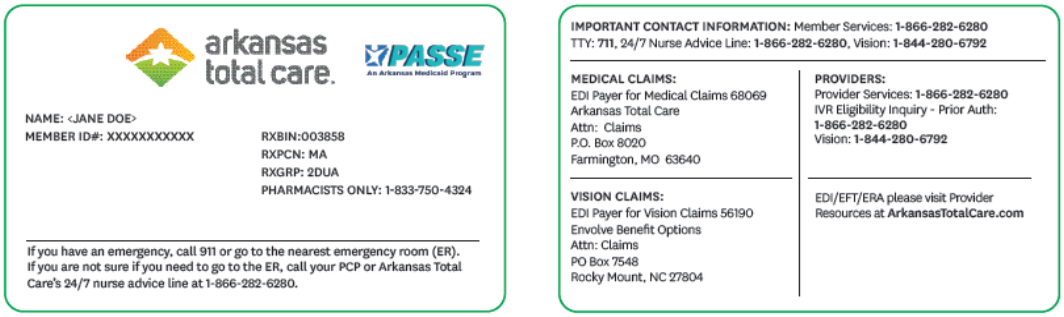
Verifying Member Benefits and Eligibility

Importance of Verifying Benefits and Eligibility

Providers are responsible for verifying member eligibility and covered services. It is imperative that providers verify benefits and eligibility each time an Arkansas Total Care member is scheduled to receive care. Claims will not be paid if it is determined that the member is not eligible for the dates of service.

Member Identification Card

All Arkansas Total Care members will receive an Arkansas Total Care member identification card. Below is a sample member identification card. Please keep in mind that the ID card may vary due to the features of the plan selected by the member.



(The above is a reasonable facsimile of the member identification card.)

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All new Arkansas Total Care members receive an Arkansas Total Care member ID card upon enrollment and should keep their state-issued ID card to receive services not covered by the plan. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card.

Note: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day that services are required.

Methods to Verify Benefits and Eligibility

Arkansas Total Care providers should verify member eligibility before every service is rendered using one of the following methods:

- Log on to our secure provider portal at Provider.ArkansasTotalCare.com. Using the portal, you can check member eligibility. Search by date of service and either the member's name and date of birth, or the member's Arkansas Total Care ID number and date of birth. Eligibility information loaded onto this website is obtained from Arkansas Medicaid and reflective of all changes made within the last 24 hours.
- Call our automated member eligibility IVR system. Call 1-866-282-6280 from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility verification system 24 hours a day. The system will prompt you to enter the member's Arkansas Total Care ID number and the month of service to check eligibility.
- If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-866-282-6280. Follow the menu prompts to speak to a provider services representative to verify eligibility prior to rendering services. The provider services representative will need the member's name, Arkansas Total Care ID number, and date of birth to verify eligibility.

Through Arkansas Total Care's secure provider portal, providers can access a list of eligible members who have selected their services or were assigned to them. To view this list, log in to the portal at Provider.ArkansasTotalCare.com.

Tip: Eligibility changes can occur throughout the month. The patient list does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify member eligibility on the date of service.

Medical Management

The components of the Arkansas Total Care medical management program are utilization management, care management and concurrent review, health management, and behavioral health. These components are discussed in detail below.

Utilization Management

The Arkansas Total Care utilization management initiatives are focused on optimizing each member's health status, sense of well-being, productivity, and access to appropriate healthcare while actively managing cost trends. The utilization management program's goals are to provide covered services that are medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and that meet professionally recognized standards of care.

Arkansas Total Care does not reward providers, employees who perform utilization reviews, or other individuals for issuing denials of authorization. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve benefit coverage. There are no financial incentives to deny care or encourage decisions that result in under-utilization. Prior authorization is the request to the utilization management department for approval of certain services before the service is rendered.

Authorization must be obtained prior to the delivery of certain elective and scheduled services. Failure to obtain authorization may result in denial of coverage.

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Medically Necessary

Medically necessary means any medical service, supply, or treatment authorized by a physician to diagnose and treat a member's illness or injury that:

- Is consistent with the symptoms or diagnosis.
- Is provided according to generally accepted medical practice standards.
- Is reasonably expected to prevent the onset of an illness, condition, injury, or disability.
- Is reasonably expected to reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, or disability.
- Is not custodial care.
- Is not solely for the convenience of the physician or the member.
- Is not experimental or investigational.
- Is provided in the most cost-effective care facility or setting.
- Does not exceed the scope, duration, or intensity of the level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment.
- When specifically applied to a hospitalization, means the diagnosis and treatment of the medical symptoms or conditions cannot be safely provided as an outpatient service.
- Will help the recipient achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and that those functional capacities are appropriate for recipients of the same age.

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caretaker, and the member's PCP, as well as any other providers, programs, or agencies that have evaluated the member.

All such determinations must be made by qualified and trained healthcare providers.

Utilization Review Criteria

Utilization management decision-making is based on appropriateness of care and service, as well as the existence of coverage. Arkansas Total Care does not reward providers or other individuals for issuing denials of authorizations or have financial incentives in place that encourage decisions resulting in under-utilization.

Arkansas Total Care has adopted the following utilization review criteria to determine whether services are medically necessary for purposes of plan benefits:

Medical Services	InterQual® Clinical Policies and Adult/Pediatric Guidelines
Behavioral Health Services	InterQual Clinical Policies and Adult/Pediatric Guidelines American Society of Addiction Medicine (ASAM) 1915i
High-Tech Imaging	Internally developed criteria by National Imaging Associates (NIA). Criteria developed by representatives in the disciplines of radiology, internal medicine, nursing, and cardiology. These criteria are available at RadMD.com.
Substance Use Disorder Services	Based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. These criteria are available at ASAM.org.
Musculoskeletal Surgical Services	TurningPoint Internally developed evidence-based guidelines. Criteria developed by representatives in the disciplines of orthopedics, internal medicine, pain management, and cardiology.

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Arkansas Total Care's medical director — or other healthcare professionals who have appropriate clinical expertise in treating the member's condition or disease — review all potential adverse determinations and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from InterQual or other criteria as mentioned above.

Providers may obtain the criteria used to make a specific adverse determination by contacting the medical management department at 1-866-282-6280. Providers have the opportunity to discuss any adverse decisions with an Arkansas Total Care physician or other appropriate reviewer at the time of the notification to the requesting provider of an adverse determination. The medical director may be contacted by calling Arkansas Total Care at 1-866-282-6280 and asking for the medical director.

Time Frames for Prior Authorization Requests and Notifications

The following time frames are required of the ordering provider for prior authorization and notification:

Service Type	Time Frame
Scheduled admissions	Prior authorization is required a minimum of five business days before the scheduled admission date for residential admissions unless the member is stepping down directly from a higher level of care.
Elective outpatient services	Prior authorization is required a minimum of five business days before the elective outpatient service date.
Emergent inpatient admissions	Notification is required within 24 hours or by the next business day following a weekend or holiday.
Continued Inpatient Stay	Notification is required within 24 hours of the last approved day.
Maternity Admissions	Notification within 24 hours or by the next business day following a weekend or holiday.
Clinical trials services	Prior authorization is required at least 30 days before receiving clinical trial services.

Utilization Determination Time Frames

Authorization decisions are made as expeditiously as possible. Below is a list of specific time frames used by Arkansas Total Care. If additional information is needed to make a determination, then it may be necessary for an extension to increase the time frame. If an extension is necessary, you will be notified of which additional information is needed as well as the new time frame to provide documentation. Failure to provide the requested additional information within the specified time frame will result in a denial. Please contact Arkansas Total Care if you would like a copy of the policy for utilization management time frames.

Plan Product Line of Business	Standard (Non-Urgent) Turnaround Time (TAT)*	Expedited (Urgent) TAT*	Retrospective
Medicaid Plan	Two business days of obtaining all necessary information.	Lesser of: One business day of obtaining all necessary information, or within 72 hours** of receipt of request.	30 calendar days
Cancer Biomarker (Genetic) Testing	Three calendar days from receipt of request	One calendar day from receipt of request	30 calendar days

* Turnaround time shall not exceed the listed time frames.

** Extensions may be allowed as permitted by NCQA and state law.

Services Requiring Prior Authorization

A list of services requiring prior authorization is available on our website. To verify whether a service requires prior authorization, visit ArkansasTotalCare.com, select the **For Providers** tab toward the top of the page, select **Provider Resources**, and then select **Pre-Auth Check** from the menu on the left side of the page. If you have any questions, call the utilization management

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department at 1-866-282-6280. Failure to obtain the required prior authorization or pre-certification may result in a denied claim or reduction in payment. Please note that all out-of-network services, excluding emergency room services, require prior authorization.

It is the responsibility of the facility in coordination with the rendering practitioner to ensure that an authorization has been obtained for all inpatient and selected outpatient services, except for emergency stabilization services. All inpatient admissions require notification and authorization.

Any anesthesiology, pathology, radiology, or hospital services related to an Arkansas Total Care-covered hospital stay requiring a prior authorization will be considered and will not require a separate prior authorization.

Services related to an authorization denial may result in denial of all associated claims.

Procedure for Requesting Prior Authorizations

The preferred method for submitting prior authorizations is through Arkansas Total Care's secure provider portal, which can be accessed by logging in at Provider.ArkansasTotalCare.com.

The provider must be a registered user of the secure provider portal. If a provider is already registered for the secure provider portal for one of our other products, that registration will grant the provider access to Arkansas Total Care as well. If the provider is not already a registered user and needs assistance or training on submitting prior authorizations, the provider should contact their dedicated provider relations specialist. Other methods of submitting the prior authorization requests are as follows:

- **Phone**
  - Call the medical management department at 1-866-282-6280. Our 24/7 Nurse Advice Line can assist with urgent authorizations after normal business hours.
- **Fax**
  - Prior authorization fax forms are posted on the Arkansas Total Care website. For physical health, please fax forms and supporting medical records to 1-833-249-2342. For behavioral health, please fax materials to 833-632-6934. .
  - **Note:** Faxes will not be monitored after regular business hours and will be responded to in accordance with the turnaround times listed in this manual. Please contact our 24/7 Nurse Advice Line at 1-866-282-6280 for urgent, after-hours urgent, inpatient notifications or requests.

Medical and Behavioral Health

The requesting or rendering provider must provide the following information to request authorization, regardless of the method used:

- Member's name, date of birth, and Arkansas Total Care ID number
- Provider's tax ID, NPI number, taxonomy code, name, and telephone number
- Facility name if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Procedure code(s)
  - **Please note:** If the procedure codes submitted at the time of authorization differ from the services actually performed, it is required, either within 72 hours or prior to the time the claim is submitted, that you call the medical management department at 1-866-282-6280 to update the authorization. Otherwise, this may result in claim denials.
- Relevant clinical information, such as past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed
  - **Please note:** Requests without the required clinical information for review will be reviewed based on available information.
- Admission date for facility stays or proposed surgery date if the request is for a surgical procedure
- Start date and end date if the request is for outpatient behavioral health
- Discharge plans

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Advanced Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Arkansas Total Care is using National Imaging Associates (NIA) to provide prior authorization services and utilization management for advanced imaging and radiology. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA
- MRI/MRA
- PET

Key provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in denial of all or a portion of the claim.

National Imaging Associates (NIA) Authorizations

NIA provides an interactive website, RadMD.com, that should be used to obtain online authorizations. For urgent authorization requests, call 1-877-617-0390 and follow the prompt for radiology authorizations. For more information, contact our provider services department at 1-866-282-6280.

TurningPoint

TurningPoint, on behalf of Arkansas Total Care, offers a Surgical Quality and Safety Management Program with a comprehensive strategy for managing the unique complexities of surgical procedures and medical device utilization.

TurningPoint's Surgical Quality and Safety Management Program helps to improve the quality of care, safety, and affordability of healthcare services for Arkansas Total Care members. The comprehensive program integrates quality and safety measures related to patient comorbidities and risk factors, evidence-based utilization management pathways, site-of-service optimization, specialized peer-to-peer engagement, FDA device and recall tracking, and advanced reporting and analytics to promote the overall health management of each patient. Refer to the table below for a list of covered procedures:

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Musculoskeletal Procedures	
Orthopedic Surgical Procedures	**Spinal Surgical Procedures**
Including all associated partial, total, and revision surgeries: • Knee arthroplasty • Unicompartmental/bicompartmental knee replacement • Hip arthroplasty • Shoulder arthroplasty • Elbow arthroplasty • Ankle arthroplasty • Wrist arthroplasty • Acromioplasty and rotator cuff repair • Anterior cruciate ligament repair • Knee arthroscopy • Hip resurfacing • Meniscal repair • Hip arthroscopy • Femoroacetabular arthroscopy • Ankle fusion • Should fusion • Wrist fusion • Osteochondral defect repair	Including all associated partial, total, and revision surgeries: • Spinal fusion surgeries: – Cervical – Lumbar – Thoracic – Sacral – Scoliosis • Disc replacement • Laminectomy/discectomy • Kyphoplasty/vertebroplasty • Sacroiliac joint fusion • Implantable pain pumps • Spinal cord neurostimulator • Spinal decompression

TurningPoint provides an interactive website, MyTurningPoint-Healthcare.com, that should be used to obtain online authorizations. For urgent authorization requests, call 1-501-263-8850 or 1-866-619-7054 and follow the prompt for authorizations. For more information, contact our provider services department at 1-866-282-6280.

Concurrent Review

The Arkansas Total Care medical management department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's utilization and discharge planning departments and, when necessary, the member's attending physician. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's current status, proposed plan of care, discharge plans, and subsequent diagnostic testing or procedures. Providers should submit records and request for additional days within one calendar day of the last approved day of a member's stay.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to Arkansas Total Care was not obtained due to extenuating circumstances (e.g. the member was unconscious at presentation, the member did not have their Arkansas Total Care ID card or other proof of Medicaid coverage, services were authorized by another payer who subsequently determined the participant was not eligible at the time of service, etc.). Requests for retrospective review must be submitted to the medical management team promptly. A decision will be made within 30 calendar days following receipt of the request. Presumptive eligibility rules apply.

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Emergency Care

Arkansas Total Care defines an **emergency medical condition** as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

- Placing the health of the individual (or, with respect to a pregnant individual, the health of the parent or the unborn child) in serious jeopardy
- Impairments of bodily functions
- Serious dysfunction of any bodily organ or part as per 42 CFR 438.114(a)

Members may access emergency services at any time without prior authorization or prior contact with Arkansas Total Care. Providers should inform members that if they are unsure as to the urgency or emergency of the situation, they are encouraged to contact their PCP and/or Arkansas Total Care's 24/7 Nurse Advice Line for assistance; however, this is not a requirement to access emergency services. Arkansas Total Care contracts with emergency service providers as well as non-emergency providers who can address the member's non-emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by Arkansas Total Care when furnished by a qualified provider, including out-of-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Arkansas Total Care. Emergency services will cover and reimburse regardless of whether the provider is in Arkansas Total Care's network and will not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition.
- A representative from the health plan instructs the participant to seek emerg ency services.

Once the member's emergency medical condition is stabilized, Arkansas Total Care requires notification for hospital admission or prior authorization for follow-up care as noted elsewhere in this manual.

Residential Psychiatric Treatment Facilities for U21 — General Requirements

- 124 — Residential treatment center only
- 128 — Sexual offender program only
- 129 — Residential treatment unit only

Residential treatment centers are free-standing residential centers. Residential treatment units are within an inpatient psychiatric provider.

Discharge Planning

Discharge planning should start upon admission. A final discharge plan must include:

- Member education that is specific to the diagnosis and includes information on recognizing signs and symptoms
- Self-care with reminders and cues to use skills developed in treatment
- Integrated care, including follow-up appointments with scheduled dates/times and a release to send treatment records to all providers the member will be following up with
- Medication management
- Supports, roles and responsibilities, school transition, and any needed follow-up with the school to include which school the member will return to
- Information on how to return to care if needed, including phone numbers and instructions
- A safety plan

Providers should send the discharge plan to both the Care Coordination and Utilization Management department within one business day of discharge so that Arkansas Total Care can ensure the member/family are following up with the discharge instructions.

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Active Treatment

Active treatment is defined as a minimum of 40 treatment hours per week, not including classroom time, five of which are conducted by a licensed mental health professional (LMHP), with a minimum of one being in an individual setting rather than a group setting. Included in the five hours per week by a LMHP, there should be a minimum of two family therapy sessions per month, as well as a weekly visit with the psychiatrist.

Incident Reporting

All incidents should be reported to Arkansas Total Care in accordance with the standards outlined in the Arkansas Total Care Provider Manual. The DHS QA Incident Report form is available at ArkansasTotalCare.com. List your facility in the **HCBS Provider** field at the bottom of the form. Send completed forms via secure email to Incident@ArkansasTotalCare.com.

Pharmacy

Arkansas Total Care is committed to providing appropriate, high-quality, and cost-effective outpatient medications as listed on the Arkansas Medicaid Preferred Drug List (PDL), when determined to be medically necessary, to all Arkansas Total Care participants. Arkansas Total Care works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered pharmacy benefits.

Arkansas Total Care covers prescription drugs and certain over-the-counter (OTC) drugs when ordered by an Arkansas Total Care prescriber. The pharmacy program covers all medications that are Medicaid-covered outpatient drugs. Certain medications may require prior authorization and/or have limitations on age, dosage, and/or maximum quantities. Through an exception process, authorizations may be granted for medically necessary medications.

This section provides an overview of the Arkansas Total Care pharmacy program. For more detailed information, please visit ArkansasTotalCare.com.

Express Scripts serves as the Pharmacy Benefit Manager (PBM) for Arkansas Total Care.

Members can get their prescriptions filled at participating network pharmacies. For additional information, please visit our website at ArkansasTotalCare.com

Injectable Drugs

Injectable drugs administered by a provider in a healthcare setting are not covered under the pharmacy benefit. Prior authorizations for these drugs can be obtained through the utilization management processes detailed in the previous section.

Working With the Pharmacy Benefits Manager (PBM)

Arkansas Total Care works with a pharmacy benefits manager (PBM) to administer retail pharmacy benefits. Certain drugs require prior authorization to be approved for payment by Arkansas Total Care.

Pharmacy Prior Authorization

The Arkansas Medicaid PDL includes a broad spectrum of brand-name and generic drugs. Generally, the generic product is preferred, except where the brand name is required by Arkansas Medicaid. Clinicians are encouraged to prescribe medications listed on the Arkansas Medicaid PDL for their patients who are members of Arkansas Total Care. Some drugs will require prior authorization. Arkansas Total Care will cover the medication if it is determined that:

- There is a medical reason the participant needs the specific medication, supported by current clinical literature.
- Depending on the medication, other medications on the PDL have not worked.
- The medication is being used for non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine, as approved by Arkansas Total Care.

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Submitting a Pharmacy Prior Authorization

Drug prior authorization requests can be submitted to Pharmacy Services via phone, fax, or web. To ensure timeliness of our members' pharmacy needs, Arkansas Total Care has a strict 24-hour turnaround time requirement to process requests.

- **Phone**
  - Prescribers may contact Pharmacy Services to initiate a prior authorization by calling 1-833-587-2011.
  - The Pharmacy Services prior authorization help desk is staffed by triage specialists seven days a week, 365 days a year, 24 hours a day.
  - During regular business hours, licensed clinical pharmacists and pharmacy technicians are available to answer questions and assist providers. A nurse advice line is available outside of regular business hours.
- **Fax**
  - Prescribers may complete the Arkansas Total Care/Pharmacy Services Medication Prior Authorization Request form available at ArkansasTotalCare.com.
  - Fax the completed form to Pharmacy Services at 1-833-582-2341.
  - Once approved, Pharmacy Services will notify the prescriber via fax.
  - When medical necessity criteria are not met based on the clinical information submitted, the prescriber will be notified of the reason via fax. The notification will include PDL alternatives, if applicable.
- **Online Prior Authorization**
  - CoverMyMeds® is an online drug prior authorization program that allows prescribers to begin the prior authorization process electronically. CoverMyMeds simplifies the prior authorization submission process by automating drug prior authorizations for any medication.
  - Visit the CoverMyMeds website at CoverMyMeds.com/main/prior-authorization-forms/.

A pharmacy can provide up to a 72-hour supply of medically necessary outpatient medications by calling the Pharmacy help desk at 1-833-750-0202.

Once approved, Pharmacy Services will notify the prescriber/clinician via fax. If the clinical information provided does not meet the medical necessity and/or prior authorization guidelines for the requested medication, Arkansas Total Care will notify the member and the prescriber of medication alternatives in addition to providing information for the appeal process.

Preferred Drug List (PDL)

The Arkansas Medicaid PDL can be found online at Arkansas.MagellanRX.com and describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to participants covered under the program. All drugs covered under the Arkansas Medicaid program are available for Arkansas Total Care participants.

The Arkansas Medicaid PDL does not:

- Require or prohibit the prescribing or dispensing of any medication.
- Substitute for the independent professional judgment of the provider or pharmacist.
- Relieve the provider or pharmacist of any obligation to the participant or others.

The Arkansas Medicaid PDL includes a broad spectrum of generic and brand-name drugs. Some preferred drugs require prior authorization. Providers are asked to use the PDL when prescribing medication to Arkansas Total Care members. If a pharmacist receives a prescription for a drug that requires a prior authorization request, the pharmacist should attempt to contact the provider to request a change to a product included in the PDL.

A paper copy of the most current PDL may be requested by calling the provider relations department at the number provided in the **Key Contacts and Important Phone Numbers** section of this manual.

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Dispensing Limits, Quantity Limits, and Age Limits

Drugs may be dispensed up to a maximum 31-day supply for each new or refilled non-opioid. Opioid prescriptions are subject to state criteria and limited to a seven-day fill for new prescriptions. A total of 75% of the days supplied for a non-controlled medication and 90% for controlled substances must have elapsed before the prescription can be refilled without a prior authorization approval. For ophthalmic drops, a total of 70% of the days supplied must have elapsed before the prescription can be refilled. Dispensing outside the quantity or age limits requires prior authorization.

Arkansas Total Care may limit how much of a medication a participant can get at one time. If the physician/clinician feels that a participant has a medical reason for getting a larger amount, they can request prior authorization. If Arkansas Total Care does not grant a prior authorization approval, the participant and physician or clinician will be notified and provided with information regarding the appeal process. Some medications on the Arkansas Medicaid PDL may have age limits. These are set for certain drugs based on Food and Drug Administration (FDA)-approved labeling, as well as current medically accepted quality standards of care as supported by clinical literature. The age limits align with current FDA and medical standards of care for the appropriate use of pharmaceuticals in improving outcomes for our participants.

Brand/Generic Coverage

Generic drugs have the same active ingredient, work the same as brand-name drugs, and provide cost savings. Generally, the generic product is preferred, except where the brand name is required by Arkansas Medicaid. If the participant or physician/clinician feels that a brand-name drug is medically necessary, the physician/clinician can ask for an authorization. Arkansas Total Care will cover the brand-name drug according to the Arkansas Medicaid guidelines if there is a valid medical reason the participant needs the particular brand-name drug. If Arkansas Total Care does not grant authorization, Arkansas Total Care will notify the participant and physician/clinician and provide information regarding the appeal process.

Over-the-Counter Medications (OTC)

The pharmacy program covers OTC medications consistent with the Arkansas Medicaid OTC drug list. All OTC medications must be written on a valid prescription by a licensed physician in order to be covered.

Step Therapy

Some medications listed on the Arkansas Medicaid PDL may require specific medications to be used before an individual can receive the medication subject to step therapy (ST). If Arkansas Total Care does not have a record that the prerequisite medication was tried, then the participant or physician/clinician may be required to provide evidence of previous trial or clinical rationale for an exception. If Arkansas Total Care does not grant an exception to the ST medication, we will notify the participant and physician/clinician and provide information regarding the appeal process.

Benefit Exclusions

The following drug categories are not part of the Arkansas Total Care benefit and are not covered by the 72-hour emergency supply policy:

- Fertility-enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Drug Efficacy Study Implementation (DESI) and identical, related, and similar (IRS) drugs that are classified as ineffective
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence
- Exclusions as specified by Arkansas Medicaid (e.g. nutritional products, repackagers/repackaged products, or drug manufacturers not registered with CMS)
- Immunizations for children younger than 19 are medical benefits
- Experimental drugs/indications and investigational drugs are not eligible for coverage

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72-Hour Emergency Supply of Medications

Arkansas Total Care will allow up to a 72-hour supply of medication to any patient awaiting a prior authorization determination. The purpose of this is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication, whether or not the prior authorization request is ultimately approved or denied. The pharmacy should contact the pharmacy help desk at 1-833-750-0202 for a prescription override to submit the 72-hour medication.

Pharmacy Services Contacts

Prior Authorization

Telephone: 1-833-587-2011

Fax: 1-833-582-2341

Web: CoverMyMeds.com/main/prior-authorization-forms/

Seven days a week, 365 days a year, 24 hours a day

Mailing Address

For Pharmacy Services paper claim submissions or other correspondence, send to the following address:

Pharmacy Services
Attn: Prior Authorization Department
5 River Park Place E., Suite 210
Fresno, CA 93720

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Care Coordination and Care Management

Care Coordination

Arkansas Total Care provides services for individuals with intellectual and developmental disabilities and/or behavioral health needs. Each Arkansas Total Care member will be assigned a Care Coordinator who will help the member with their health goals and serve as the member's primary point of contact with Arkansas Total Care.

A member of the Care Coordination team will contact a member within 15 business days of becoming a member. During this call, a health and service assessment will be completed. Following initial contact, a Care Coordinator will be assigned who will reach out to the member to coordinate an in-person meeting to complete the Person-Centered Service Plan (PCSP).

Care Coordinators are equipped to help members with the following:

- Finding a PCP or other provider
- Scheduling an appointment with a PCP or other provider
- Providing health education and coaching
- Coordinating with other healthcare providers for diagnostics, ambulatory care, and hospital services
- Assisting with social determinants of health, including access to healthy food and exercise
- Promoting activities focused on the health of the patient and their community, including, without limitation, outreach, quality improvement, and patient panel management
- Coordinating community-based management of medication therapy
- Filing grievances and appeals
- Securing interpretation services when needed
- Reporting any potential fraud issues
- Getting a copy of member materials, including materials in another language or format
- Organizing transportation services
- Facilitate the creation of a PCSP

Care Management

Arkansas Total Care's Care Management program is tailored to members' health needs — from coordinating care to disease management, each of our services helps members get the most out of their benefits. Care Managers work alongside Care Coordinators and are available for clinical consultation to ensure that each enrolled member has an ongoing source of care appropriate to their needs, as well as to ensure continuity of care across all services.

Care Mangers can help members manage conditions or health-related events, including the following:

- Change in condition
- ER visit or hospital admission
- Education of disease processes
- Fall or injury
- New diagnosis or medication
- Need for additional health-related training
- Transition from residential facilities/intermediate care facility into the community
- Complex discharge needs

This list does not include all conditions we help manage through the Care Management Program. If members would like to participate in Arkansas Total Care's Care Management program, they may call the member services department at 1-866-282-6280 (TTY: 711). They may also reach out to their Care Coordinator.

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Claims

The appropriate CMS billing form is required for paper and electronic data interchange (EDI) claim submissions. The CMS billing forms usage guidelines are CMS 1450 for facilities and CMS 1500 for professionals. In general, Arkansas Total Care follows the CMS billing requirements for paper, EDI, and secure web-submitted claims. Arkansas Total Care is required by state and federal regulations to capture specific data regarding services rendered to members. Providers must adhere to all billing requirements to ensure timely processing of claims and avoid unnecessary upfront rejections or denials. Reimbursement policies may be viewed on our website.

Verification Procedures

All claims filed with Arkansas Total Care are subject to verification procedures. These include, but are not limited to, verification of the following information:

- All required fields are completed on an original CMS 1500 Claim Form, CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or claims submitted on our secure provider portal either individually or in a batch.
- All claim submissions are subject to 5010 validation procedures based on CMS industry standards.
- Member ID and date of birth combinations must match a participating Arkansas Total Care member exactly.
- Claims must contain the CLIA number when CLIA-waived or CLIA-certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA-waived or CLIA-certified services are billed. For EDI-submitted claims, the CLIA certification number must be placed in: X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier or X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests).
- Provider Type 95 — Must bill with a Medicaid ID type.
- Provider Type 25 — For residential treatment, TOB 86x is to be billed.
- Taxonomy codes are required. Please see further details in this manual for taxonomy requirements.
- All diagnosis, procedure, modifier, location (place of service), revenue, type of admission, and source of admission codes are valid for:
  - Date of Service
  - Provider type and/or provider specialty billing
  - Age and/or sex for the date of service billed
  - Bill type
- All diagnosis codes are documented to the **highest number of digits** available.
- National Drug Codes (NDC) are billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:
  - F2 — International unit
  - GR — Gram
  - ME — Milligram
  - ML — Milliliter
  - UN — Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-10-CM for the date of service billed.
- For a CMS 1500 Claim Form, the criteria look at all procedure codes billed and the diagnosis they reference. If a procedure points to the diagnosis as primary and that code is not valid as a primary diagnosis code, then that service line will be denied.
- All inpatient facilities are required to submit a Present on Admission (POA) indicator. Claims will be denied or rejected if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:
  - N — No
  - U — Unknown
  - W — Not applicable
  - Y — Yes

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- The member is eligible for services under Arkansas Total Care during the time period in which services were provided.
- Services were provided by a participating provider, or if provided by an out-of-network provider, authorization has been received to provide services to the eligible member. This excludes services by an out-of-network provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services.
- An authorization has been given for services that require prior authorization by Arkansas Total Care.
- Third-party coverage has been clearly identified and appropriate COB information has been included with the claim submission.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service.
- The service provided is a covered benefit under the member's contract on the date of service, and the appropriate prior authorization processes were followed.
- Payment for services is contingent on compliance with referral and prior authorization policies and procedures as well as the billing guidelines outlined in the guide.

Clean Claim Definition

A **clean claim** refers to a claim for payment of healthcare expenses that is submitted on a CMS 1500 or a UB04 claim form, in a format required by HIPAA, with all required fields completed in accordance with Arkansas Total Care's published claim filing requirements.

Non-Clean Claim Definition

A **non-clean** or **unclean claim** is an incomplete claim that could contain invalid or missing data elements, a claim that has been suspended in order to get more information from the provider, or a claim that requires manual intervention/processing.

Upfront Rejections vs. Denials

An **upfront rejection** is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the companion guide located in **Appendix IX** of this manual. A list of common upfront rejections can be located in **Appendix I** of this manual. Upfront rejections will not enter our claims adjudication system, so there will not be an explanation of payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically. If a claim is rejected, the identified issue must be corrected and the claim resubmitted as an original claim.

If all edits pass and the claim is accepted, it will then be entered into the system for processing. A **denial** is defined as a claim that has passed edits and is entered into the system, but that has been billed with invalid or inappropriate information that cause the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found below with explanations in **Appendix II** of this manual.

Timely Filing

Providers must submit all claims and encounters within 365 calendar days of the date of service. When Arkansas Total Care is the secondary payer, claims must be received within 365 calendar days of the primary payer EOP.

- Initial Claims and Claims Dispute/Appeals — Days are calculated from the date of service to the date received by Arkansas Total Care, or from the EOP date. For observation and inpatient stays, the date is calculated from the date of discharge.
- Claims Dispute/Appeals — Days are calculated from the date of the EOP issued by Arkansas Total Care to the date received.
- Coordination of Benefits — Days are calculated from the date of EOP from the primary payers to the date received.

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Who Can File Claims?

All providers who have rendered services for Arkansas Total Care members can file claims. It is important that providers ensure Arkansas Total Care has accurate and complete information on file. Please confirm with the provider services department or your designated provider relations representative that the following information is current in our files:

- Provider name as noted on most current W-9 form
- NPI, if applicable
- Group NPI, if applicable
- TIN
- Taxonomy code; this is a required field when submitting a claim with an NPI
- Physical location address as noted on most current W-9 form
- Billing name and address as noted on most current W-9 form

We recommend that providers notify Arkansas Total Care 30–60 days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end of the year 1099 IRS form will be mailed, a new W-9 form will be required. Changes to a provider's TIN and/or address are **not** acceptable when conveyed via a claim form or a 277 electronic file.

Claims for billable services provided to Arkansas Total Care members must be submitted by the provider who performed the services, or by the provider's authorized billing vendor.

Electronic Claims Submission

Providers are encouraged to participate in Arkansas Total Care's electronic claims filing program through Centene® Corporation. Arkansas Total Care (Centene) has the capability to receive an ANSI XS12N 837 professional, institutional or encounter transaction. In addition, Arkansas Total Care (Centene) has the capability to generate an ANSI X12N 835 electronic remittance advice known as an EOP. For more information on electronic filing, contact:

Arkansas Total Care c/o Centene EDI Department
Phone: 1-800-225-2573 ext. 6075525
Email: EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and EOPs to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Arkansas Total Care has the ability to receive coordination of benefits (COB or secondary) claims electronically. Arkansas Total Care follows the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

Arkansas Total Care's Payer ID is 68069. For a list of the clearinghouses that we currently work with, please visit our website at ArkansasTotalCare.com.

Electronic Visit Verification (EVV)

The 21st Century Cures Act, signed into law in 2016, requires state agencies to implement a system of electronic visit verification (EVV) for personal care services and home healthcare services provided and reimbursed under Medicaid. The EVV mandate is designed to enhance quality and accuracy of care services. On October 22, 2019, CMS approved the Arkansas EVV Good Faith Effort Exemption request. The implementation of the EVV submission became effective for dates of service December 1, 2022, and beyond.

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EVV is uses electronic means to verify provider visits for personal or home healthcare services. The information collected during such visits includes:

- The date of service
- The start time and end times for service provided
- The type of healthcare service performed
- The location of the service provided
- Information about the service provider

EVV offers a modern way for providers to record their visits by location, time, and tasks. Visits can be logged using an app on the caregiver's cell phone, or over the member's landline phone.

Arkansas Total Care works with HHAeXchange to process EVV submissions. To avoid claim denials, any visits for the services above must be submitted through an EVV system. You can submit these visits via HHAeXchange or a chosen third-party EVV system that aggregates with HHAeXchange. Providers must have valid Arkansas Medicaid Provider IDs in order to submit visits.

Providers must send their rosters to Arkansas Total Care in order to correctly configure in the HHAeXchange system. Note that inaccurate or missing provider information may result in delayed payment. Rosters should be emailed to ArkCredentialing@centene.com.

Specific Data Record Requirements

Claims transmitted electronically must contain all of the required data of the X12 5010 Companion Guides. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements.

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to Arkansas Total Care, all EDI claims must first be forwarded to one of Arkansas Total Care's clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and plan-specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is important to review this error report daily to identify any claims that were not transmitted to Arkansas Total Care. The name of this report can vary based on the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Arkansas Total Care, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Arkansas Total Care by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected upfront and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the upfront rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is important to review this report daily. The report shows rejected claims that must be reviewed and corrected in a timely manner. Claims passing eligibility requirements are then passed to the claims processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgments for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Arkansas Total Care. If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

Note: Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to submit the rejected claim as an original claim.

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Invalid Electronic Claim Record Upfront Rejections/Denials

All claim records sent to Arkansas Total Care must pass the clearinghouse proprietary edits and plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as having been received by Arkansas Total Care. In these cases, the claim must be corrected and resubmitted within the required filing deadline, as previously mentioned in the **Timely Filing** section of this manual. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and resubmit claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA support at 1-800-225-2573 ext. 6075525, or via email at EDIBA@centene.com. If you are prompted to leave a voicemail, you will receive a return call within 24 business hours.

Specific Arkansas Total Care Electronic Edit Requirements — 5010 Information

- Institutional Claims — 837Iv5010 edits
- Professional Claims — 837Pv5010 edits

Corrected EDI Claims

- CLM05-3 required 7 or 8.
- IN 2300 Loop/REF segment is F8; Ref 02 must input original claim number assigned.
- Failure to include the original claim number will result in upfront rejection of the adjustment (error code 76).

Exclusions

The following inpatient and outpatient claim times are excluded from EDI submission options and must be filed on paper:

- Claim records requiring supportive documentation or attachments (e.g. consent forms). **Note:** COB claims may be filed electronically.
- Medical records to support billing miscellaneous codes
- Claims for services that are reimbursed based on purchase price (e.g. custom DME, prosthetics). The provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review (e.g. complicated or unusual procedure). The provider is required to submit medical records with the claim.
- Claims for services requiring documentation and a Certificate of Medical Necessity (e.g. oxygen, motorized wheelchairs)

Electronic Billing Inquiries

Please direct any inquiries to the appropriate contact shown below:

Action	Contact
Submitting claims through clearinghouses Arkansas Total Care's Payer ID for all clearinghouses (medical and behavioral health) is **68069**.	Arkansas Total Care uses Availity as our primary clearinghouse, which provides an extensive network of connectivity. You are free to use whichever clearinghouse you currently use, as Availity maintains active connections with a large number of clearinghouses.
General EDI questions	EDI support phone: 1-800-225-2573 ext. 6075525 **or** 1-314-505-6525 EDI support email: EDIBA@centene.com
Claims transmission report questions	Contact your clearinghouse's technical support team.
Claims transmission questions (e.g. Has my claim been received or rejected?)	EDI support phone: 1-800-225-2573 ext. 6075525 EDI support email: EDIBA@centene.com
Remittance advice questions	Contact the Arkansas Total Care provider services department or log in to our secure provider portal at Provider.ArkansasTotalCare.com.
Provider payee, UPIN, tax ID, payment address changes	Notify Arkansas Total Care's provider services department in writing and include an updated W-9 form.

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Important Steps to Successful Submission of EDI Claims

- Select a clearinghouse to use.
- Contact the clearinghouse regarding which data records are required.
- Verify with Arkansas Total Care's provider services department that the provider is set up in the Arkansas Total Care system prior to submitting any EDI claims.
- You will receive two reports from the clearinghouse. Always review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and that are being transmitted to Arkansas Total Care, as well as any claims that do not meet the clearinghouse requirements. The second report will be a claim status report showing claims that have been accepted or rejected by Arkansas Total Care. Always review the acceptance and claims status report for rejected claims. If rejections are noted, correct and resubmit.
- Most importantly, all claims must be submitted with the appropriate coding. See the CMS 1500 (02/12) and CMS 1450 (UB-04) claim form instructions and claim form for details.

Online Claims Submission

For providers who have internet access and choose not to submit claims via EDI or paper, Arkansas Total Care has made it easy and convenient to submit claims directly from the secure provider portal at Provider.ArkansasTotalCare.com.

Providers must request access to the secure portal by registering a username and password. If you have technical support questions, please contact Arkansas Total Care's provider services department.

Once you have access to the secure portal, you may file first-time claims individually or submit first-time batch claims. You will have the ability to find, view, and correct any previously processed claims. Detailed instructions for submitting claims via the secure provider portal are stored in the portal.

Paper Claims Submission

The mailing address for first-time claims (medical and behavioral health), corrected claims, and requests for reconsideration is as follows:

Arkansas Total Care
Attn: Claims
P.O. Box 8020
Farmington, MO 63640-8020

The mailing address for non-claim-related complaints and medical necessity appeals is as follows:

Arkansas Total Care
Attn: Appeals
P.O. Box 25010
Little Rock, AR 72221

The mailing address for medical and behavioral health claims disputes/appeals is as follows:

Arkansas Total Care
P.O. Box 8020
Farmington, MO 63640-8020

Arkansas Total Care encourages all providers to submit claims electronically. The companion guides for electronic billing are available on our website. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are considered invalid and will be rejected. If a paper claim has been rejected, the provider should correct the error and resubmit as an original claim. If the paper claim passes the specific edits and is denied after acceptance, the provider should submit the denial letter with the corrected claim.

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Acceptable Forms

Arkansas Total Care accepts only the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claim forms. Other claim forms will be rejected upfront and returned to the provider.

Professional providers and medical suppliers should complete the CMS 1500 (02/12) claim form. Institutional providers should complete the CMS 1450 (UB-04) claim form. Arkansas Total Care does not supply claim forms to providers. Providers may purchase these from a supplier of their choice. All paper claim forms must be typed with either 10- or 12-point Times New Roman font on the required original red-and-white version to ensure clean acceptance and processing. Black-and-white forms, handwritten forms, and nonstandard forms will be rejected upfront and returned to the provider. To reduce document handling time, do not use highlights, italics, bold text, ink stamps, or staples for multiple-page submissions. If you have questions regarding which type of form to complete, contact Arkansas Total Care's provider services department.

Important Steps to Successful Submission of Paper Claims

- Providers must file claims using standard claim forms (UB-04 for hospitals and facilities; CMS 1500 for physicians or practitioners).
- Complete all required fields on an original, red CMS 1500 (02/12) or CMS 1450 (UB-04) claim form. Non-red, nonstandard, and handwritten claim forms will be rejected upfront and sent back to the provider.
- Ensure all diagnosis codes, procedure codes, modifier, location (place of service), type of bill, type of admission, and source of admission codes are valid for the date of service.
- Ensure all diagnosis and procedure codes are appropriate for the age of the member.
- Ensure all diagnosis codes are coded to the highest number of digits available.
- Ensure the member was eligible for services during the time period in which the services were provided.
- Ensure the provider has received authorization to provide services to the eligible member when appropriate.
- Ensure an authorization has been given for services that require prior authorization by Arkansas Total Care.
- Providers billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form.
- Ensure all paper claim forms are typed or printed with either 10- or 12-point Times New Roman font. Do not use highlights, italics, bold text, ink stamps, or staples for multiple-page submissions.
- Ensure print is properly aligned on the form. Arkansas Total Care utilizes OCR software to convert paper forms to EDI transactions; misaligned information may not process correctly and may result in a rejected claim.

Claims that do not meet the necessary requirements are not considered clean claims and will be returned to providers with a written notice describing the reason for return.

Corrected Claims, Requests for Reconsideration or Claim Disputes

All requests for corrected claims, reconsiderations, or claim disputes must be received within 180 days of the date of the original EOP or denial for contracted providers. Prior processing will be upheld for corrected claims or provider claims requests for reconsideration or disputes/appeals received outside of the 180-day time frame for contracted providers, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance.

Qualifying circumstances include:

- A catastrophic event that substantially interferes with normal business operations of the provider, damage or destruction of the provider's business office or records by a natural disaster, mechanical administrative delays, or errors by Arkansas Total Care or the federal and/or state regulatory body.
- The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
  - The provider's records document that the member refused or was physically unable to provide their Arkansas Total Care ID card or other verifying information.
  - The provider can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered.
  - The provider has not filed a claim for the member prior to the claim under review.

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Relevant Claim Definitions

- **Corrected claim** — A provider is changing the original claim.
- **Request for reconsideration** — A provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
- **Claim dispute** — A provider disagrees with the outcome of the request for reconsideration.

Corrected Claims

Corrected claims must clearly indicate they are corrected using one of the following methods:

- Submit a corrected claim via the secure provider portal. Follow the instructions on the portal for submitting a correction.
- Submit a corrected claim electronically via a clearinghouse.
  - Institutional Claims (UB): Field CLM05-3 = 7 and Ref*8 = Original Claim Number
  - Professional Claims (CMS): Field CLM05-3 = 7 and REF*8 = Original Claim Number
- Submit a corrected paper claim via mail to the following address:

  Arkansas Total Care
  Attn: Corrected Claims
  P.O. Box 8020
  Farmington, MO 63640-8020

  - Upon submission of a corrected paper claim, the original claim number must be typed in Field 22 (CMS 1500) and in Field 64 (UB-04) with the corresponding frequency codes (7 = replacement or corrected; 8 = voided or canceled) in Field 22 of the CMS 1500 and Field 4 of the UB-04 form.
  - Corrected claims must be submitted on standard red-and-white forms. Handwritten, black-and-white, or otherwise nonstandard corrected claims will be rejected upfront.

Requests for Reconsideration

A request for reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. Generally, medical records are not required for a request for reconsideration. However, if the request for reconsideration is related to a code audit, code edit, or authorization denial, and if you received an authorization for the service billed, medical records must accompany the request for reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted using one of the following methods:

- Calling the provider services department
  - This method may be used for requests for reconsideration that do not require submission of supporting or additional information. An example of this would be when a provider may believe a particular service should be reimbursed at a certain rate, but the payment amount did not reflect that rate.
- Using the Request for Reconsideration form found on our website. This is our **preferred method**.
- Sending a written letter that includes a detailed description of the reason for the request
  - To ensure timely processing, the letter must include sufficient identifying information, which includes, at a minimum, the member name, member ID number, date of service, total charges, provider name, original EOP, and/or the original claim number found in Box 22 of the CMS 1500 form or Field 64 of the UB-04 form. The corresponding frequency code should also be included with the original claim number (7 = replacement or corrected; 8 = voided or canceled) in Field 22 of the CMS 1500 and Field 4 of the UB-04 form.
  - A copy of the submitted claim does not need to be attached.

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Written requests for reconsideration and any applicable attachments must be mailed to the following address:

Arkansas Total Care
Attn: Request for Reconsideration
P.O. Box 8020
Farmington, MO 63640-8020

If the request for reconsideration results in an overturn of the original decision, the provider will receive a revised EOP.

Claim Dispute

A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration. If a dispute form is submitted and a reconsideration request is not located in our system, then the dispute will be considered a reconsideration and treated as outlined on the previous page.

A claim dispute must be submitted using the **claim dispute form** located under the Provider Resources tab of ArkansasTotalCare.com. The form must be completed in its entirety. The completed form may be mailed to the following address:

Arkansas Total Care
Attn: Claim Dispute
P.O. Box 8020
Farmington, MO 63640-8020

Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs)

Arkansas Total Care partners with specific vendors to provide an innovative web-based solution for electronic funds transfers (EFTs) and electronic remittance advices (ERAs). This service is provided at no cost to providers and allows online enrollment. Providers are able to enroll after they have received their completed contract or submitted a claim. Please visit our website for information about EFTs and ERAs, or contact the provider services department.

Benefits include:

- Elimination of paper checks — All deposits are transmitted via EFT to the designated bank account.
- Convenient payments and retrieval of remittance information
- Electronic remittance advices presented online
- HIPAA 835 electronic remittance files for download directly to a HIPAA-compliant practice management for patient accounting system
- Reduced accounting expenses — Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- Improved cash flow — Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintained control over bank accounts — Providers keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Quick payment matching to advices — Providers can associate electronic payments with ERAs quickly and easily.
- Management of multiple payers — Reuse enrollment information to connect with multiple payers and assign different payers to different bank accounts as desired.

For more information, please visit our website at ArkansasTotalCare.com. If further assistance is needed, please contact our provider services department at 1-866-282-6280.

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Virtual Credit Card (VCC)

To reduce the environmental impact of our payments and to enhance the provider experience, all payments for Arkansas Total Care claims will be issued via Virtual Credit Card (VCC). The VCC program from Change Healthcare is a widely used payment option in healthcare that we are making available to our provider network. Providers wishing to receive electronic funds transfer (EFT) rather than VCC payments may elect to do so.

Other Payment Options:

- You may opt out of the VCC program at any time by calling 1-800-317-9280 or visiting Echovcards.com/letter. To access this site, you will need your Tax ID and verification access code

Risk Adjustment and Correct Coding

Risk adjustment is a critical element that will help ensure the long-term success of the PASSE. Accurate calculation of risk adjustment requires accuracy and specificity in diagnostic coding. Providers should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-10-CM, CPT®, and HCPCS code sets. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity. Assign the most precise ICD-10 code that fully explains the narrative description in the medical chart of the symptom or diagnosis.
- Ensure medical record documentation meets CMS signature requirements and that it is clear, concise, consistent, complete, and legible. Note that each encounter must stand alone.
- Submit claims and encounter information in a timely manner.
- Alert Arkansas Total Care of any erroneous data submitted and follow Arkansas Total Care's policies to correct those errors promptly.
- Provide medical records as requested.
- Provide ongoing training to staff regarding appropriate use of ICD-10 coding for reporting diagnoses.

Accurate and thorough diagnosis coding is imperative to Arkansas Total Care's ability to manage members, comply with risk adjustment data validation audit requirements, and effectively offer a Medicaid product under the PASSE. Claims submitted with inaccurate or incomplete data may require retrospective chart review.

Coding of Claims/Billing Codes

Arkansas Total Care requires claims to be submitted using codes from the current version of ICD-10-CM, ASA, DRG, CPT, and Level II HCPCS code sets for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code-related reasons that a claim may be rejected or denied:

- The code billed is missing, invalid, or was deleted at the time of service.
- The code is inappropriate for the age of the member.
- The diagnosis code is missing digits.
- The procedure code is pointing to a diagnosis that is not appropriate to be billed as primary.
- The code billed is inappropriate for the location or specialty billed.
- The code billed is part of a more comprehensive code billed on the same date of service.

Note: Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Arkansas Total Care.

Billing from independent provider-based Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) for covered RHC/FQHC services furnished to members should be made with specificity regarding diagnosis codes and procedure code/modifier combinations.

Code all documented conditions that coexist at the time of the encounter or visit, and that require or affect patient care treatment or management. Do not code conditions that were previously treated and/or no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

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For more information regarding billing codes, coding, and code auditing/editing, please contact Arkansas Total Care's provider services department or visit our website at ArkansasTotalCare.com. Clinical and payment policies are located under the Provider Resources tab.

Clinical Laboratory Improvement Amendments (CLIA) Billing Instructions

CLIA numbers are required for CMS 1500 claims where CLIA-certified or CLIA-waived services are billed. If the CLIA number is not present, the claim will be rejected or denied. Below are billing instructions on how and/or where to provide the CLIA certification or waiver number on the following claim submission types:

- **Paper Claims**
  - If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided in Box 23.
  - **Note:** An independent clinical lab that elects to file a paper claim form shall file the CMS 1500 form for a referred lab service (as it would any lab service). The line item services must be submitted with a modifier of 90. An independent clinical lab that submits claims in paper format may not combine non-referred (self-performed) and referred services on the same CMS 1500 claim form. When the referring lab bills for both non-referred and referred tests, it shall submit two separate claims — one claim for non-referred tests and another for referred tests. If billing for services that have been referred to more than one lab, the referring lab shall submit a separate claim for each lab to which services were referred, unless one or more of the reference labs are billing separately. When the referring lab is also the billing lab, the reference lab's name, address, and ZIP code shall be reported on Item 32 of the CMS 1500 claim form to show where the service/test was actually performed. The NPI shall be reported on Item 32a. Additionally, the CLIA certification or waiver number of the reference lab shall be reported on Item 23 of the CMS 1500 form.
- **EDI**
  - If a single claim is submitted for those lab services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in X12N 837 (HIPAA) Loop 2300, REF02. REF01 = X4; **OR**
  - If a claim is submitted with both lab services for which CLIA certification or waiver is required and non-CLIA-covered lab tests, report the CLIA certification or waiver number in X12N 837 (HIPAA) Loop 2400, REF02. REF01 = X4.
  - **Note:** The billing lab submits, on the same claim, tests referred to another (referral/rendered) lab, with modifier 90 reported on the line item, and reports the referral lab CLIA certification or waiver number in X12N 837 (HIPAA) Loop 2400, REF02. REF01 = X4. Please refer to the 5010 implementation guides for the appropriate loops in which to enter the CLIA number. If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided.
- **Web**
  - Complete Box 23 with the CLIA certification or waiver number as the prior authorization number for those lab services for which a CLIA certification or waiver is required.
  - **Note:** An independent clinical lab that elects to file a paper claim form shall file the CMS 1500 form for a referred lab service (as it would any lab service). The line item services must be submitted with a modifier of 90. An independent clinical lab that submits claims in paper format may not combine non-referred (self-performed) and referred services on the same CMS 1500 claim form. When the referring lab bills for both non-referred and referred tests, it shall submit two separate claims — one claim for non-referred tests and another for referred tests. If billing for services that have been referred to more than one lab, the referring lab shall submit a separate claim for each lab to which services were referred, unless one or more of the reference labs are billing separately. When the referring lab is also the billing lab, the reference lab's name, address, and ZIP code shall be reported on Item 32 of the CMS 1500 claim form to show where the service/test was actually performed. The NPI shall be reported on Item 32a. Additionally, the CLIA certification or waiver number of the reference lab shall be reported on Item 23 of the CMS 1500 form.

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Taxonomy Code Billing Requirement

Taxonomy numbers are required for all Arkansas Total Care claims. Claims submitted without taxonomy numbers will be rejected upfront with an EDI reject code of 91. If the claim was submitted on paper, a rejection letter will be returned indicating that the taxonomy code was missing.

The verbiage associated with reject code 91 is as follows: **Invalid** or **Missing Taxonomy Code**. Please contact the provider services department to resolve this issue. Below are three scenarios involving the taxonomy code billing requirement.

Scenario One: Rendering NPI is different from billing NPI
CMS 1500 form

Required Data	Paper CMS 1500 Form	Electronic Submission	
		Loop ID	Segment/Data Element
Rendering NPI	**Unshaded** portion of Box 24J	2310B	NM109
		2420A	NM109
Taxonomy qualifier ZZ	**Shaded** portion of Box 24I	2310B	PRV02 REF01
		2420A	PRV02 REF01
Rendering provider taxonomy number	**Shaded** portion of Box 24J	2310B	PRV03 REF02
		2420A	PRV03 REF02
Group ID	Box 33a	2010AA	NM109
Billing provider group taxonomy using qualifier ZZ (2000a PROV02 = qualifier PXC), e.g. Box 33b ZZ208D00000X EDI PRV*PE*PXC*208D00000X Billing provider group FTIN (EI)/SSN (SY)	Box 33b	2000A	PRV03
		2010A	REF01 REF02

Scenario Two: Rendering NPI and billing NPI are the same
CMS 1500 form

It is not necessary to submit the rendering NPI and rendering taxonomy in this scenario; however, if Box 24I and 24J are populated, then all data must be populated.

Required Data	Paper CMS 1500 Form	Electronic Submission	
Applicable NPI	Box 33a	2010AA	NM109
Applicable taxonomy using qualifier ZZ (2000A PROV02 = qualifier PXC)	Box 33b	2000A	PRV03
Billing provider group FTIN (EI)/SSN (SY), e.g. REF*EI*999999999		2010A	REF01 REF02

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Scenario Three: Taxonomy requirement for UB 04 forms

Required Data	Paper UB 04	Electronic Submission
Taxonomy code with B3 qualifier	Box 81CC	Billing level 2000A Loop and PRVR segment

Inpatient Psychiatric Claims

When billing inpatient psychiatric services, complete Field Locator 6 with a date span. On the service line, enter revenue code, initial start date, and total days.

Claim Reconsiderations Related to Code Editing

Claims reconsiderations resulting from claim editing are handled per the provider claims dispute process outlined in this manual. When submitting reconsiderations, please submit medical records, invoices, and all related information to assist with the appeals review.

If you disagree with a code or other edit and request claims reconsideration, you must submit medical documentation (the medical record) related to the reconsideration. If medical documentation is not received, the original code or other edit will be upheld.

Billing Instructions: Intermediate Care Facilities (ICF)/Individuals with Intellectual Disabilities (IID)

Type of Bill (TOB): Required — Enter the appropriate three-digit code as follows:

- First digit — Type of Facility
  - 6 = Intermediate Care (LOC = ICF/MR)
- Second digit — Classification
  - 5 = Intermediate care level I
  - 6 = Intermediate care level II
  - 7 = Intermediate care level III
- Third digit — Frequency
  - 1 = Admit through discharge claim
  - 2 = Interim — First claim
  - 3 = Interim — Continuing claim
  - 4 = Interim — Final claim
  - 7 = Adjustment/replacement of prior claim
  - 8 = Void/cancellation of a prior claim

Note: 61X is no longer a recognized TOB for ICF/IID.

Revenue Code: Required — Enter the applicable revenue code(s) identifying the service provided. Bill a Level of Care (LOC) revenue code only once a month, unless the LOC changes during the month. Use the following revenue codes and descriptions:

- 183 = LOA home — Traditional-style bed or ICF/IID
- 184 = LOA home — Home-style facility
- 191 = Intermediate I — Traditional-style bed
- 192 = Intermediate II — Traditional-style bed
- 193 = Intermediate III — Traditional-style bed
- 194 = ICF/IID

NPI — The 10-digit NPI must be entered.

Attending Provider: Required — The attending provider name and the NPI cannot be the billing provider. The individual attending provider information must be entered in this field. The attending provider must be enrolled with Arkansas Medicaid.

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Code Editing

Arkansas Total Care uses HIPAA-compliant code auditing software to improve accuracy and efficiency in claims reporting, processing, and payment. The software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier, and place of service codes against correct coding guidelines.

While code auditing software is a useful tool to ensure provider compliance with correct coding, it will not wholly evaluate all clinical patient scenarios. Consequently, Arkansas Total Care uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted.

Arkansas Total Care may have policies that differ from correct coding principles. Additionally, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

Arkansas Total Care may request medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with current coding guidelines.

CPT® and HCPCS Coding Structure

The Healthcare Common Procedure Coding System (HCPCS) is a set of healthcare procedure codes based on the American Medical Association's (AMA) Current Procedural Terminology (CPT). The system was designed to standardize coding to ensure accurate claims payment, and it consists of two levels of standardized coding.

Level I HCPCS Codes (CPT): This code set is published and maintained by the AMA. CPT codes are a five-digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are updated (added, revised, and/or deleted) on an annual basis.

Level II HCPCS Codes: The Level II HCPCS code set is used to describe supplies, products, and services that are not included in the CPT code descriptions (durable medical equipment, orthotics and prosthetics, etc.). The Level II set is an alphanumeric coding system that is maintained by CMS. These codes are updated on an annual basis.

Miscellaneous/Unlisted Codes: These codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous or unlisted codes are subject to a manual review. If the records are not received, the provider will receive a denial indicating that medical records are required. The medical documentation should clearly define the procedure performed, including but not limited to office notes, operative reports, pathology reports, and related pricing information. Once received, a registered nurse (RN) will review the medical records to determine if there are more specific codes to accurately describe the service or procedure rendered. Clinical validation also includes identifying and reviewing other procedures and services billed on the claim that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

Temporary National Codes: These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may be used only until a permanent code is established. These codes consist of G, Q, K, S, H, and T code ranges.

HCPCS Code Modifiers: Modifiers are used to indicate additional information about the HCPCS or CPT codes billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10)

ICD-10 is an alphanumeric system used by providers to classify diagnoses and symptoms. These codes consist of three to seven digits, allowing for a high level of specificity in coding a range of health problems.

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Revenue Codes

These four-digit numeric codes are used by institutional providers to represent services, procedures, and/or supplies provided in a hospital or facility setting. Corresponding HCPCS procedure codes may be required on the claim in addition to the revenue code.

Edit Sources

The claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, current research, and more.

The following sources are used when determining correct coding guidelines for the software:

- CMS (including National Correct Coding Initiative (NCCI) and claims processing manual guidelines, current PTP and MUE tables, and HCPCS manual)
- American Medical Association (CPT and ICD-10 publications)
- Public domain specialty provider associations (American College of Surgeons, American Academy of Orthopedic Surgeons, American College of Obstetricians and Gynecologists, etc.)
- State provider manuals, fee schedules, periodic provider updates (bulletins/transmittals)
- CMS coding resources such as National Physician Fee Schedule, Provider Benefit Manual, MLN Matters, and Provider Transmittals
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario
- Health plan policies and provider contract considerations

In addition to nationally recognized coding guidelines, the software has flexibility to allow business rules that are unique to the needs of individual product lines.

Code Editing and the Claims Adjudication Cycle

Code editing is the final step in the claims adjudication process. Once a claim has completed all previous adjudication steps, such as benefits and member/provider eligibility review, the claim is ready for analysis.

As a claim progresses through the code-editing cycle, each service line on the claim is processed through the code-editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Depending on the code edit applied, the software will make the following recommendations:

- **Deny:** Code editing recommends denial of a claim line. The appropriate explanation code is documented on the provider's EOP along with reconsideration/appeal instructions.
- **Pend:** Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The decision is documented on the provider's EOP along with reconsideration/appeal instructions.
- **Replace and pay:** Code editing recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing, as the original billing remains on the claim.

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Code Editing Principles

The below principles do not represent an all-inclusive list of code-editing principles, but rather an area sampling of edits that are applied to physician and/or outpatient facility claims.

Unbundling Edits

- **Procedure-to-Procedure (PTP) Practitioner and Hospital Edits**
  - CMS has designated certain combinations of codes that usually are not separately reimbursable on the same date of service. These are known as PTP or column I/column II edits. Within the PTP edit category, there are practitioner edits (applicable to claims submitted by physicians, non-physician practitioners, and ambulatory surgical centers), and hospital edits (applicable to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy, speech-language pathology, and comprehensive outpatient rehabilitation facilities).
  - The procedure code listed in column I is the most comprehensive code; reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component to the successful outcome of the column I code.
- **Medically Unlikely Edits (MUE) for Practitioners, DME Providers, and Facilities**
  - An MUE is the maximum units of service that a provider would report under most circumstances for a single member on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, nature of the service/procedure, nature of the analyte, equipment-prescribing information, and clinical judgment. Not all HCPCS/CPT codes have an MUE.
- **Code Bundling Rules Not Sourced to CMS**
  - Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are designed specifically for professional and outpatient facility claims editing.
- **Procedure Code Unbundling**
  - Two or more procedure codes are used to report a service when a single, more comprehensive one should have been used. The less comprehensive code will be denied.
- **Mutually Exclusive Editing**
  - These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.
- **Incidental Procedures**
  - These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.
- **Global Surgical Period Editing/Medical Visit Editing**
  - CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. Global surgery data are taken from the CMS Medicare Fee Schedule Database (MFSDB).
  - Procedures are assigned a zero-, 10-, or 90-day global surgical period. Procedures assigned a 90-day global surgical period are designated as major procedures. Procedures assigned a zero- or 10- day global surgical period are designated as minor procedures.
  - Evaluation and management services for a major procedure (90-day period) that are reported one-day preoperatively, on the same date of service, or during the 90-day post-operative period are not recommended for separate reimbursement.
  - Evaluation and management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.
  - Evaluation and management services for established patients that are reported with surgical procedures that have a zero-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

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- **Diagnostic Services Bundled to the Inpatient Admission (Three-Day Payment Window)**
  - This rule identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered to be bundled into the inpatient admission and are not separately reimbursable.
- **Multiple Code Rebundling**
  - This rule analyzes instances in which a provider billed two or more procedure codes when a single, more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. Some codes are allowed a limited number of times on a single date of service, over a given period of time, or during a member's lifetime.

State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member's lifetime. A frequency edit is applied by code-editing software when the procedure code is billed in excess of these guidelines.

Duplicate Edits

The code-editing software evaluates prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate of the prospective claim. The software also looks across different providers to determine if another provider was paid for the same procedure, for the same member, on the same date of service. Additionally, the software analyzes multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician may bill for office visits for the same member on the same date of service.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services, or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

This rule identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

This rule evaluates claims billed with an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

This evaluates claims billed with a co-surgeon or team surgeon that normally do not require a co-surgeon/team surgeon. CMS guidelines define whether an assistant, co-surgeon, or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co-surgeon, or team surgeon.

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Add-On and Base Code Edits

These edits analyze claims in which an add-on CPT code was billed without the primary service CPT code. Add-on codes are denied if the primary service code was denied. This rule also looks for circumstances in which the primary code was billed in a quantity greater than one, when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

This rule looks for claims in which modifier -50 has been billed, but the same procedure code is submitted on a different service line on the same date of service without modifier -50. This rule is highly customized, as many health plans allow this type of billing.

Replacement Edits

These edits recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, if a provider bills more than one outpatient consultation code for the same member in the member's history, this rule will deny the office consultation code and replace it with the appropriate evaluation and management service, established patient, or subsequent hospital care code. Another example of the rule's function is when a provider has billed a new patient evaluation and management code within three years of a previous new patient visit. This rule will replace the second submission with the appropriate established patient visit. A crosswalk is used to determine the appropriate code to add.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician.

Inpatient Facility Claim Editing

- **Potentially Preventable Readmissions Edit**
  - This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities, such as skilled nursing facilities, are not considered readmissions and therefore are not considered for reimbursement. CMS determines the readmission time interval as 30 days.

Viewing Claims Coding Edits — Code Editing Assistant

The **Code Editing Assistant** is a web-based code-editing reference tool designed to mirror how code-editing products evaluate codes and code combinations. The tool is available for providers who are registered on the secure provider portal. You can access the tool in the Claims Module by selecting **Claim Editing Tool** from the portal's menu.

This tool offers many benefits, including the ability to:

- **Prospectively** access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted; and
- **Proactively** determine the appropriate code or code combination representing the service to ensure accurate billing.

The Code Editing Assistant reviews the codes entered to determine if the code or code combinations are correct based on the age, location, modifier (if applicable), or other code(s) entered.

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The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information that may be used to determine if an edit is appropriate.

The Code Editing Assistant can be accessed from Arkansas Total Care's secure provider portal available at Provider.ArkansasTotalCare.com.

Disclaimer: This tool is used to apply coding logic only. It will not take into account individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of the Code Editing Assistant tool.

Claim Reconsiderations Related to Claim Editing

Claim reconsiderations resulting from claim editing are handled per the provider claims dispute process outlined in this manual. When submitting claim reconsiderations, please submit medical records, invoices, and all related information to assist with the review. If you disagree with a code edit and request claim reconsideration, you must submit documentation (medical records) related to the reconsideration. If medical documentation is not received, the original code edit will be upheld.

The reconsideration may include the following information:

- Statement detailing why the service is medically necessary
- Medical evidence that supports the proposed treatment
- Documentation explaining how the proposed treatment will prevent illness or disability
- Documentation explaining how the proposed treatment will alleviate physical, mental, or developmental effects of the patient's illness
- Documentation explaining how the proposed treatment will help the patient maintain functional capacity
- A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary
- Documentation showing how the recommended service has been successful in other patients

Third-Party Liability

Third-party liability (TPL) refers to any other health insurance plan, carrier (such as individual, group, employer-related, self-insured or self-funded, Medicare or commercial carrier, automobile insurance, and worker's compensation), or program that is or may be liable to pay all or part of the healthcare expenses of the member.

If TPL coverage is determined after services are rendered, Arkansas Total Care will coordinate with the provider to pay any claims that may have been denied for payment due to TPL.

Subrogation (Car accidents, worker's compensation, etc.) contact information: Rawlings: 888-285-1276

Billing the Member

Covered Services

Charges that Are NOT the Responsibility of the Member

A member is not liable for the following charges:

- A claim or portion of a claim denied for lack of medical necessity
- Charges in excess of the contracted allowable rate
- A claim or portion of a claim denied due to provider error
- A claim or portion of a claim denied because of errors made by Arkansas Total Care
- A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed
- A claim or portion of a claim denied because a provider failed to obtain prior, concurrent, or retroactive authorization for a service

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Note: Arkansas Total Care pays the difference, if any, between the Arkansas Total Care maximum allowable fee and the total of all payments previously received by the provider for the same service when the primary payer is commercial. Arkansas Total Care members are not responsible for deductibles, copayments, or coinsurance amounts to the extent that such payments, when added to the amounts paid by third parties, equal or exceed the Medicaid maximum for that service, even if the Arkansas Total Care payment is zero.

Arkansas Total Care pays the member cost share when coordinating with Medicare. Arkansas Total Care will not make any payment if the amount received from the third-party insurance is equal to or greater than the Arkansas Total Care allowable rate.

Charges that ARE the Responsibility of the Member

A member is responsible for:

- Charges incurred during a time of ineligibility
- Charges for non-covered services, including services received in excess of Arkansas Total Care benefit limitations, if the member has chosen to receive and agreed to pay for those non-covered services
- Charges for services that the member has chosen to receive and agreed to pay for as a private-pay patient

Note: Arkansas Total Care pays the difference between the amount paid by private insurance and the Medicaid maximum allowable amount. Medicaid will not make any payment if the amount received from the third-party insurance is equal to or greater than the Medicaid allowable rate.

Non-Covered Services

Contracted providers may bill Arkansas Total Care members for non-covered services only if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the rendering of service. The agreement must be specific to the services being rendered and clearly document the following:

- The specific service(s) to be provided
- A statement that the service is not covered by Arkansas Total Care
- A statement that the member chooses to receive and pay for the specific service

Note: The member is not obligated to pay for the service if it is later found that service was covered by Arkansas Total Care at the time it was provided, even if Arkansas Total Care did not pay the provider for the service because the provider did not comply with Arkansas Total Care requirements.

Member Rights and Responsibilities

Members are informed of their rights and responsibilities. Arkansas Total Care network providers are expected to respect and honor members' rights. Arkansas Total Care and participating providers are prohibited from treating a member adversely for exercising his or her rights. Copies of policies and procedures regarding Member Rights and Responsibilities can be requested through ArkansasTotalCare.com.

Arkansas Total Care members have the right to:

- Receive information in accordance with § 438.10, which includes, but is not limited to:
  - An oral interpretation in all languages and written translation available in each prevalent non-English language, including written materials with taglines in the top non-English languages in Arkansas
  - Large print availability of written translations or oral interpretations to understand the information provided to them
  - Written materials that are critical to obtaining services, appeal, and grievance notices, and denial and termination notices, available in the top non-English languages in Arkansas
  - Written materials available in alternative formats upon request and at no cost
  - Auxiliary aids and services available upon request and at no cost
  - Written materials, including taglines, in the top non-English languages in Arkansas, as well as large print, no smaller than 18-point font, of written translations or oral interpretations
  - Interpretation services available, free of charge, including oral interpretation and the use of auxiliary aids such as TTY and American Sign Language (ASL)

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- Choose a participating provider for any service the member is eligible and authorized to receive under their PCSP, including a PCP.
- Execute an advance directive without discrimination in provision of care or otherwise.
- Live in an integrated and supported setting in the community and have control over aspects of their lives.
- Understand their PCSP and receive the services contained within it for which there is an authorization.
- Be protected in the community.
- Be treated with respect and with due consideration for their dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Participate in decisions regarding their healthcare, including the right to refuse treatment.
- Obtain needed, available, and accessible healthcare services covered under the PASSE.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation as specified in other federal regulations on the use of restraints and seclusion.
- Request and receive a copy of their medical records, and to request that medical records be amended or corrected.
- Exercise their rights without adverse treatment from Arkansas Total Care.
- Be provided written notice of a change in their care coordination provider within seven business days.
- Receive a member handbook and referral network directory within a reasonable amount of time following attribution.
- Request any of the following information about Arkansas Total Care at no cost:
  - How Arkansas Total Care works.
  - Arkansas Total Care's quality scores and performance measures as tracked by DHS or CMS.
  - Arkansas Total Care's non-discrimination policies and those responsible for overseeing said policies. Members can also request a record of accessibility and discrimination claims made against Arkansas Total Care.
  - A list of any counseling or referral services not provided by Arkansas Total Care because of moral or religious. objections, as well as information on how members may obtain that information

Arkansas Total Care members have the responsibility to:

- Be familiar with Arkansas Total Care procedures to the best of their ability.
- Contact Arkansas Total Care to get information and have questions answered.
- Give providers accurate and complete medical information.
- Follow care prescribed by providers, or to let providers know why treatment cannot be followed, as soon as possible.
- Keep appointments and follow-up appointments.
- Access preventive care services.
- Live healthy lifestyles and avoid behaviors known to be harmful.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the best of their ability.
- Provide Arkansas Total Care and all their healthcare and supporting providers with accurate and complete information needed for care.
- Make their PCP aware of all other providers who are treating them to ensure communication and coordination in care. This includes behavioral health providers.
- Ask questions of providers to learn the risks, benefits, and costs of treatment options so that they can consider all factors before making care decisions.
- Follow Arkansas Total Care's grievance process if the member has a disagreement with a provider.
- Choose a PCP from Arkansas Total Care's network.
- Treat providers and staff with dignity and respect.
- Participate in the creation of a PCSP.

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Provider Rights and Responsibilities

Providers have the right to:

- Be treated by Arkansas Total Care members and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical histories for members' care.
- Have members act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other office running smoothly.
- Expect other network providers to act as partners in members' treatment plans.
- Expect members to follow their healthcare instructions and directions, such as taking the right amount of medication at the right times.
- Make a complaint or file an appeal against Arkansas Total Care and/or a member.
- Have access to information about Arkansas Total Care quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
- Contact the provider services department with any questions, comments, or problems.
- Collaborate with other healthcare professionals who are involved in the care of Arkansas Total Care members.
- Not be excluded, penalized, or terminated from participating with Arkansas Total Care for having developed or accumulated a substantial number of patients in Arkansas Total Care with high-cost medical conditions.

Providers have the responsibility to:

- Help or advocate for members to make decisions within their scope of practice about relevant and/or medically necessary care and treatment, including the responsibility to:
  - Recommend new or experimental treatments.
  - Provide information regarding the nature of treatment options.
  - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered.
  - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment, as well as the benefits of such treatment options.
- Treat members with fairness, dignity, and respect.
- Not discriminate against members on the basis of race; color; gender; national origin; limited language proficiency; religion; age; health status; the existence of a pre-existing mental or physical disability/condition, including pregnancy and/or hospitalization; and the expectation for frequent or high-cost care.
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding that confidentiality.
- Give members a notice that clearly explains their privacy rights and responsibilities as they relate to the provider's practice and scope of service.
- Provide members with an account of the use and disclosure of their personal health information in accordance with HIPAA regulations.
- Allow members to request restriction on the use and disclosure of their personal health information.
- Allow members to request amendments to their personal health information or record and respond to the request as outlined in 46 CFR 164.526
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
- Provide clear and complete information to members — in a language they can understand — about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process.
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that, by refusing or stopping treatment, the condition may worsen or be fatal.

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- Respect members' advance directives and include these documents in their medical records.
- Allow members to appoint a parent or guardian, family member, or other representative if they cannot fully participate in their treatment decisions.
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
- Follow all state and federal laws and regulations related to patient care and rights.
- Participate in Arkansas Total Care data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of provider performance data.
- Review clinical practice guidelines distributed by Arkansas Total Care.
- Comply with the Arkansas Total Care medical management program.
- Disclose overpayments or improper payments to Arkansas Total Care in writing, explain the reason for the overpayment, and return the overpayment to ARTC within 60 calendar days from the date of overpayment.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Obtain and report to Arkansas Total Care information regarding other insurance coverage the member has or may have.
- Give Arkansas Total Care timely, written notice if the provider is leaving or closing a practice.
- Contact Arkansas Total Care to verify member eligibility and benefits, if appropriate.
- Invite member participation in understanding any medical or behavioral health problems that the member may have and develop mutually agreed upon treatment goals when possible.
- Provide members with information regarding office location, hours of operation, accessibility, and translation services.
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
- Provide hours of operation to Arkansas Total Care members that are no less than those offered to other patients.
- Collaborate with Arkansas Total Care's Care Coordination team, including participant's in the PCSP development process.
- Participate in Timely Access and Wait Time audits conducted by ARTC and DHS or their delegates

Cultural Competency

Arkansas Total Care views cultural competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community, as well as within an organization and at all service levels the organization engages in. A sincere and successful cultural competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of healthcare delivery, cultural competency is the promotion of sensitivity to the needs of patients who are members of various racial, religious, age, gender, and/or ethnic groups, and accommodating their culturally based attitudes, beliefs, and needs within the framework of access to healthcare services and the development of diagnostic and treatment plans and communication methods to support the delivery of competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Arkansas Total Care is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, thereby reducing effectiveness of the entire healthcare process.

Failure to use culturally and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Treatment non-compliance
- Feelings of being uncared for, looked down on, or devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Misdiagnosis due to lack of information sharing
- Wasted time
- Increased complaints

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The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Arkansas Total Care is committed to helping you reach this goal. Take into consideration the following as you provide care to Arkansas Total Care members:

- What are your own cultural values and identity?
- How can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- Do you embrace differences as allies in your patients' healing process?

The U.S Department of Health and Human Services (HHS) Office of Minority Health has published a suite of online educational programs to advance health equity at every point of contact through the development and promotion of culturally and linguistically appropriate services. Visit ThinkCulturalHealth.HHS.gov to access these free online resources. As part of Arkansas Total Care's cultural competency program, we require our employees and in-network providers to ensure the following:

- Members understand that they have access to medical interpreters, signers, and TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of a member's primary language, race, and/or ethnicity as it relates to the member's health or illness.
- Providers and their office staff routinely interacting with members have been given the opportunity to participate in, and have participated in, cultural competency training and development offered by Arkansas Total Care.
- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual preference, and other characteristics that may influence the member's perspective on healthcare.
- Provider office sites have materials posted and printed in English and Spanish and made available in other languages upon request.

Providers should establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act, including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public facility, or be subjected to discrimination by any such facility.

Mainstreaming

Arkansas Total Care considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disabilities, except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered service or availability of a facility
- Providing a member a covered service that is different, in a different manner, at a different time, or at a different location, from other public- or private-pay members (e.g. separate waiting rooms or delayed appointment times)

Americans with Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a provider's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with disabilities from the following:

- Exclusion from participation in the benefits of services, programs, or activities of a public entity
- Denial of the benefits of services, programs, or activities of a public entity
- Discrimination by any such entity

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Providers should ensure that their offices are as accessible as possible to people with disabilities.

Providers are required to comply with ADA accessibility guidelines. Arkansas Total Care must inspect the office of any provider who provides services on site and who seeks to participate in the provider network to determine whether the office is architecturally accessible to people with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the provider, if different from the building entrance.

If the office or facility is not accessible under the above terms, the provider may participate in the provider network only if the provider 1) requests and is determined by Arkansas Total Care to qualify for an exemption from the above, consistent with the requirements of the ADA, or 2) agrees, in writing, to remove the barrier to make the office or facility accessible to people with mobility impairments within 180 days of Arkansas Total Care identifying the barrier.

Providers should also make efforts to provide appropriate accommodations, such as large print materials and easily accessible doorways. Arkansas Total Care offers sign language and telephonic interpreter services at no cost to the provider or member. Call your provider relations representative at 1-866-282-6280 for more information.

Reporting Suspected Abuse and Neglect

All Arkansas Total Care providers and their employees and administrators of a facility are mandatory reporters of suspected physical and/or sexual abuse and neglect of Arkansas Total Care members. This requirement is further detailed under the Arkansas Child Maltreatment Act and Arkansas Adult Maltreatment Act. These laws have been established to detect, prevent, reduce, and eliminate abuse, neglect, exploitation, and abandonment of children and adults in need, including Arkansas Total Care members. If you suspect elder abuse or the abuse of an adult with a disability, call Adult Protective Services at 1-800-490-8505. If you suspect child abuse, call Child Protective Services at 1-800-482-5964.

Abuse is defined as one or more of the following acts:

- The infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish
- The willful deprivation by a caretaker of goods or services necessary to maintain physical or mental health
- Sexual harassment, rape, or abuse

Sexual abuse is defined as intentionally, knowingly, or recklessly causing or attempting to cause the rape of, involuntary sexual intercourse with, sexual assault of, statutory sexual assault of, aggravated indecent assault of, indecent assault of, or incest with a member.

Neglect is the failure to provide for oneself or the failure of a caretaker to provide goods or services essential to avoid a clear and serious threat to a member's physical or mental health.

Common signs of abuse include:

- Bruises or broken bones
- Weight loss
- Memory loss
- Personality changes
- Social isolation
- Changes in banking habits
- The giving away of assets such as money or property

Advance Directives

The Patient Self-Determination Act of 1990 requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members written information about their right to have an Advance Directive. An Advance Directive is a legal document through which a member may provide directions or express preferences concerning their medical care and/or

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appoint someone to act on their behalf. Members can use Advance Directives when they are unable to make or communicate decisions about their medical treatment. Advance Directives are prepared before any condition or circumstance occurs that causes the member to be unable to actively make a decision about their medical care.

In Arkansas, there are two types of Advance Directives:

- Living will or healthcare instructions
- Appointment of a healthcare power of attorney

Arkansas Total Care is committed to ensuring that members are aware of and able to avail themselves of their rights to execute Advance Directives. Arkansas Total Care is equally committed to ensuring that our providers and staff are aware of, and comply with, their responsibilities under federal and state law regarding Advance Directives.

Arkansas Total Care service coordinators and care management staff will provide and/or ensure that network practitioners are providing written information to all adult members receiving medical care with respect to their rights under state law — whether statutory or recognized by the courts of the state — to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. Advance Directives are addressed by the treating physician with the member during an office visit. Neither Arkansas Total Care nor providers will condition the authorization or provision of care or otherwise discriminate against a member based on whether the member has executed an Advance Directive. Arkansas Total Care will facilitate communications between a member or member's representative and the member's provider if/when the need is identified to ensure that they are involved in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment.

Complaint Process

Provider Complaint Process

Provider complaints and appeals must follow the process outlined below. Please note that medical necessity and authorization denials are handled in the appeals process outlined in the section titled **Member Complaint and Appeal Process**. Claim payments are not appealable. Claim complaints must be handled via the claim dispute and complaint process.

The mailing address for medical and behavioral health claim disputes is as follows:

Arkansas Total Care
P.O. Box 8020
Farmington, MO 63640-8020

The mailing address for non-claim related complaints and medical necessity appeals is as follows:

Arkansas Total Care
Attn: Appeals
P.O. Box 25010
Little Rock, AR 72221

The grievance and appeals department reviews the following:

- Appeals related to authorization denials

Complaints

A complaint is a verbal or written expression by a provider that indicates dissatisfaction or dispute with Arkansas Total Care's policies, procedures, or any other aspect of Arkansas Total Care's functions. If the complaint is related to claims payment, the provider must follow the process for claim reconsideration or claim dispute as noted in the Claims section of this manual prior to filing a complaint. Provider complaints made directly to Arkansas Total Care that cannot be resolved immediately will be sent to the Grievances and Appeals team for resolution. Provider complaints received by fax or mail will be followed up the following business day after receipt.

Authorization and Coverage Appeals*

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Authorization and coverage appeals must follow the appeal process below.

An appeal is the mechanism that allows providers the right to appeal actions of Arkansas Total Care, such as a prior authorization denial. A provider has 30 calendar days from Arkansas Total Care's notice of action to file an appeal. Arkansas Total Care shall acknowledge receipt of each appeal within five business days of receiving it. Arkansas Total Care shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Arkansas Total Care receives the appeal. Arkansas Total Care may extend the time frame for resolution of the appeal up to 14 calendar days if the appellant requests the extension, or if Arkansas Total Care demonstrates that there is need for additional information and that the delay is in the member's best interest. For any extension not requested by the member, Arkansas Total Care shall provide written notice to the member for the delay.

Expedited appeals may be filed with Arkansas Total Care if the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider who requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the time frame for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal. Arkansas Total Care may extend this time frame by up to an additional 14 calendar days if the member requests the extension, or if Arkansas Total Care provides satisfactory evidence that a delay in rendering the decision is in the member's best interest.

Providers may also invoke any remedies as determined in the Participating Provider Agreement.

* Per 42 CFR §438.400(b), the procedure by which certain individuals ("Appellants") may request a review by the PASSE of an adverse benefit determination. The procedure by which certain individuals (known as "appellants") may challenge an adverse benefit determination Decision/Adverse Action by requesting PASSE review of the action.

Member Grievance and Appeal Process

To ensure Arkansas Total Care members' rights are protected, all Arkansas Total Care members are entitled to a complaint/grievance and appeal process. The procedures for filing a complaint/grievance or appeal are outlined in the Arkansas Total Care member handbook. Additionally, information regarding the complaint/grievance and appeal process can be found on our website or by calling Arkansas Total Care at 1-866-282-6280.

If a member is displeased with any aspect of services rendered, they should contact our member services department at 1-866-282-6280. A representative will assist them.

If the member continues to be dissatisfied, they may file a formal complaint/grievance. Our member services department is available to assist with this process. Information regarding this process is available at ArkansasTotalCare.com.

- A member may designate in writing to Arkansas Total Care that an authorized representative is acting on their behalf regarding the complaint/grievance and appeal process.
- If an appeal results in an adverse determination, the grievances and appeals department must notify the appellant that a request for a fair hearing must be filed with the appropriate office within 30 calendar days of receipt of resolution of the appeal.
- Site reviews are performed at provider offices and facilities when the member complaint threshold is met. A site review evaluates the following:
  - Physical accessibility
  - Physical appearance
  - Adequacy of waiting and examining room space
  - Adequacy of medical/treatment record keeping

The mailing address for non-claim related complaints/grievances and medical necessity appeals is as follows:

Arkansas Total Care
Attn: Grievances and Appeals
P.O. Box 25010
Little Rock, AR 72221

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Members have the right to request to continue their benefits during an appeal or fair hearing if:

- The request is timely in accordance with 42 CFR 438.420.
- The appeal involves the termination, suspension, or reduction of previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not yet expired and the member or legal representative files for continuation in accordance with Arkansas Total Care policy.

Members may include a request to continue benefits in their appeal and fax it to 866-811-3255. If the final resolution of the appeal or hearing is adverse to the appellant, Arkansas Total Care may recover the cost of the continuation of benefits furnished during the appeal or fair hearing.

Provider Appeal Rights

Refer to Section 160.00 of the **Arkansas Medicaid Provider Manual**.

Provider Due Process

190.001 **Medicaid Fairness Act** **12-15-11**

The Medicaid Fairness Act, Ark. Code Ann. §§ 20-77-1701 – 20-77-1716, requires that the Department of Human Services and its outside contractors treat providers with fairness and due process.

190.002 **Definitions** **9-15-09**

A. Adverse decision/adverse action: Any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or member in regard to receipt of and payment for Medicaid claims, and services including but not limited to decisions as to:
- Appropriate level of care or coding
- Medical necessity
- Prior authorization
- Concurrent reviews
- Retrospective reviews
- Least restrictive setting
- Desk audits
- Field audits and on-site audits
- Inspections

B. Appeal: An appeal under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218

C. Claim: A request for payment of services

D. Concurrent review or concurrent authorization: A review to determine whether a specified member currently receiving specific services may continue to receive services

E. Denial: A denial or partial denial of a claim or authorization of services

F. Department:
- The Arkansas Department of Human Services
- All of the divisions and programs of the Arkansas Department of Human Services, including the state Medicaid Program
- All of the Arkansas Department of Human Services' contractors, fiscal agents, and other designees and agents

G. Medicaid: The medical assistance program under Title XIX of the Social Security Act that is operated by the Arkansas Department of Human Services and its contractors, fiscal agents, and all other designees and agents

H. Person: Any individual, company, firm, organization, association, corporation, or other legal entity

I. Primary care physician: A physician whom the department has designated as responsible for the referral or management, or both, of a Medicaid member's healthcare

J. Prior authorization: The approval by the state Medicaid program for specified services for a specified Medicaid member before the requested services may be performed and before payment will be made by the state Medicaid program

K. Provider: A person enrolled to provide health or medical care services or goods authorized under the state Medicaid program

L. Recoupment: Any action or attempt by the Department of Human Services to recover or collect Medicaid payments already made to a provider with respect to a claim by:

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- Reducing, withholding, or affecting in any other manner current or future payments to a provider, **OR**
- Demanding payment back from a provider for a claim already paid

M. Retrospective review: The review of services or practice patterns after payment, including, but not limited to:

- Utilization reviews
- Medical necessity reviews
- Professional reviews
- Field audits and on-site audits
- Desk audits

N. Reviewer: Any person, including reviewers, auditors, inspectors, surveyors, and others who, in reviewing a provider or a provider's provision of services and goods, perform review actions, including, but not limited to:

- Reviews for quality
- Reviews for quantity
- Utilization
- Practice patterns
- Medical necessity
- Peer review
- Compliance with Medicaid standards

O. Technical deficiency: An error or omission in documentation by a provider that does not affect direct patient care of the member. Technical deficiency does not include:

- Lack of medical necessity or failure to document medical necessity in a manner that meets professionally recognized applicable standards of care
- Failure to provide care of a quality that meets professionally recognized local standards of care
- Failure to obtain prior, concurrent, or mandatory authorization if required by regulation
- Fraud
- A pattern of abusive billing
- A pattern of noncompliance
- A gross and flagrant violation

190.003 Administrative Appeals 12-1-05

A. The following appeals are available in response to an adverse decision:

- A member may appeal on their own behalf.
- A provider of medical assistance that is the subject of the adverse action may appeal on the member's behalf.
- If the adverse action denies a claim for covered medical assistance that was previously provided to a Medicaid-eligible member, the provider of such medical assistance may appeal on the provider's behalf. The provider does not have standing to appeal a non-payment decision if the provider has not furnished any service for which payment has been denied.

B. All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

C. Providers may appear in person, through a corporate representative, or with prior notice to the department, through legal counsel.

D. Beneficiaries may represent themselves or be represented by a friend, any other spokesperson except a corporation, or legal counsel.

E. A Medicaid member may attend any hearing related to their care, but the department may not make their participation a requirement for provider appeals. The department may compel the member's presence via subpoena, but failure of the member to appear shall not preclude the provider's appeal.

F. If an administrative appeal is filed by both a provider and member concerning the same subject matter, the department may consolidate the appeals.

G. Any person who considers themselves injured in their person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25 15-201 – 25-15-218.

H. This rule shall apply to all pending and subsequent appeals that have not been finally resolved at the administrative or judicial level as of April 5, 2005.

190.004 Records 9-15-09

When the Department of Human Services makes an adverse decision in a Medicaid case and a provider then lodges an administrative appeal, the department shall deliver its file on the matter to the provider well in advance of the appeal so that the

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provider will have time to prepare. The file shall include the records of any utilization review contractor or other agent, subject to any other federal or state law, regarding confidentiality restrictions.

190.005 Technical Deficiencies 9-15-09

The Department of Human Services may not recoup from providers for technical deficiencies if the provider can substantiate through other documentation that the services or goods were provided and that the technical deficiency did not adversely affect the direct patient care of the member.

A technical deficiency in complying with a requirement in federal statutes or regulations shall not result in a recoupment unless:

- **A.** The recoupment is specifically mandated by federal statute or regulation, **OR**
- **B.** The state can show that failure to recoup will result in a loss of federal matching funds or in another penalty against the state.

The Department of Human Services may initiate a corrective action plan or other non-monetary measure in response to technical deficiencies. If a provider fails to comply with a corrective action plan for a pattern of non-compliance with technical requirements, then appropriate monetary penalties may be imposed if permitted by law. However, the department first must be clear as to what the technical requirements are by providing clear communication in writing or a promulgated rule where required.

190.006 Explanations of Adverse Decisions Required 9-15-09

Each denial or other deficiency that the Department of Human Services makes against a Medicaid provider shall be prepared in writing and shall specify:

- **A.** The exact nature of the adverse decision
- **B.** The statutory provision or specific rule alleged to have been violated
- **C.** The specific facts and grounds constituting the elements of the violation

190.007 Rebilling at an Alternate Level Instead of Complete Denial 9-15-09

The denial notice from the department shall explain the reason for the denial in accordance with rule 190.006 above and shall specify the level of care that the department deems appropriate based on the documentation submitted by the provider.

If a legally qualified and authorized provider's claim is denied, the provider shall be entitled to re-bill at the level that would have been appropriate according to the department's basis for denial, absent fraud, or a pattern of abuse by the provider. A referral from a PCP or other condition met prior to the denial shall not be re-imposed.

A provider's decision to re-bill at the alternate level does not waive the provider's or member's right to appeal the denial of the original claim.

Nothing prevents the department from reviewing the claim for reasons unrelated to the level of care and taking action that may be warranted by the review, subject to other provisions of law.

190.008 Prior Authorizations — Retrospective Reviews 9-15-09

The Department of Human Services may not retrospectively recoup or deny a claim from a provider if the department previously authorized the care unless the retrospective review establishes that:

- **A.** The previous authorization was based on misrepresentation by act or omission, **AND**
- **B.** If the true facts had been known, the specific level of care would not have been authorized, **OR**
- **C.** The previous authorization was based on conditions that later changed, thereby rendering the care medically unnecessary.

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Recoupment based on lack of medical necessity shall not include payments for any care that was delivered before the change of circumstances that rendered the care medically unnecessary.

190.009 **Medical Necessity** **12-1-05**

There is a presumption in favor of the medical judgment of the attending physician in determining medical necessity of treatment.

190.010 **Promulgation Before Enforcement** **9-15-09**

The Department of Human Services may not use state policies, guidelines, manuals, or other such criteria in enforcement actions against providers unless the criteria have been promulgated.

Nothing in this rule requires or authorizes the department to attempt to promulgate standards of care that physicians use in determining medical necessity or rendering medical decisions, diagnoses, or treatment.

Medicaid contractors shall use Medicaid provider manuals promulgated pursuant to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

190.011 **Copies** **12-1-05**

If the department or its contractor requires a provider to supply duplicates of documents already furnished to the department or its contractors, the department division or contractor making the request shall pay the actual cost of photocopies, not to exceed 15 cents per page, for duplicates produced and supplied by providers in response to such requests.

190.012 **Notices** **9-15-09**

When the Department of Human Services sends letters or other forms of notices with deadlines to providers or beneficiaries, the deadline shall not begin to run before the next business day following the date of the postmark on the envelope, the facsimile transmission confirmation sheet, or the electronic record confirmation unless otherwise required by federal statute or regulation.

190.013 **Deadlines** **9-15-09**

The Department of Human Services may not issue a denial or demand for recoupment to providers for missing a deadline if the department or its contractor contributed to the delay or if the delay was reasonable under the circumstances, including, but not limited to, the following:

- **A.** Intervening weekends or holidays
- **B.** Lack of cooperation by third parties
- **C.** Natural disasters
- **D.** Other extenuating circumstances

This rule is subject to good faith on the part of the provider.

190.014 **Federal Law** **12-1-05**

If any provision of these policies and procedures is found to conflict with current federal law, including promulgated federal regulations, the federal law shall override that provision.

Quality Improvement Plan

Overview

Arkansas Total Care's culture, systems, and processes are structured around our mission to improve the community one person at a time. The Quality Assessment and Performance Improvement (QAPI) program uses a systematic approach to quality improvement initiatives by applying reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the level of care and service among plan initiatives, including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network

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services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. Arkansas Total Care requires all providers to cooperate with all quality improvement activities and allow us to use provider performance data to ensure success of the QAPI program.

Arkansas Total Care will promote the delivery of appropriate care with the primary goal of improving the health of our members. Where the member's condition is not amenable to improvement, Arkansas Total Care will implement measures to prevent any further decline in condition or deterioration of health status, or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and the designation of adequate resources to support the interventions. Whenever possible, the QAPI program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health of our members.

QAPI Program Structure

The Arkansas Total Care Board of Directors (BOD) has the ultimate oversight for the care and service provided to our members. The BOD oversees the QAPI program and has established various committees to monitor and support the QAPI program.

The Medical Quality Management Committee (MQMC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the MQMC is to:

- Enhance and improve quality of care;
- Provide oversight and direction regarding policies, procedures, and protocols for member care and services; and
- Offer guidelines based on recommendations for appropriateness of care and services.

This is accomplished by a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers, and staff regarding the quality improvement, utilization management, and credentialing and recredentialing programs.

The following standard sub-committees report directly to the Medical/Quality Management Committee — developed by the PASSE to oversee the QAPI strategic plan.

- Credentialing Committee
- Grievance and Appeals Committee
- Performance Improvement Team
- Joint Operations Committee
- Drug Utilization Review Committee
- Utilization Management Committee
- Community Advisory Committee

Provider Involvement

Arkansas Total Care recognizes the integral role practitioner involvement plays in the success of its QAPI program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Arkansas Total Care encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as the MQMC, Credentialing Committee, and select ad hoc committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI program is comprehensive and addresses both the level of clinical care and the level of service provided to Arkansas Total Care members. The Arkansas Total Care QAPI program incorporates all demographic groups and ages, benefit packages, care settings, providers, and services in quality improvement activities. This includes services for preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and operations, among others.

To that end, the Arkansas Total Care QAPI program scope encompasses the following:

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- Acute and chronic care management
- Behavioral healthcare
- Compliance with member confidentiality laws and regulations
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member grievance system
- Member experience
- Patient safety
- Primary care provider changes
- Provider and plan after-hours telephone accessibility
- Provider appointment availability
- Provider complaint system
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and recredentialing)
- Utilization management, including under- and over-utilization

Arkansas Total Care's primary quality improvement goal is to improve members' health through a variety of meaningful activities implemented across all care settings and aimed at improving quality of care and services delivered.

Quality Improvement goals include, but are not limited to, the following:

- A high level of health status and quality of life will be experienced by Arkansas Total Care members.
- Network quality of care and service will meet industry-accepted standards of performance.
- Arkansas Total Care services will meet industry-accepted standards of performance.
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across plan-functional areas.
- Member satisfaction will meet the plan's established performance targets.
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with immunizations, prenatal care, diabetes, asthma, early detection of chronic kidney disease, and well child visits.
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained.

Arkansas Total Care's QAPI program objectives include, but are not limited to, the following:

- Establish and maintain a health system that promotes continuous quality improvement.
- Adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice.
- Select areas of study based on demonstration of need and relevance to the population served.
- Develop standardized performance measures that are clearly defined, objective, measurable, and that allow tracking over time.
- Use Management Information Systems (MIS) in data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes.
- Allocate personnel and resources necessary to:
  - Support the quality improvement program, including data analysis and reporting, **AND**
  - Meet the educational needs of members, providers, and staff relevant to quality improvement efforts.
- Seek input and work with members, providers, and community resources to improve quality of care.
- Oversee peer review procedures that will address deviations in medical management and healthcare practices, and devise action plans to improve services.
- Establish a system to provide frequent, periodic quality improvement information to participating providers to support them in their efforts to provide high-quality healthcare.
- Recommend and institute focused quality studies in clinical and non-clinical areas, where appropriate.
- Conduct and report annual CAHPS surveys and certified HEDIS results for Arkansas Total Care members.
- Achieve and maintain NCQA accreditation.
- Monitor for compliance with regulatory and NCQA requirements.

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Practice Guidelines

Evidence-based preventive health and clinical practice guidelines are provided to assist providers, members, medical consenters, and caregivers in making decisions regarding healthcare in specific clinical situations. Guidelines are adopted from recognized sources, in consultation with network providers (including behavioral health as indicated), and based on the health needs and opportunities for improvement identified as part of the QAPI program, valid and reliable clinical evidence, or a consensus of healthcare professionals in the particular field, as well as the needs of members.

Preventive health and clinical practice guidelines are reviewed annually and updated upon significant new scientific evidence or change in national standards, or at least every two years. Arkansas Total Care will distribute updated guidelines to all affected providers and make all current preventive health and clinical practice guidelines available through provider orientations and other group sessions, provider e-newsletters, online via the HEDIS Resource Page, online via the secure provider portal, and through targeted mailings.

A complete listing of approved preventive health and clinical practice guidelines is available at ArkansasTotalCare.com. The full guidelines are available to print; hard copies may be requested by contacting the Arkansas Total Care quality improvement department.

Patient Safety and Quality of Care

Patient safety is a key focus of the Arkansas Total Care QAPI program. Monitoring and promoting patient safety is integrated throughout activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event up to and including the death of a member. Arkansas Total Care employees (including medical management staff, member services staff, provider services, complaint coordinators, and others), panel practitioners, facilities or ancillary providers, members or member representatives, medical directors, or the BOD may advise the quality improvement department of potential quality of care issues. Adverse events may also be identified through claims-based reporting and analysis. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received by the quality improvement department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

The Arkansas Total Care MQMC reviews and adopts an annual QAPI program and work plan based on managed care-appropriate industry standards. The MQMC adopts traditional quality/risk/utilization management approaches to identify problems, issues, and trends with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicate the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focus studies, and other quality improvement initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and level of care and services delivered against established standards and guidelines for the provision of that care or service. Each quality improvement initiative is also designed to allow Arkansas Total Care to monitor improvement over time.

Annually, Arkansas Total Care develops a QAPI work plan for the upcoming year. The QAPI work plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates MQMC activities, reporting, and studies from all areas of the organization (clinical and service), and includes timelines for completion and reporting to the MQMC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI work plan.

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Arkansas Total Care communicates activities and outcomes of its QAPI program to both members and providers through avenues such as member newsletters, provider newsletters, and ArkansasTotalCare.com.

At any time, Arkansas Total Care providers may request additional information on the health plan programs, including a description of the QAPI program and a report on Arkansas Total Care's progress in meeting QAPI program goals by contacting the quality improvement department.

Quality Rating System

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of just cost differences.

As federal and state governments move toward a healthcare industry that is driven by quality, HEDIS rates have become more important, not only to the health plan, but to the individual provider. Purchasers of healthcare may use HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate the clinical management of its members. Physician-specific scores are used as evidence of preventive care from primary care office practices.

HEDIS® Rate Calculations

HEDIS rates can be calculated in two ways: **administrative data** and **hybrid data**.

Administrative data consist of claims and encounter data submitted to the health plan. Measures typically calculated using administrative data include annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and behavioral health services.

Hybrid data consist of both administrative data and a sample of medical record data. Hybrid data require review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, CPT II, ICD-10, and HCPCS codes can reduce the necessity of medical record review. HEDIS measures requiring medical record review include childhood and adolescent immunizations, cervical cancer screening, colorectal cancer screening, blood pressure control, diabetic blood pressure control, diabetic HbA1c control, diabetic retinal eye exam, diabetic kidney health evaluations, prenatal and postpartum care, well child visits, and weight assessment and counseling for nutrition and physical activity.

Who Conducts Medical Record Reviews (MRR) for HEDIS®

Arkansas Total Care may contract with an independent national medical record review (MRR) vendor to conduct the HEDIS MRR on our behalf. MMR audits for HEDIS are conducted on an ongoing basis with a particular focus from January through May of each year. At that time, a sample of members' medical records may be selected for review; as a provider, you will receive a call and/or a letter from an MRR representative. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, the sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment, or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA-compliant Business Associate Agreement (BAA) with Arkansas Total Care, which will allow them to collect PHI on our behalf.

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How can providers improve their HEDIS scores?

- Understand the specifications established for each HEDIS measure by engaging in educational trainings offered by Arkansas Total Care.
- Submit claims and encounter data for each and every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Arkansas Total Care. Claims and encounter data are the most clean and efficient ways to report for HEDIS.
- Submit claims and encounter data correctly, accurately, and in a timely manner by using appropriate CPT, CPT II, ICD-10, and HCPCS codes. If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate, complete, and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure that chart documentation reflects all services provided. Keep accurate chart/medical record documentation of each member service, and document conversations/services.

Submit claims and encounter data using all applicable CPT II codes related to HEDIS measures, such as diabetic HbA1c, diabetic retinal eye exams, blood pressure controll, and prenatal and postpartum care, where appropriate.

Contact the quality improvement department at QI_AR_HEDIS@centene.com if you have any questions related to HEDIS.

Provider Satisfaction Survey

Arkansas Total Care conducts an annual provider satisfaction survey that includes questions to evaluate the provider experience with Arkansas Total Care and our services. The survey is conducted by an impartial external vendor. Participants are randomly selected by the vendor and meet specific requirements outlined by Arkansas Total Care. Participants are kept anonymous. We encourage you to respond promptly to the survey if you receive it, as the results are analyzed and used as a basis for forming provider-related quality improvement initiatives.

Regulatory Matters

Medical Records

All member medical records are confidential and must not be released without the written authorization of the member or their parent/legal guardian, except as permitted or required by federal regulation. When the release of medical records is appropriate, the extent of that release should be based on medical necessity or a need-to-know basis and follow the minimum necessary standard. All release of specific clinical or medical records containing information related to substance use disorders must meet federal guidelines at 42 CFR Part 2 as well as any applicable state laws.

Required Information

To be considered complete and comprehensive, the member's medical record file should include, at minimum, provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (such as X-rays or laboratory tests). Medical records should be accessible at the site of the member's participating PCP. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented and prepared in accordance with all applicable state rules and regulations and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the standards set forth below:

- The member's name and/or medical record number must be on all chart pages.
- Personal/biographical data is present (employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.

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- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, "NKA" or "NKDA" is documented.
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in the chart for adults.
- Evidence is present that preventive screening and services are offered in accordance with Arkansas Total Care practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents 18 years and younger, past medical history relating to prenatal care, birth, any operations, and/or childhood illnesses is present.
- The working diagnosis is consistent with the findings.
- The treatment plan is appropriate for the diagnosis.
- There is documentation of treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women is present.
- Signed and dated required consent forms are included.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate are documented.
- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans; all entries should be initialed by the PCP to signify review.
- Referrals to specialists and ancillary providers are documented, including follow-up of outcomes and summaries of treatment rendered elsewhere, and including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 10 years and older, appropriate notations concerning use of tobacco, alcohol, and substance use is present. For members seen three or more times, substance abuse history should be queried.
- Documentation of failure to keep an appointment is present where applicable.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months, or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem is documented.
- Confidentiality of member information and records is maintained.
- Evidence that an Advance Directive has been offered to adults 18 years of age and older is documented.

Access to Records and Audits by Arkansas Total Care

Subject only to applicable state and federal confidentiality or privacy laws, providers shall permit Arkansas Total Care or its designated representative access to the provider's records, at the provider's place of business in this state during normal business hours, or remote access of such records, in order to audit, inspect, review, perform chart reviews, and duplicate such records. If performed on site, access to records for the purpose of an audit shall be scheduled at mutually agreed upon times, with at least 30 business days prior written notice by Arkansas Total Care or its designated representative, but not more than 60 days following such written notice.

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Electronic Medical Record (EMR) Access

Arkansas Total Care may request access to providers' electronic medical record (EMR) system to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to Arkansas Total Care for this access.

Medical Records Transfer for New Members

All PCPs are required to document in members' medical record attempts to obtain historical medical records for all newly assigned Arkansas Total Care members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or if they are unable to provide addresses of the previous providers, then this should be noted in the medical record.

Federal and State Laws Governing the Release of Information

The release of certain information is governed by a myriad of federal and/or state laws. These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, behavioral health, alcohol/substance abuse treatment, and communicable disease records. For example, HIPAA requires that covered entities, such as health plans and providers, release PHI only when permitted under the law, such as for treatment, payment, and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol/substance abuse treatment records (42 CFR Part 2, or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Other laws at the state level place further restrictions on the release of certain information, such as behavioral health, communicable disease, and more.

For more information about any of these laws, refer to the following:

- HIPAA: Visit the CMS website at cms.hhs.gov.
- 42 CFR Part 2 regulations: Visit the Substance Abuse and Mental Health Services Administration (SAMHSA) at samhsa.gov.
- State laws: Consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within the Arkansas Total Care network are independently obligated to know, understand, and comply with these laws. Arkansas Total Care takes privacy and confidentiality seriously. We have established processes, policies, and procedures to comply with HIPAA and other applicable federal and/or state confidentiality and privacy laws.

Please contact the Arkansas Total Care compliance officer by phone at 1-877-617-0390 or in writing with any questions about our privacy practices. Details on where to send written communications are available below:

Arkansas Total Care
Attn: Compliance Officer
P.O. Box 25010
Little Rock, AR 72221
Email: AR_Privacy@centene.com

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Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity, any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces

For more information, visit hhs.gov/civil-rights/for-individuals/section-1557/index.html.

Waste, Abuse, and Fraud

Arkansas Total Care takes the detection, investigation, and prosecution of fraud and abuse seriously and has a waste, abuse, and fraud (WAF) program that complies with the federal and state laws. Arkansas Total Care, in conjunction with its parent company, Centene, operates a WAF unit. Arkansas Total Care routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code-editing software performs systematic audits during the claims payment process. To better understand this system, please review the **Claims** section of this manual. Centene's Special Investigations Unit (SIU) performs retrospective audits, which, in some cases, may result in taking actions against providers who commit WAF. These actions include, but are not limited to, the following:

- Remedial education and training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Some of the most common WAF practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT codes
- Diagnosis and/or procedure code not consistent with the member's age
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential WAF hotline at 1-866-685-8664. Arkansas Total Care takes all reports of potential WAF seriously and investigates all reported issues.

WAF Program Compliance Authority and Responsibility

The Arkansas Total Care compliance officer has overall responsibility and authority for carrying out the provisions of the compliance program. Arkansas Total Care is committed to identifying, investigating, sanctioning, and prosecuting suspected WAF.

The Arkansas Total Care provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations.

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False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the federal government. The act prohibits the following:

- Knowingly presenting, or causing to be presented a false claim for payment or approval
- Knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim
- Conspiring to commit any violation of the False Claims Act
- Falsely certifying the type or amount of property to be used by the government
- Certifying receipt of property on a document without completely knowing that the information is true
- Knowingly buying government property from an unauthorized officer of the government
- Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the government

For more information regarding the False Claims Act, visit cms.hhs.gov.

Agreement Outlining Minimum Standards for PASSE HCBS Providers

Ensuring the health and safety of individuals who are enrolled in the Arkansas Medicaid PASSE program and are served through the Arkansas Community Employment Supports (CES) 1915(c) waiver and state plan amendment authority under 1915(i) Arkansas Community Independence Services is a shared responsibility among the Arkansas Department of Human Services (DHS), each PASSE, and each provider of home- and community-based services.

Accordingly, DHS has developed the attached Agreement for use by each PASSE and their PASSE HCBS providers to be placed in their manuals for those performing home- and community-based services.

This agreement is based on former requirements under the CES waiver. Each PASSE must include the content of each of the sections, although they may modify the format according to their individual manual specifications. These are minimum standards in addition to federal, state, and local statutes, acts and regulations that apply, and any other qualifications established by the PASSE. All other provisions, except other certification, outlined in this agreement apply to all providers providing home- and community-based services, including the Arkansas Community Independence Program.

SECTION	100	ORGANIZATIONAL/MANAGEMENT REQUIREMENTS OF PASSE HCBS PROVIDERS AND ANNUAL CERTIFICATION REQUIREMENTS
SECTION	200	HIRING PROCEDURES AND PERSONNEL RECORD MAINTENANCE
SECTION	300	INCIDENT REPORTING
SECTION	400	EMERGENCY RESPONSE REQUIREMENTS FOR CSSP PROVIDERS
SECTION	500	BENEFICIARY AND LEGAL GUARDIAN RIGHTS

Section 100 Organizational/Management Requirements and Solicitation

Organizational Requirements

The PASSE is responsible for the credentialing of PASSE HCBS providers.

All HCBS providers must be enrolled in Arkansas Medicaid as an HCBS provider. In order to enroll in Arkansas Medicaid as a PASSE HCBS provider, the HCBS provider must be credentialed as such by the PASSE.

a. The PASSE must submit to DHS for approval the method by which the PASSE will credential HCBS providers.
b. The PASSE is required to submit a yearly attestation that all PASSE HCBS providers have been certified on an annual basis. DHS will audit the PASSE's records to ensure compliance with the annual certification requirement. Any PASSE HCBS provider discovered not to have been certified annually will be disenrolled as a Medicaid provider. Failing to annually certify HCBS providers that are enrolled with Medicaid may lead to sanctions by DHS in accordance with Section 14.1.

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c. The PASSE's credentialing process must be approved by DHS and include the following, at a minimum, for HCBS providers:
    i. Audit requirements
    ii. Inspection requirements
    iii. Complaint resolution process
    iv. Performing provider requirements
    v. Any other information required for the PASSE to credential an HCBS provider as such

1. Provider Governing Documents Available for Inspection: All governing documents, policies, procedures, or other equivalent operating documents of a PASSE HCBS provider shall at all times be readily available for PASSE and DHS inspection and review upon request.
2. Legal Existence and Good Standing: A PASSE HCBS provider shall at all times be duly organized, validly existing and in good standing as a legal entity under the laws of the state of Arkansas, with the power and authority under the appropriate federal, state, or local statues to own and operate its business as presently conducted.

Management Requirements

1. Point of Contact: Each PASSE HCBS provider must appoint a single member of management as the point of contact for all quality assurance matters. The DHS PASSE unit, in conjunction with the PASSE, will oversee compliance with the below minimum standards.
2. Executive Director: Each PASSE HCBS provider must appoint an executive director or other titled officer position that is vested with the authority and responsibility of overseeing all day-to-day operations.

200 Hiring Procedures & Personnel Record Maintenance

Hiring Procedures and Required Personnel Records

A. Prior to Employment. The PASSE HCBS provider must obtain and verify each of the following from an applicant prior to employment:
    1. A completed job application that includes all the applicant's required current and up-to date credentials
    2. A signed criminal conviction statement
    3. All required criminal background checks, as outlined in A.C.A. § 20-38-101 et. seq. and §20-48-812, or any applicable successor statutes. The PASSE and DHS require criminal background checks for the applicant, their spouse, and any children or other adult over the age of 18 if a beneficiary is to be permitted to stay overnight in an applicant's residence.
    4. A signed declaration of truth of statement
    5. Completed reference checks
    6. A successfully passed drug screening
    7. If the applicant is applying for a position where transportation is required, a current and valid driver's license or a commercial driver's license (CDL), as appropriate

B. Post-Employment. The PASSE HCBS provider shall obtain and verify within 30 days of an applicant's employment:
    1. A completed Adult Maltreatment Central Registry check (see A.C.A. § 12-12-1716, or any successor statutes), or a second submission request if a response has not been received. An Adult Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adults over the age of 18 who reside in a residence where a beneficiary is approved and permitted to stay overnight.
    2. A completed Child Maltreatment Central Registry check (A.C.A. § 12-18-901 et. seq., or any successor statutes), or a second submission request if a response has not been received. A Child Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adults over the age of 18 who reside in a residence where a beneficiary is approved and permitted to stay overnight.
    3. A successfully passed criminal background check for the employee, their spouse, and any children or other adults over the age of 18 residing in a residence where a beneficiary is approved and permitted to stay overnight

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300 Incident Reporting

Reportable Incidents

PASSE HCBS providers must submit an incident report to the DHS PASSE quality assurance unit and the appropriate PASSE, using the reporting form via secure email upon the occurrence of any one of the following events:

1. Death of beneficiary
2. The use of any restrictive intervention, including seclusion or physical, chemical, or mechanical restraint on a beneficiary
3. Suspected maltreatment or abuse of a beneficiary
4. Any injury to a beneficiary that:
   - Requires the attention of an Emergency Medical Technician, a paramedic, or a physician
   - May cause death
   - May result in a substantial permanent impairment
   - Requires hospitalization
5. Threatened or attempted suicide by a beneficiary
6. The arrest of a beneficiary, or commission of any crime by a beneficiary
7. Any situation in which the whereabouts of a beneficiary is unknown for more than two hours (e.g. elopement and/or wandering), or where services are interrupted for more than two hours
8. Any event where a staff member threatens, abuses, or neglects a beneficiary
9. Unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary
10. Medication errors made by staff that cause or have the potential to cause serious injury or illness to a beneficiary, including, but not limited to, loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, a wrong dose, a dose being administered at the wrong time by the wrong route, and the administration of the wrong medication
11. Any violation of a beneficiary's rights that jeopardizes the health, safety, or quality of life of the beneficiary
12. Any incident involving property destruction by a beneficiary
13. Vehicular accidents involving a beneficiary
14. Biohazard incidents involving a beneficiary
15. An arrest or conviction of a staff member providing direct care services
16. Any use or possession of a non-prescribed medication or an illicit substance by a beneficiary
17. Any other event that might have resulted in harm to a beneficiary or could have reasonably endangered the health, safety, or welfare of the beneficiary

In addition to submitting incident reports for the reportable incidents described above to the DHS PASSE quality assurance unit using the reporting form via secure email, PASSE HCBS providers are also to forward a copy of each incident report to the client's assigned PASSE. If the incident involves an employee of a PASSE HCBS provider and the provider is in multiple PASSE networks, the incident must be sent to all.

Incident reports involving unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary are considered sentinel events and will be investigated by DHS. In addition to sentinel events, DHS will investigate if the network provider and/or network provider staff is suspected to be at fault. All other incidents will be investigated by the appropriate PASSE.

Reporting Time Frames

A. Immediate Reporting. Providers must report the following incidents to the DHS PASSE quality assurance unit emergency number (501-371-1329) within one hour of occurrence, regardless of time of day, as well as the on-call emergency number for the appropriate PASSE:
   - A death not related to the natural course of the patient's illness
   - Serious physical or psychological injury to a beneficiary

   The provider must report the following incidents to Incident@ArkansasTotalCare.com within two hours of occurrence:
   - Member elopes from service and cannot be located

B. Incidents Involving Potential Publicity. Incidents, regardless of category, that a PASSE HCBS provider should reasonably know might be of interest to the public and/or media must be immediately reported to the DHS PASSE quality

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assurance unit and the appropriate PASSE.

C. All Other Incident Reports. Except as otherwise provided above in subsection A and B, all reportable incidents must be reported to the DHS PASSE quality assurance unit, and the appropriate PASSE, using the automated PASSE HCBS Incident Report Form via secure email no later than two days following the incident. Any incident that occurs on a Friday is still considered timely if reported by the Monday immediately following.

Required Incident Report Contents

A. Initial Incident Report. Each initial incident report filed by a PASSE HCBS provider must contain the following information:
   1. Date of the incident
   2. Detailed description of the accident/injury
   3. Time of the incident
   4. Location of incident
   5. Persons involved in the incident
   6. Other agencies contacted regarding incident, and the name of the individual in the agency that was contacted
   7. Whether the guardian was notified of the incident and time of notification
   8. Whether the police were involved, and if so, a detailed description of their involvement
   9. Any action taken by provider or staff of provider, both at the time of the incident and subsequent to the incident
   10. Any expected follow-up
   11. Name of the person who prepared the report

When applicable, the PASSE HCBS provider shall notify the parent or legal guardian of the beneficiary any time an incident report is submitted.

B. Follow-up Incident Reports. Information that is not available at the time of the initial incident report filing must be submitted in follow-up or final incident reports. These reports should be submitted in the same manner as soon as the additional information becomes available.
   - The initial report should be resubmitted with the "follow-up" or "final" report areas checked and dated in the appropriate space on the incident report form.
   - The current date should precede the new information in the text/narrative sections to differentiate follow-up information from the information originally submitted.
   - A new PASSE Incident Report Form should be submitted for follow-up and final reports only when there is insufficient space on the original form. Whenever a new form is submitted, the date of the original written report must be included for cross-referencing.

Mandated Reporters

The Arkansas Child Maltreatment Act and the Arkansas Adult Maltreatment Act deem all staff of PASSE HCBS providers to be mandated reporters of any suspected adult or child abuse, neglect, exploitation, and maltreatment. Failure on the part of a PASSE HCBS provider to properly report suspected abuse, neglect, exploitation, and maltreatment to the appropriate hotline is a violation of these minimum standards.

Incident Reporting Requirements for Children's Residential & Acute Psychiatric Providers

Providers of children's psychiatric residential, sub-acute, and psychiatric acute services are required to provide information to Arkansas Total Care for critical incidents as outlined below. These providers are required to submit critical incident reports to Arkansas Total Care via the outlined incident reporting process. These critical incident reports are required to be submitted to Arkansas Total Care within the timeframe required by the provider's licensing body:

- Death of a member
- Suspected maltreatment of a member
- Injury to a member that requires emergency room care or a paramedic
- Injury to a member that may result in a substantial permanent impairment
- Injury to a member that requires hospitalization
- Arrest
- Any situation in which the member eloped from a service and cannot be located within two hours
- Any significant peer-on-peer or member-on-staff incidents or assaults

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The following elements must be included in the incident report:

- Member name
- Member date of birth (DOB)
- Member Arkansas Total Care and/or Medicaid ID
- Overview of incident, including details such as date, time, antecedents, actions taken, etc.
- All follow-up action items

400 Emergency Response Requirements for CSSP Providers

Emergency Response Services

Applicants/providers must establish, implement, and maintain a site-specific emergency response plan, which must include:

- A 24-hour emergency telephone number
- The applicant/provider must:
  - Provide the 24-hour emergency telephone number to all clients.
  - Post the 24-hour emergency number on all public entries to each site.
  - Include the 24-hour emergency phone number on answering machine greetings.
  - Identify local law enforcement and medical facilities within a 50-mile radius that may be emergency responders to client emergencies.
- Direct access to a mental health professional within 15 minutes of an emergency/crisis call and face-to-face crisis assessment within two hours
- Response strategies are based on the following:
  - Time and place of occurrence
  - Individual's status (client/non-client)
  - Contact source (family, law enforcement, healthcare provider, etc.)
- Requirements for a face-to-face response to requests for emergency intervention received from a hospital or law enforcement agency regarding a current client
- All face-to-face emergency responses shall be:
  - Available 24 hours a day, seven days a week
  - Made by a mental health professional within two hours of the request (unless a different time frame is within clinical standards guidelines and mutually agreed upon by both the requesting party and the MHP responding to the call)
- Emergency services training standards to ensure that emergency services are age-appropriate and comply with accreditation requirements. Providers shall maintain documentation of all emergency services training in each trainee's personnel file.
- Requirements for clinical review by the clinical supervisor or emergency services director within 24 hours of each after-hours emergency intervention, with such additional reporting as may be required by the provider's policy
- Requirements for documentation of all crisis calls, responses, collaborations, and outcomes
- Requirements that emergency responses not vary based on the client's funding source. If a client is eligible for inpatient behavioral healthcare funded through the community mental health centers, and the provider is not a community mental health center with access to these funds, the provider must:
  - Determine whether the safest, least restrictive alternative is psychiatric hospitalization; and
  - Contact the appropriate community mental health center (CMHC) for consult and request that the CMHC access local acute care funds for those over the age of 21.

Required Incident Report Contents

A. Initial Incident Report. Each initial incident report filed by a PASSE HCBS provider must contain the following information:
   1. Date of the incident

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2. Detailed description of the accident/injury
3. Time of the incident
4. Location of incident
5. Persons involved in the incident
6. Other agencies contacted regarding incident, and the name of the individual in the agency that was contacted
7. Whether the guardian was notified of the incident and time of notification
8. Whether the police were involved, and if so, a detailed description of their involvement
9. Any action taken by provider or staff of provider, both at the time of the incident and subsequent to the incident
10. Any expected follow-up
11. Name of the person who prepared the report

When applicable, the PASSE HCBS provider shall notify the parent or legal guardian of the beneficiary any time an incident report is submitted.

B. Follow-up Incident Reports. Information that is not available at the time of the initial incident report filing must be submitted in follow-up or final incident reports. These reports should be submitted in the same manner as soon as the additional information becomes available.
   - The initial report should be resubmitted with the **follow-up** or **final** report areas checked and dated in the appropriate space on the incident report form.
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- Injury to a member that requires hospitalization
- Arrest
- Any situation in which the member eloped from a service and cannot be located within two hours
- Any significant peer-on-peer or member-on-staff incidents or assaults

The following elements must be included in the incident report:

- Member name
- Member date of birth (DOB)
- Member Arkansas Total Care and/or Medicaid ID
- Overview of incident, including details such as date, time, antecedents, actions taken, etc.
- All follow-up action items

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500 Beneficiary and Legal Guardian Rights

Beneficiary/Guardian Rights Policy

Each PASSE HCBS provider must implement policies that enumerate in clear and understandable language each beneficiary's rights and the rights of the legal guardian of each beneficiary. The PASSE HCBS provider must take reasonable steps to ensure beneficiaries and their legal guardians are (1) informed of their rights; (2) provided copies of the policies enumerating their rights prior to the initiation of services and at any other time upon request; and (3) that the information is transmitted in a manner that the beneficiary and their legal guardian are able to read and understand.

Beneficiary Rights

Each PASSE HCBS provider must, at a minimum, ensure the following beneficiary rights:

1. The right to be free from:
   - Physical or psychological abuse or neglect
   - Retaliation
   - Coercion
   - Humiliation
   - Financial exploitation

   The PASSE HCBS provider must ensure that the application of corporal punishment to beneficiaries is prohibited. "Corporal punishment" refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.
2. The freedom to control their own financial resources
3. The freedom to receive, purchase, possess, and use individual personal property. Any restriction on this right must be supported by an assessed need and justified in the beneficiary's PCSP
4. The freedom to actively and meaningfully make decisions affecting their life and access pertinent information in a timely manner to facilitate such decision making
5. The right to privacy. Any restriction on this right must be supported by an assessed need and justified in the PCSP
6. The right to have a choice of roommate when sharing a bedroom
7. The freedom to associate and communicate publicly or privately with any person or group of people of the beneficiary's choice at any time. Any restriction on this right must be supported by an assessed need and justified in the PCSP
8. The freedom to have visitors of their choosing at any time
9. The freedom of religion
10. The right to be free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment
11. The opportunity to seek employment and work in competitive, integrated settings
12. Freedom from being required to work without compensation
13. The right to be treated with dignity and respect
14. The right to receive due process
    - PASSE HCBS providers must ensure beneficiaries have access to legal entities for appropriate and adequate representation, advocacy support services, and must adhere to research and ethics guidelines (45 CFR § 46.101 et. seq.).
    - PASSE HCBS provider rules may not contain provisions that result in the unfair, arbitrary, or unreasonable treatment of a beneficiary.
15. The right to contest and appeal PASSE HCBS provider decisions affecting the beneficiary
16. The right to request and receive an investigation in connection with an alleged infringement of a beneficiary's rights
17. The freedom to access their own records, including information regarding how their funds are accessed and utilized and what services were billed for on the beneficiary's behalf. Additionally, all beneficiaries and legal guardians must be informed of how to access the beneficiary's service records and the PASSE HCBS provider must ensure that appropriate equipment is available for them to obtain such access.
    - Beneficiaries may not be prohibited from having access to their own service records, unless a specific state law indicates otherwise.

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18. The right to live in a manner that optimizes, but does not regiment, beneficiary initiative, autonomy, and independence in making life choices, including but not limited to:
    - Choice of HCBS providers
    - Service delivery
    - Release of information
    - Composition of the service delivery team
    - Involvement in research projects, if applicable
    - Daily activities
    - Physical environment
    - With whom to interact
19. Other legal and constitutional rights

Financial Safeguards

This section applies if the PASSE HCBS provider serves as a representative payee of a beneficiary, is involved in managing the funds of the beneficiary, receives benefits on behalf of the beneficiary, or temporarily safeguards funds or personal property for the beneficiary.

A. Financial Safeguards and Procedures. The PASSE HCBS provider must demonstrate that there is a system in place to protect the financial interests of all beneficiaries. PASSE HCBS provider personnel that have any involvement with beneficiary funds and the beneficiary, or with the beneficiary's legal guardian, must receive a copy of the PASSE HCBS provider's Financial Safeguards Policies and Procedures.
    1. The PASSE HCBS provider is responsible for ensuring that each beneficiary's funds are used solely for the benefit of the beneficiary.
    2. The PASSE HCBS provider must ensure that the beneficiary is able to receive the benefit of those items/services for which they are paying. By way of illustration, if a beneficiary is paying for internet, the beneficiary should have a device with which to access the internet. If the beneficiary pays for a cell phone plan, then the beneficiary should have a functioning cell phone.

B. Access to Financial Records. Beneficiaries and their legal guardians must have access to financial records concerning the beneficiary's account/funds at all times.

C. Financial Safeguards Policy and Procedures. The PASSE HCBS provider must implement policies that define:
    1. How beneficiaries will provide informed consent for the expenditure of their funds
    2. How beneficiaries will access their financial records
    3. How beneficiary accounts/funds will be segregated and maintained for accounting purposes
    4. The safeguards and procedures in place to ensure that beneficiary funds are used only for designated and appropriate purposes
    5. How interest will be credited to the accounts of the beneficiaries, if applicable
    6. A mechanism that provides evidence that beneficiary funds were expended in the manner authorized

D. Consent Requirements. The PASSE HCBS provider shall obtain consent from the beneficiary or their legal guardian prior to implementing the following:
    1. Limiting the amount of funds a beneficiary may expend or invest in a specific instance
    2. Designating the amount a beneficiary may expend or invest for a specific purpose
    3. Establishing time frames where a beneficiary is required to or prohibited from expending or investing their funds
    4. Delegating responsibility for expending or investing a beneficiary's funds

Restraints & Restrictive Intervention

A. Behavior Management Plan Required. A provider is prohibited from using any restraints or restrictive interventions on a beneficiary unless the beneficiary has a developed and implemented behavior management plan which incorporates alternative strategies to avoid the use of restraints and restrictive interventions, and includes the use of positive behavior support strategies as an integral part of the behavior management plan (see Section 502 "Behavior Management Plans"). There is a limited exception to this requirement when the use of an emergency restraint is necessary (see Section 503 (E) "Emergency Restraint").

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B. Definitions of Restraints and Interventions:
   1. "Physical restraint" or "personal restraint": The application of physical force without the use of any device (manually holding all or part of the body), for the purpose of restraining the free movement of a beneficiary's body. This does not include briefly holding, without undue force, a beneficiary in order to calm them, or holding a beneficiary's hand to escort them safely from one area to another.
   2. "Physical intervention": The use of a manual technique intended to interrupt or stop a behavior from occurring
   3. "Restrictive intervention": Procedures that restrict or limit a beneficiary's freedom of movement, restricts access to their property, prevents them from doing something they want to do, requires them to do something they do not want to do, or removes something they own or have earned. The definition would include the use of a "time out" in which a beneficiary is temporarily, and for a specified period of time, removed from positive reinforcement or denied opportunity to obtain positive reinforcement for the purpose of providing the beneficiary with the opportunity to regain self-control. Under no circumstances may a beneficiary be physically prevented from leaving.
   4. "Mechanical restraint": Any physical apparatus or equipment used to limit or control a challenging behavior. This would include any apparatus or equipment that cannot be easily removed by the beneficiary, restricts the beneficiary's free movement or normal functioning, or restricts normal access to a portion or portions of the beneficiary's body.
      – Under no circumstances are mechanical restraints permitted to be used on a beneficiary.
   5. "Chemical restraint": The use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition
      – Under no circumstances are chemical restraints permitted to be used on a beneficiary.
   6. "Seclusion": The involuntary confinement of a beneficiary alone in a room or an area from which the beneficiary is physically prevented from having contact with others or leaving
      – Under no circumstances is seclusion permitted to be used on a beneficiary.

C. Use of Restraints and Interventions. Permitted restraints and interventions may be used only when a challenging behavior exhibited by the beneficiary threatens the health or safety of the beneficiary or others. The use of restraints or interventions must be supported by a specific assessed need as justified in the beneficiary's PCSP, and only performed as provided in the beneficiary's behavior management plan.
   1. Required prior counseling: Before a "time out," an absence from a specific social activity, or a temporary loss of personal possession is implemented, the beneficiary must first be counseled about the consequences of the behavior and the choices they can make.
   2. Direct observation: A beneficiary must be continuously under direct visual and auditory observation by staff members during any use of restraints or interventions.
   3. Specialized restraint and intervention training: All personnel who are involved in the use of restraints or interventions must receive training on and be qualified to perform, implement, and monitor the particular restraint or intervention as applicable. Additionally, personnel should receive training in behavior management techniques and abuse and neglect laws, rules, regulations, and policies.
   4. Restraint and intervention identification: The PASSE HCBS provider is required to advise all staff, families, and beneficiaries on how to recognize and report the unauthorized use of a restraint or restrictive intervention.

D. Required Restraint and/or Intervention PCSP Information. Any PCSP and behavior management plan permitting the use of restraints or interventions must include the following information:
   1. Identify the specific and individualized assessed need for the use of the restraint or intervention.
   2. Document the positive interventions and supports used prior to any modifications to the PCSP that permits use of restraint or interventions.
   3. Document the less intrusive methods of behavior modification that were attempted but did not work.
   4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
   5. Include regular collection and review of data to measure the ongoing effectiveness of the modification to the PCSP that permitted the use of a restraint or intervention.
   6. Include established time limits for periodic reviews to determine if the use of restraint or intervention is still necessary or can be terminated.

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7. Include the informed consent of the beneficiary or legal guardian.
8. Include an assurance that the use of the restraint or intervention will cause no harm to the beneficiary.

E. Emergency Restraint. Personal restraints (use of staff member's body to prevent injury to the beneficiary or another person) are allowed in cases of emergency, even if a behavior management plan incorporating the use of restraints has not been developed and implemented. An emergency exists in the following situations:
   1. The beneficiary has not responded to de-escalation or other positive behavior support strategies and the behavior continues to escalate.
   2. The beneficiary is a danger to themselves or others.
   3. The safety of the beneficiary and those nearby cannot be assured through positive behavior support strategies.

F. Reporting Each Incident Where Restraint or Intervention Was Used. An incident report must be completed and submitted to the DHS PASSE quality assurance unit and appropriate PASSE, in accordance with Section 300 herein, no later than the end of the second business day following the date any restraint or restrictive intervention is administered. If the use of a restraint or restrictive intervention occurs more than three times in any 30-day period, permitted use of restraints and interventions must be discussed by the PCSP development team, addressed in the PCSP, and implemented pursuant to an appropriate behavior management plan. Any use of restraint or intervention, whether permitted or prohibited, also must be documented in the beneficiary's daily service log, maintained in their service record, and must include the following information:
   1. The behavior initiating the use of restraint or intervention
   2. The length of time the restraint or intervention was administered
   3. The name of the personnel that authorized the use of the restraint or intervention
   4. The names of all individuals involved and outcomes of the use of the restraint or intervention

Medication Logs

1. Prescription Medications. Providers delivering direct care services must maintain medications logs detailing the administration of prescribed medications to the beneficiary. The prescribed medication logs must be readily available review, and document the following for each administration of a prescribed medication:
   - Name and dosage of the medication administered
   - Route the medication was administered
   - Date and time the medication was administered (recorded at the time of medication administration)
   - Initials of the staff administering or assisting with the administration of the medication
   - Any side effects or adverse reactions to the medication
   - Any errors in administering the medication
2. PRN and Over-the-Counter Medications. PASSE HCBS providers delivering direct care services must also maintain logs concerning the administration of PRN and OTC medications. The logs for the administration of prescription PRN and over-the-counter medications must document the following:
   - How often the medication is used
   - Date and time each medication was administered (recorded at the time of medication administration)
   - The circumstances in which the medication is used
   - The symptom for which the medication was used
   - The effectiveness of the medication
3. Medication Administration Error Reporting/Charting. Any medication administration errors occurring or discovered must be recorded in the medication log and immediately reported to a supervisor. "Medication administration errors" include, but are not limited to, the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time or by the wrong route, the administration of the wrong medication, and the discovery of an unlocked medication lock box that is supposed to be locked at all times.
   - An incident report must be filed with DHS PASSE quality assurance unit and appropriate PASSE, in accordance with Section 300, for any medication administration error that caused or had the potential to cause serious injury or illness to a beneficiary.

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4. Required Oversight Documentation. Each PASSE HCBS provider delivering direct care services must ensure that supervisory level staff review on at least a monthly basis all beneficiary medication logs to determine if:
   - All medications were administered accurately as prescribed.
   - The medication is effectively addressing the reason for which it was prescribed.
   - Any side effects are noted, reported, and being managed appropriately.

Daily Service Activity Logs

Daily service activity logs must be maintained by all PASSE HCBS providers delivering direct care services in order to provide specific information relating to the individually identified goals and desired outcomes for the beneficiary, so that the care coordinator, PCSP developer, and PCSP development team can measure and record the progress on each of the beneficiary's identified goals and desired outcomes. There is no required format for a daily service activity log; however, the daily service activity logs must document the following:

1. The name and sign-in/sign-out times for each direct care staff member
2. The specific services furnished
3. The date and actual beginning and ending time of day the services were performed
4. Name(s) of the staff/person(s) providing the service(s)
5. The relationship of the services to the goals and objectives described in the beneficiary's individualized PCSP
6. Daily progress notes/narrative signed and dated by the staff delivering the service(s), describing each beneficiary's progress or lack thereof with respect to each of his or her individualized goals and objectives. This would include any behavior management plan data required to be maintained pursuant to Section 502(E) above.

Beneficiary Service Records

A. Required Service Record Documentation. Each PASSE HCBS provider delivering direct care services to a beneficiary must establish a service record for the beneficiary. At a minimum, the service record file must contain:
   1. A copy of the PCSP
   2. Behavior management plan with proper beneficiary/legal guardian approval, if applicable
   3. Daily service activity logs
   4. Fully approved medication management plan and medication logs, or a signed election to self-administer medication if applicable
   5. Fully executed copy of lease, residency agreement, or other form of written agreement that provides protections that address eviction processes and appeals comparable to those provided under a landlord-tenant law
   6. Any documentation providing additional individuals with access to a beneficiary's service record
   7. Guardianship order, if applicable

B. Beneficiary Records Maintenance & Storage Retention Requirements:
   1. Confidentiality. A PASSE HCBS provider shall maintain complete service records/files and treat all information related to beneficiaries as confidential. Access to beneficiary service files must be limited to only those staff members who have a need to know the information contained in the records of the beneficiary. The only individuals that may access a beneficiary's files and records are:
      - The beneficiary
      - The legal guardian of the beneficiary, if applicable
      - Professional staff providing direct care or care coordination services to the beneficiary
      - Authorized provider administrative staff
      - Any other individual authorized by the beneficiary or their legal guardian

      Adult beneficiaries who are legally competent shall have the right to decide whether their family will be involved in planning and implementing their PCSP, and a signed release or document shall be present in their service record either granting permission for family involvement or declining family involvement.
   2. HIPAA Regulations. Each PASSE HCBS provider shall ensure that information that is used for reporting or billing shall be shared according to confidentiality guidelines that recognize applicable regulatory requirements such as HIPAA.
   3. Electronic and Paper Records/File Maintenance. Electronic service records are acceptable. Paper and electronic service records must be uniformly organized and easily accessible. A list of the order of the service record information shall either be present in each beneficiary's service record or provided to the DHS PASSE quality assurance unit and appropriate PASSE upon request. The documents in active service records should be organized in a systematic fashion. An indexing and filing system must be maintained for all service records.

4. Storage Location. The location of the files/service records, and the information contained therein, must be controlled from a central location.
5. Direct Care Staff Access. The PASSE HCBS provider shall ensure all direct care and care coordination staff has adequate access to the beneficiary's file/service record, including current PCSP and other pertinent information necessary to ensure the beneficiary's health, welfare, and safety (e.g. name and telephone number of physician(s), emergency contact information, insurance information, etc.).
6. Record/File Retention. Each PASSE HCBS provider must retain all files/services records for five years from the date of service, or until all audit questions or review issues, appeals hearings, investigations, or administrative or judicial litigation to which the files/services records may relate are finally concluded, whichever period is later. Failure to furnish medical records upon request may result in sanctions being imposed. Federal legislation further requires that any accounting of private healthcare information or HIPAA polices or complaints must be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.
7. Access Sheets. Access sheets shall be located in the front of the service record to maintain confidentiality according to 5 U.S.C. § 552a. If there is a signed release for a list of authorized persons to review the service record, only those not listed will need to sign the access sheet with date, title, reason for reviewing, and signature. If there is not a signed release for authorized persons to review, all persons must sign the access sheet whenever the service record is reviewed or any material is placed in the service record.

Training Requirements

1. First Aid Training. Within 30 days of hiring, all staff that may be required to provide emergency direct care services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.
   - The course must provide a certificate of completion that can be maintained in the staff's personnel file.
   - Any services provided by a staff person prior to receiving the above described first aid training can be performed only in a training role, under the supervision of another staff person that has already had the required first aid training.
   - Training certification must be maintained and kept up to date throughout the time any staff is providing services.
2. Beneficiary Specific Training. Prior to beginning service delivery, staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supportive living services required pursuant to the beneficiary's PCSP, including but not limited to:
   - General training on beneficiary's PCSP
   - Behavior management techniques/programming
   - Medication administration and management
   - Setting-specific emergency and evacuation procedures
   - Appropriate and productive community integration activities
   - Training specific to certain medical needs

   Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must be maintained in the personnel file of the supportive living staff member at all times. This type of individualized, beneficiary-specific training shall be required each time a beneficiary's PCSP is updated, amended, or renewed.
3. Other Required Training. Staff must receive appropriate training on the following topics at least once every two calendar years:
   - HIPAA policies and procedures
   - Procedures for Incident Reporting
   - Emergency and evacuation procedures
   - Introduction to behavior management
   - Arkansas guardianship statutes
   - Arkansas abuse of adult statutes
   - Arkansas Child Maltreatment Act
   - Nurse Practice Act
   - Appeals procedure for individuals served by the program
   - Beneficiary financial safeguards
   - Community integration training
   - Procedures for preventing and reporting maltreatment of children and adults
   - Other topics where circumstances dictate staff should receive training to ensure the health, safety, and welfare of the beneficiary

   Documentation evidencing that training on the topics has been completed must be maintained in the personnel file of the staff member at all times.

Beneficiary Accessibility Requirements

PASSE HCBS provider owned/leased/rented residential settings must be fully accessible by the beneficiary, compatible with the services being provided to the beneficiary, and compatible with the needs of each beneficiary and their staff, as provided in the beneficiary's PCSP. Each PASSE HCBS provider owned/leased/rented residential facility must be in compliance with U.S.C. § 12101 et. seq. American with Disabilities Act of 1990, and 29 U.S.C. §§ 706 (8), 794–794(b) Disability Rights of 1964.

Safe and Comfortable Environment

The PASSE HCBS provider must ensure that each PASSE HCBS provider owned/leased/rented residential settings provide a safe and comfortable environment tailored towards the needs of the beneficiary, as provided for in their PCSP. This shall include, but not be limited to, the following:

1. All PASSE HCBS provider owned/leased/rented residential settings must meet all local and state building codes, regulations and laws.
2. The temperature must be maintained within a normal comfort range for the climate.
3. The interior and exterior of the residential setting must be maintained in a sanitary and repaired condition.
4. The residential setting must be free of offensive odors.
5. The residential setting must be maintained free of infestations of insects and rodents.
6. All materials, equipment, and supplies must be stored and maintained in a safe condition. Cleaning fluids and detergents must be stored in original containers with labels describing contents.

Emergency and Evacuation Procedures

The PASSE HCBS provider must establish emergency procedures that include detailed actions to be taken in the event of emergency and promote safety. Details of emergency plans and procedures must be in written form, and shall be available and communicated to all members of the staff and other supervisory personnel.

A. There shall be written emergency procedures for:
    1. Fires
    2. Natural disasters
    3. Utility failures
    4. Medical emergencies
    5. Safety during violent or other threatening situations

   Additionally, the emergency procedures must satisfy the requirements of applicable authorities, and contain practices appropriate for the locale (example: nuclear evacuations for those living near a nuclear plant).
B. The PASSE HCBS provider shall maintain an emergency alarm system for each type of drill (fire and tornado).
C. Beneficiaries, as appropriate, must be educated and trained about emergency and evacuation procedures.
D. Evacuation procedures must address:
    1. When evacuation is appropriate
    2. Complete evacuation from the physical facility
    3. The safety of evacuees
    4. Accounting for all persons involved
    5. Temporary shelter, when applicable
    6. Identification of essential services
    7. Continuation of essential services
    8. Emergency phone numbers
    9. Notification of the appropriate emergency authorities

Safety Equipment

PASSE HCBS providers must maintain the following items in each setting in which beneficiaries reside:

1. Functioning smoke detectors, heat sensors, carbon monoxide detectors and/or sprinklers
2. Functioning fire extinguishers
3. Functioning flash light
4. Functioning hot water heater
5. Emergency contact numbers (law enforcement, poison control, etc.)
6. First-aid kit

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Required Independence and Integration

Beneficiaries must be safe and secure in their homes and communities, taking into account their informed and expressed choices. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.

A. PASSE HCBS providers must take reasonable steps to ensure that beneficiaries are safe and secure in their homes and communities, taking into account the beneficiary's informed and expressed choices.
B. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.
C. Beneficiaries shall be allowed free use of all space within the group living setting/alternative living site with due regard for privacy, personal possessions of other residents/staff, and reasonable house rules.
D. Settings must be able to provide beneficiaries access to community resources and be located in a safe and accessible location. Beneficiaries must have access to the community in which they are being served. The site shall assure adequate/normal interaction with the community as a group and as an individual. This can be achieved through transportation or through local community resources.
E. The living and dining areas must be provided with normalized furnishings for the usual functions of daily living and social activities.
F. The kitchen shall have equipment, utensils, and supplies to properly store, prepare, and serve three meals a day. Beneficiaries must have access to food at any time. Any modification to this requirement must be based on an assessed need and documented in the beneficiary's PCSP.
G. Bedroom areas are required to meet the following:
    1. Bedrooms shall be arranged so that privacy is assured for beneficiaries. Sole access to these rooms cannot be through a bathroom or other bedrooms. Bedrooms must be equipped with a functioning lock with only appropriate staff having keys.
    2. Beneficiaries must have a choice of roommate when shared by one or more individuals. The PASSE HCBS provider must actively address the need to designate space for privacy and individual beneficiary interests.
    3. Physical arrangements shall be compatible with the physical needs of the individuals.
    4. Each beneficiary shall have an individual bed. Each bed must have a clean, adequate, and comfortable mattress.
        a. Beds are of suitable dimensions to accommodate the beneficiary who is using it. Mattresses must be waterproof as necessary.
        b. Each beneficiary must have a suitable pillow, pillowcase, sheets, blanket, and spread.
        c. Bedding must be appropriate to the season and beneficiary's personal preferences. Bed linens must be replaced with clean linens at least weekly.
    5. Bedroom furnishings for beneficiaries shall include shelf space, individual chest or dresser space, and a mirror. An enclosed closet space adequate for the belongings of each beneficiary must be provided.
    6. The space is 80 square feet per beneficiary in multi-sleeping rooms, and 100 square feet in single bedrooms.
H. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
I. Bathroom areas are required to meet the following criteria:
    1. Sole access may not be through another beneficiary's bedroom. Commodes, tubs, and showers used by beneficiaries must provide for individual privacy.
    2. A minimum of one commode and sink is provided for every four beneficiaries. Lavatories and commode fixtures are designed and installed in an accessible manner so that they are usable by the beneficiaries living in the residential setting.
    3. A minimum of one tub or shower is provided for every eight beneficiaries.
    4. Must be well ventilated by natural or mechanical methods.

HCBS Setting Requirements

All PASSE HCBS providers must meet the HCBS setting regulations as established by CMS. The federal regulation for the rule is 42 CFR 441.301(c) (4)–(5). All PASSE HCBS provider-owned/leased/rented residential settings must have the following characteristics:

1. Be chosen by the beneficiary from among setting options including non-disability specific settings (as well as an independent setting), and an option for a private unit in a residential setting.

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a. Choice must be identified/included in the beneficiary's PCSP.
b. Choice must be based on the beneficiary's needs, preferences, and, for residential settings, resources available for room and board.

2. Ensure a beneficiary's rights of privacy, dignity, and respect and freedom from coercion and restraint.
3. Must optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including daily activities, physical environment, and with whom to interact.
4. Facilitate beneficiary choice regarding services and supports and who provides them.
5. The setting must be integrated in and support full access to the greater community by the beneficiary, including the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as beneficiaries not receiving CES waiver services.
6. The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity.
7. Each beneficiary has privacy in their sleeping or living unit, which must include the following:
   a. Units have entrance doors lockable by the beneficiary, with only appropriate staff having keys to doors.
   b. Beneficiaries sharing units have a choice of roommates in that setting.
   c. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
8. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
9. Beneficiaries are able to have visitors of their choosing at any time.
10. The setting is physically accessible to the beneficiary.
11. Any modification of the additional conditions specified in items 6–10 above must be justified in the beneficiary's PCSP. The following requirements must be documented in the beneficiary's PCSP:
    a. Identify a specific and individualized assessed need.
    b. Document the positive interventions and supports used prior to any modifications to the PCSP.
    c. Document less intrusive methods of meeting the need that have been tried but did not work.
    d. Include a clear description of the condition that is directly proportionate to the specific assessed need.
    e. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
    f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    g. Include the informed consent of the beneficiary.
    h. Include an assurance that interventions and supports will cause no harm to the beneficiary.

EDI Companion Guide Overview

The Companion Guide provides Arkansas Total Care trading partners with guidelines for submitting the ASC X12N/005010x222 Health Care Claim: Professional (837P) and ASC X12N/005010x223 Health Care Claim: Institutional (837I). The Arkansas Total Care Companion Guide documents any assumptions, conventions, or data issues that may be specific to Arkansas Total Care business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Arkansas Total Care and its affiliates.

This document does not replace the HIPAA ASC X12N 5010A TR3 for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Arkansas Total Care. This document provides information on Arkansas Total Care-specific code handling and situation handling that is within the parameters of the HIPAA administrative simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA TR3, their structure, and content. Information contained within the HIPAA TR3s has not been repeated here, although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A TR3 can be purchased at http://store.x12.org.

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The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Arkansas Total Care and its trading partners. Refer to the TPA for guidelines pertaining to Arkansas Total Care legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Arkansas Total Care business rules or technical requirements regarding the implementation of HIPAA-compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the TPA. **If there is an inconsistency with the terms of this guide and the terms of the TPA, the terms of the TPA shall govern.**

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Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Arkansas Total Care.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (TA1, 999). A TA1 Acknowledgment is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgment may be used to verify a successful transmission or to indicate various types of errors. Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

TA1 Interchange Acknowledgment

The TA1 Interchange Acknowledgment provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

999 Functional Acknowledgment

The 999 Functional Acknowledgment reports on all Implementation Guide edits from the functional group and transaction Sets.

277CA Health Care Claim Acknowledgment

The X12N005010X214 Health Care Claim Acknowledgment (277CA) provides a more detailed explanation of the transaction set. Arkansas Total Care also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop. **Note:** The STC03 — Action Code will only be a "U" if the claim failed on HIPAA validation errors, not pre-adjudication errors.

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, Arkansas Total Care checks five values within the ISA for redundancy:

- ISA06, ISA08, ISA09, ISA10, ISA13

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of "025" (Duplicate Interchange Control Number).

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Arkansas Total Care checks the ST02 value (Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted.

Note: ISA08 & GS03 could also be the Single Payer ID

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New Trading Partners

New trading partners should access sites.edifecs.com/index.jsp?conduent, register for access, and perform the steps in the Arkansas Total Care trading partner program. The EDI Support Desk (EDIBA@ArkansasTotalCare.com) will contact you with additional steps necessary upon completing your registration.

Claims Processing Acknowledgments

Senders receive four types of acknowledgment transactions: the TA1 transaction to acknowledge the interchange control envelope (ISA/IEA) of a transaction, the 999 transaction to acknowledge the functional group (GS/GE) and transaction set (ST/SE), the 277CA transaction to acknowledge healthcare claims, and the Arkansas Total Care audit report. At the claim level of a transaction, the only acknowledgment of receipt is the return of the claim audit report and/or a 277CA.

Coordination of Benefits (COB) Processing

To ensure the proper processing of claims requiring coordination of benefits, Arkansas Total Care recommends that providers validate the patient's membership number and supplementary or primary carrier information for every claim.

Code Sets

Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and Reversals

The 837 defines what values submitters must use to signal payers that the Inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both professional and institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3.

Data Format/Content

Arkansas Total Care accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for "CC" (century) within birthdates are 18, 19, or 20.
- Dates that include hours should use the format CCYYMMDDHHMM. Use military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010, at 9:15 p.m.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g. 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a patient's birth date cannot be after the patient's service date.

Decimals

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125. Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Monetary and Unit Amount Values

Arkansas Total Care accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters suggested for use by Arkansas Total Care are specified in the interchange header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation.

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Phone Numbers

Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number 336-555-1212 should be presented as 3365551212. Area codes should always be included. Arkansas Total Care requires the phone number to be AAABBBCCCC, where AAA is the area code, BBB is the telephone number prefix, and CCCC is the ending telephone number.

Additional Items

- Arkansas Total Care will not accept more than 97 service lines per UB-04 claim.
- Arkansas Total Care will not accept more than 50 service lines per CMS 1500 claim.
- Arkansas Total Care will only accept single-digit diagnosis pointers in the SV107 of the 837P.
- The Value Added Network Trace Number (2300-REF02) is limited to 30 characters.

Identification Codes and Numbers

General Identifiers

Federal Tax Identifiers

Any Federal Tax Identifier (Employer ID or Social Security Number) used in a transmission should omit dashes or hyphens. Arkansas Total Care sends and receives only numeric values for all tax identifiers.

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Arkansas Total Care expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Arkansas Total Care will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Arkansas Total Care EDI.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional Claim. The table also clarifies which other elements must be submitted when the NPI is used.

Billing Provider

The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers perform services for a subscriber/patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A) You should only use 2420A when it is different than Loop 2310B/NM1*82.

Referring Provider

Arkansas Total Care has no specific requirements for referring provider information.

Atypical Provider

Atypical Providers are not always assigned an NPI number; however, if an Atypical Provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An Atypical Provider that provides non-medical services is not required to have an NPI number (e.g. carpenters, transportation, etc). Existing Atypical Providers need only send the Provider Tax ID in the REF segment of the billing provider loop. **NOTE:** If an NPI is billed in any part of the claim, it will not follow the Atypical Provider logic.

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Arkansas Total Care requires all practitioners to have a NPI, and for all practitioners billed as the rendering provider on electronic and paper claims transactions to include their NPI on the claim transaction when billing.

Effective March 1, 2024, providers that meet the below criteria are recommended to submit their Arkansas Medicaid ID to Arkansas Total Care on each claim submission.

- All atypical providers and practitioners that bill for the following provider types: 67, 70, 71, 72, 73,74, 75, 82, 84, 86, 87, 95, 96, 97.
- All providers that bill under a single NPI number with multiple associated Medicaid IDs.

All claims meeting the above criteria may encounter processing delays/errors when the Arkansas Medicaid ID is not billed. The tables below indicate where this information should be provided in the 837p.

Professional EDI Claims Billing Provider NPI, Taxonomy, and Medicaid ID:

2010BB – Billing Provider Secondary Identification			
2010BB – Billing Provider Secondary Identification	REF	For healthcare providers, submit the Medicaid Provider ID in REF02, the NPI in Loop 2010AA, and taxonomy in Loop 2000A. For atypical providers, submit the Medicaid ID only in REF02.	
		REF01	Value = G2 (Provider Commercial Number)
		REF02	Length = 9 Value = Billing Provider Secondary Identification (Medicaid Provider ID)

Professional EDI Claims Rendering Provider Medicaid ID:

2010B – Rendering Provider Secondary Identification			
2310B – Rendering Provider Secondary Identification	REF	For healthcare rendering providers, submit the Medicaid Provider ID in REF02 and submit the NPI and Taxonomy in Loop 2310B.	
		REF01	Value = G2 (Provider Commercial Number)
		REF02	Length = 9 Value = Rendering Provider Secondary Identification (Medicaid Provider ID)

Subscriber Identifiers

Submitters must use the entire identification code as it appears on the subscriber's card in the 2010BA element.

Claim Identifiers

Arkansas Total Care issues a claim identification number upon receipt of any submitted claim. The ASC X12 TR3 may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the claim audit report and in the CLP segment of an 835 transaction. Arkansas Total Care returns the submitter's Patient Account Number (2300, CLM01) on the claim audit report and the 835 Claim Payment/Advice (CLP01).

Connectivity Media for Batch Transactions

Secure File Transfer

Arkansas Total Care encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Arkansas Total Care offers two options for connectivity via FTP.

- Method A — The trading partner will push transactions to the Arkansas Total Care FTP server, and Arkansas Total Care will push outbound transactions to the Arkansas Total Care FTP server.
- Method B — The trading partner will push transactions to the Arkansas Total Care FTP server, and Arkansas Total Care will push outbound transactions to the trading partner's FTP server.

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Encryption

Arkansas Total Care offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS. Note that this method applies only when connecting to Arkansas Total Care's Secure FTP. Arkansas Total Care does not support retrieving files automatically via HTTPS from an external source at this time. If PGP or SSH keys are used, they will be shared with the trading partner. They are not required for those connecting via SFTP or HTTPS.

Direct Submission

Arkansas Total Care also offers posting an 837 batch file directly on the secure provider portal for processing.

Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for Arkansas Total Care business rules requirements. The business rules that define these requirements are identified in the 837 Professional Data Element Table as well as in a comprehensive list in the 837 Professional Claims – Arkansas Total Care Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999, while Arkansas Total Care business edit errors are returned on the Arkansas Total Care claim audit report.

Reporting

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
ISA/IEA Interchange Control		TA1
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide violations	999 Arkansas Total Care claim audit report (a proprietary confirmation and error report)
Detail Segments	Arkansas Total Care business edits (see audit report rejection reason codes and explanation)	Arkansas Total Care claim audit report (a proprietary confirmation and error report)
Detail Segments	HIPAA Implementation Guide violations and Arkansas Total Care business edits	277CA

277CA/Audit Report Rejection Codes	
Error Code	**Rejection Reason**
01	INVALID MBR DOB
02	INVALID MBR
06	INVALID PROVIDER
07	INVALID MBR DOB & PROVIDER
08	INVALID MBR & PROVIDER
09	MBR NOT VALID AT DOS
10	INVALID MBR DOB; MBR NOT VALID AT DOS
12	PROVIDER NOT VALID AT DOS
13	INVALID MBR DOB; PRV NOT VALID AT DOS
14	INVALID MBR; PRV NOT VALID AT DOS
15	MBR NOT VALID AT DOS; INVALID PRV
16	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID PRV
17	INVALID DIAG CODE

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277CA/Audit Report Rejection Codes	
Error Code	Rejection Reason
18	INVALID MBR DOB; INVALID DIAG
19	INVALID MBR; INVALID DIAG
21	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS
22	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS
23	INVALID PRV; INVALID DIAGNOSIS CODE
24	INVALID MBR DOB; INVALID PRV; INVALID DIAG CODE
25	INVALID MBR; INVALID PRV; INVALID DIAG CODE
26	MBR NOT VALID AT DOS; INVALID DIAG CODE
27	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID DIAG CODE
29	PROVIDER NOT VALID AT DOS; INVALID DIAG CODE
30	INVALID MBR DOB; PRV NOT VALID AT DOS; INVALID DIAG
31	INVALID MBR; PRV NOT VALID AT DOS; INVALID DIAG
32	MBR NOT VALID AT DOS; PRV NOT VALID; INVALID DIAG
33	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID PRV; INVALID DIAG
34	INVALID PROC
35	INVALID MBR DOB; INVALID PROC
36	INVALID MBR; INVALID PROC
37	INVALID FUTURE SERVICE DATE
38	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG
39	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG
40	INVALID PRV; INVALID PROC
41	INVALID MBR DOB, INVALID PRV; INVALID PROC
42	INVALID MBR; INVALID PRV; INVALID PROC
43	MBR NOT VALID AT DOS; INVALID PROC
44	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID PROC
46	PRV NOT VALID AT DOS; INVALID PROC
48	INVALID MBR; PRV NOT VALID AT DOS; INVALID PROC
49	MBR NOT VALID AT DOS; INVALID PRV; INVALID PROC
51	INVALID DIAG; INVALID PROC
52	INVALID MBR DOB; INVALID DIAG; INVALID PROC
53	INVALID MBR; INVALID DIAG; INVALID PROC
55	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID PROC
57	INVALID PRV; INVALID DIAG; INVALID PROC
58	INVALID MBR DOB; INVALID PRV; INVALID DIAG; INVALID PROC
59	INVALID MBR; INVALID PRV; INVALID DIAG; INVALID PROC
60	MBR NOT VALID AT DOS;INVALID DIAG;INVALID PROC
61	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID DIAG; INVALID PROC

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277CA/Audit Report Rejection Codes	
Error Code	Rejection Reason
63	PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
64	INVALID MBR DOB; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
65	INVALID MBR; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
66	MBR NOT VALID AT DOS; INVALID PRV; INVALID DIAG; INVALID PROC
67	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID PRV; INVALID DIAG; INVALID PROC
72	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
73	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
74	SERVICES PERFORMED PRIOR TO CONTRACT EFFECTIVE DATE
75	INVALID UNITS OF SERVICE
76	ORIGINAL CLAIM NUMBER REQUIRED
77	INVALID CLAIM TYPE
78	DIAGNOSIS POINTER- NOT IN SEQUENCE OR INCORRECT LENGTH
81	INVALID UNITS OF SERVICE, INVALID PRV
83	INVALID UNITS OF SERVICE, INVALID PRV, INVALID MBR
89	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG
91	INVALID MISSING TAXONOMY OR NPI/INVALID PROV
92	INVALID REFERRING/ORDERING NPI
93	MBR NOT VALID AT DOS; INVALID PROC
96	GA OPR NPI REGISTRATION-STATE
A2	DIAGNOSIS POINTER INVALID
A3	SERVICE LINES GREATER THAN 97 SERVICE LINES SUBMITTED INVALID
B1	RENDERING AND BILLING NPI ARE NOT TIED ON STATE FILE IN REJECTION
B2	NOT ENROLLED WITH MHS IN AND/OR STATE WITH RENDERING NPI/TIN ON DOS. ENROLL WITH MHS AND RESUBMIT CLAIM
B5	INVALID CLIA
C7	NPI REGISTRATION — STATE GA OPR
C9	INVALID/MISSING ATTENDING NPI
HP/H1/H2	ICD-9 AFTER END DATE/ICD-10 SENT BEFORE EFFECTIVE DATE/MIXED ICD VERSIONS

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Appendix

Appendix I: Common Causes for Upfront Rejections

Common causes for upfront rejections include but are not limited to:

- Unreadable Information. The ink is faded, too light, or too bold (bleeding into other characters or beyond the box). The font is too small.
- Member DOB is missing.
- Member name or identification number is missing.
- Provider name, TIN, or NPI number is missing.
- Attending provider information is missing from Loop 2310A on institutional claims when the CLM05-1 bill type is 11, 12, 21, 22, or 72, or missing from Box 48 on the paper UB claim form.
- Date of service is not prior to the received date of the claim (future date of service).
- Date of service or date span is missing from required fields. Example: “Statement From” or “Service From” dates.
- Type of bill is invalid.
- Diagnosis code is missing, invalid, or incomplete.
- Service line detail is missing.
- Date of service is prior to member’s effective date.
- Admission type is missing (Inpatient Facility Claims — UB-04, Field 14).
- Patient status is missing (Inpatient Facility Claims — UB-04, Field 17).
- Occurrence code/date is missing or invalid.
- Revenue code is missing or invalid.
- CPT/procedure code is missing or invalid.
- A missing CLIA number in Box 23 or a CMS 1500 for CLIA or CLIA-waived service.
- Incorrect form type used.
- A missing taxonomy code and qualifier in Box 24 I, 24 J, or 33 B on the CMS 1500 form, or Box 81 CC on the UB04 form (see further requirements in this manual).

Appendix II: Common Causes of Claims Processing Delays and Denials

- Procedure or modifier codes entered are invalid or missing.
  - This includes GN, GO or GP modifier for therapy services.
- Diagnosis code is missing the fourth or fifth digit.
- DRG code is missing or invalid.
- Explanation of benefits from the primary insurer is missing or incomplete.
- Third-party liability information is missing or incomplete.
- Member ID is invalid.
- Place of service code is invalid.
- Provider TIN and NPI do not match.
- Revenue code is invalid.
- Dates of service span do not match the listed days/units.
- TIN is invalid.

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Appendix III: Common EOP Denial Codes

- See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic EOPs will use standard HIPAA denial codes.

EX Code	Description
18	DENY: DUPLICATE CLAIM SERVICE
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
29	DENY: TIME LIMIT FOR FILING HAS EXPIRED
46	DENY: THIS SERVICE IS NOT COVERED
0B	ADJUST: CLAIM TO BE RE-PROCESSED CORRECTED UNDER NEW CLAIM NUMBER
A1	DENY: NO AUTHORIZATION ON FILE THAT MATCHES SERVICE(S) BILLED
AB	ACE LINE ITEM REJECTION
AQ	ACE CLAIM LEVEL RETURN TO PROV. MUST CALL PROV SERVICES FOR MORE DETAIL
AT	ACE CLAIM LEVEL REJECTION
fq	DENY: RESUBMIT CLAIM UNDER FQHC RHC CLINIC NPI NUMBER
IM	DENY: MODIFIER MISSING OR INVALID
M3	DENY: NO ASSOCIATED FACILITY CLAIM RECEIVED
w1	CO-SURGEON/TEAM SURGEON DISALLOWED PER CMS SURGICAL BILLING GUIDELINES
w2	ASSISTANT & PRIMARY SURGEON PROCEDURE CODES MUST MATCH PER CMS
w3	ASSISTANT, CO-SURGEON, OR TEAM SURGEONS NOT TYPICALLY REQUIRED PER CMS
w4	INAPPROPRIATE LEVEL OF E/M SERVICE BILLED PER AMA GUIDELINES
w5	PRIMARY SERVICE IS DENIED; THEREFORE, ADD-ON SERVICE IS DENIED PER AMA
w6	STATE-SPECIFIC GUIDELINE: PROCEDURE CODE TO REVENUE CODE MISMATCH
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE, OR UNBUNDLED
xE	PROCEDURE CODE IS DISALLOWED WITH THIS DIAGNOSIS CODE(S) PER PLAN POLICY
xf	MAXIMUM ALLOWANCE EXCEEDED
y1	DENY: SERVICE RENDERED BY NON AUTHORIZED NON PLAN PROVIDER
ya	DENIED AFTER REVIEW OF PATIENT'S CLAIM HISTORY
yf	HCI PARTIALLY APPROVED UNITS; CLAIM NEEDS MANUAL PRICING
yq	DUPLICATE CLAIMS OR MULTIPLE PROVIDERS BILLING SAME/SIMILAR CODE(S)
yr	INCORRECT PROCEDURE CODE FOR DIAGNOSIS PER NCD/CMS
ys	REIMBURSEMENT INCLUDED IN ANOTHER CODE PER CMS/AMA/MEDICAL GUIDELINES
yt	INCORRECT PROCEDURE CODE FOR MEMBER AGE OR GENDER PER CMS/AMA/PLAN
yu	INCORRECT CPT/HCPCS/REV/MODIFIER OR UNLISTED CODE BASED ON CPT/CMS GUIDELINES
yv	OUTPATIENT SERVICES INCLUDED IN INPATIENT ADMIT PER CMS/PLAN GUIDELINES
yw	NOT COVERED OR ELIGIBLE SERVICE PER CMS OR PLAN GUIDELINES
yx	INCLUDED IN GLOBAL SURGICAL OR MATERNITY PACKAGE PER CMS OR ACOG
yy	REIMBURSEMENT REDUCTION BASED ON CPT AND/OR CMS
yz	INCORRECT USE OF MODIFIER -26 OR -TC BASED ON CMS
Za	DENY - PROVIDER BILLING ERROR
ZW	AFTER RVW, PREV DECISION UPHELD, SEE PROV HANDBOOK FOR APPEAL PROCESS

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Appendix IV: Instructions for Supplemental Information

CMS 1500 (02/12) Form, Shaded Field 24A–G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) claim form field 24-A-G:

- National Drug Code (NDC)
- Narrative description of unspecified/miscellaneous/unlisted codes
- Contract rate

The following qualifiers are to be used when reporting these services:

- ZZ narrative description of unspecified/miscellaneous/unlisted codes
- N4 NDC
- CTR contract rate

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of item 24. Enter the first qualifier and number/code/information on 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollar signs.

When adding supplemental information for NDC, enter the information in the following order:

- Qualifier
- NDC
- One space:
  - Unit/basis of measurement qualifier
  - F2 — International Unit
  - ME — Milligram
  - UN — Unit
  - GR — Gram
  - ML — Milliliter
- Quantity:
  - The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (e.g. 99999999.999).
  - When entering a whole number, do not use a decimal (e.g. 2).
  - Do not use commas.

Unspecified/Miscellaneous/Unlisted Codes

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached															
														NPI	

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker													N	G2	12345678901
10	01	05	10	01	05	11		E1399		12	165 00	1	N	NPI	0123456789

NDC Codes

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

Appendix V: Common HIPAA-Compliant EDI Rejection Codes

These codes are the Standard National Rejection Codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Error ID	Error Description
01	INVALID MBR DOB
02	INVALID MBR
06	INVALID PRV
07	INVALID MBR DOB & PRV
08	INVALID MBR & PRV
09	MBR NOT VALID AT DOS
10	INVALID MBR DOB; MBR NOT VALID AT DOS
12	PRV NOT VALID AT DOS
13	INVALID MBR DOB; PRV NOT VALID AT DOS
14	INVALID MBR; PRV NOT VALID AT DOS
15	MBR NOT VALID AT DOS; INVALID PRV
16	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID PRV
17	INVALID DIAG
18	INVALID MBR DOB; INVALID DIAG
19	INVALID MBR; INVALID DIAG
21	MBR NOT VALID AT DOS;PRV NOT VALID AT DOS
22	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS
23	INVALID PRV; INVALID DIAG
24	INVALID MBR DOB; INVALID PRV; INVALID DIAG
25	INVALID MBR; INVALID PRV; INVALID DIAG
26	MBR NOT VALID AT DOS; INVALID DIAG
27	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID DIAG
29	PRV NOT VALID AT DOS; INVALID DIAG
30	INVALID MBR DOB; PRV NOT VALID AT DOS; INVALID DIAG
31	INVALID MBR; PRV NOT VALID AT DOS; INVALID DIAG
32	MBR NOT VALID AT DOS; PRV NOT VALID; INVALID DIAG
33	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID; INVALID DIAG
34	INVALID PROC
35	INVALID DOB; INVALID PROC
36	INVALID MBR; INVALID PROC
37	INVALID OR FUTURE DATE
38	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG
39	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG
40	INVALID PRV; INVALID PROC
41	INVALID PRV; INVALID PROC; INVALID MBR DOB
42	INVALID MBR; INVALID PRV; INVALID PROC
43	MBR NOT VALID AT DOS; INVALID PROC

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Error ID	Error Description
44	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID PROC
46	PRV NOT VALID AT DOS; INVALID PROC
48	INVALID MBR; PRV NOT VALID AT DOS, INVALID PROC
49	INVALID PROC; INVALID PRV; MBR NOT VALID AT DOS
51	INVALID DIAG; INVALID PROC
52	INVALID MBR DOB; INVALID DIAG; INVALID PROC
53	INVALID MBR; INVALID DIAG; INVALID PROC
55	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS, INVALID PROC
57	INVALID PRV; INVALID DIAG; INVALID PROC
58	INVALID MBR DOB; INVALID PRV; INVALID DIAG; INVALID PROC
59	INVALID MBR; INVALID PRV; INVALID DIAG; INVALID PROC
60	MBR NOT VALID AT DOS; INVALID DIAG; INVALID PROC
61	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID DIAG; INVALID PROC
63	PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
64	INVALID MBR DOB; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
65	INVALID MBR; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
66	MBR NOT VALID AT DOS; INVALID PRV; INVALID DIAG; INVALID PROC
67	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID PRV; INVALID DIAG; INVALID PROC
72	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
73	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
74	REJECT. DOS PRIOR TO 6/1/2006; OR INVALID DOS
75	INVALID UNIT
76	ORIGINAL CLAIM NUMBER REQUIRED
77	INVALID CLAIM TYPE
81	INVALID UNIT; INVALID PRV
83	INVALID UNIT; INVALID MBR & PRV
89	INVALID PRV; MBR NOT VALID AT DOS; INVALID DOS
91	MISSING OR INVALID TAXONOMY CODE
A2	DIAGNOSIS POINTER INVALID
A3	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
B1	RENDERING AND BILLING NPI ARE NOT TIED ON STATE FILE
B2	NOT ENROLLED WITH MHS AND/OR STATE WITH RENDERING NPI/TIN ON DOS. ENROLL WITH MHS AND RESUBMIT CLAIM
B5	MISSING/INCOMPLETE/INVALID CLIA CERTIFICATION NUMBER
H1	ICD-9 IS MANDATED FOR THIS DATE OF SERVICE
H2	INCORRECT USE OF THE ICD-9/ICD-10 CODES
HP	ICD-10 IS MANDATED FOR THIS DATE OF SERVICE
ZZ	CLAIM NOT PROCESSED

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Appendix VI: Claim Form Instructions

Billing Guide for a CMS 1500 and CMS 1450 (UB-04) Claim Form

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

Note: Claims with missing or invalid required field information will be rejected or denied.