arkansas total care™

Provider Manual

ArkansasTotalCare.com | 1-866-282-6280 (TDD/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 Managed Care Organization, Arkansas Total Care staff work with members and providers to ensure that both parties have the information and resources they need 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 phone numbers where you can reach our staff for all your needs as one of our valued provider partners.

About Us

Arkansas Total Care is a Provider-Led Arkansas Shared Savings Entity (PASSE), a partnership between an insurance payer, a provider group, and a specialty services provider. We serve participants in the Arkansas Medicaid program as a Managed Care Organization.

PASSE's were developed in Arkansas to provide more extensive care coordination to high-needs Intellectual/Developmentally Disabled (IDD) persons and persons with Behavioral Health (BH) needs. In our PASSE, Arkansas Total Care acts as the insurance payer, Mercy Health is the Provider Group and Life Share is our Specialty Services Provider. The goal of partnering with a provider group 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 connecting members to community resources.

About this Manual

The 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 from the "For Providers" section of our website, www.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:

1. National Provider Identifier (NPI) number
2. Tax ID Number (TIN)
3. Member's Arkansas Total Care ID or Medicaid ID

HEALTH PLAN INFORMATION		
Website	https://www.ArkansasTotalCare.com/	
Health Plan address	Arkansas Total Care P.O. Box 25010 Little Rock, AR 72221	
Department	**Phone**	**Fax**
Provider Services	1-866-282-6280 TTY: 711	1-833-249-2348
Member Services		1-833-249-2342
Inpatient and Outpatient Prior Authorization (PA) Requests		1-833-632-6934
Concurrent Review/Clinical Information		1-833-513-5041
Admissions		1-833-632-6934
Medical Management		1-833-513-5041
24/7 Nurse Advice Line		NA
Envolve Pharmacy Services – pharmacy.envolvehealth.com		NA
Advanced Imaging (MRI, CT, PET) (NIA)	1-866-500-7685	NA
Envolve Vision Visionbenefits.envolvehealth.com	1-866-282-6280	NA
To report suspected fraud, waste and abuse	1-866-685-8664	NA
EDI Claims assistance	1-800-225-2573 ext. 6075525	e-mail: EDIBA@centene.com

SECURE PROVIDER PORTAL

Arkansas Total Care offers a robust secure provider portal with functionality that is critical to serving members and to ease administration for the Arkansas Total Care product for providers. The Portal can be accessed at www.ArkansasTotalCare.com. All Providers and designated office staff have the opportunity to register for the secure provider portal. Upon registration, tools are available 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 may:

- Check eligibility and view member roster;
- View the specific benefits for a member;
- View the status of all claims that have been submitted regardless of how submitted;
- Update provider demographic information (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 specific to a member, including preventive care or services needed for chronic conditions; and
- 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 permission access 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.

CREDENTIALING AND RECREDENTIALING

The credentialing and recredentialing process exists to verify 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/provider already participates with Arkansas Health & Wellness in the Medicaid or a Medicare product, the practitioner/provider will NOT be separately credentialed for the Arkansas Total Care product.

Notice: In order to maintain a current practitioner/provider profile, practitioners/providers are required to notify Arkansas Total Care of any relevant changes to their credentialing information in a timely manner but in no event 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; and
- 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, or 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/Medicaid services (OIG-Office of Inspector General).

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

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

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

Credentialing Committee

The Credentialing Committee, including the Medical Director or his/her physician designee, has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures. Committee meetings are typically held at least monthly and more often as 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 committee 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. The purpose of this process is to identify any changes in the practitioner's/provider's licensure, sanctions, certification, competence, or health status which may affect the practitioner's/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.

In between credentialing cycles, Arkansas Total Care conducts provider performance monitoring activities on all network practitioners/providers. Arkansas Total Care reviews monthly reports released by both Federal and State entities to identify any network practitioners/providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid. Arkansas Total Care also reviews member complaints/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 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 of 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 844-263-2437 or arkcredentialing@centene.com. The Credentialing Department can also be contacted for status of provider additions, terminations, or changes from providers with an existing Provider Agreement.

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 from 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:

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

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

Primary Care Practitioner (PCP)

The Primary Care Practitioner (PCP) is a specific physician or physician group operating under the scope of his or her 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 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 supports continuity of care, and patient safety. This leads to elimination of redundant services, cost effective care, and better health outcomes.

Arkansas Total Care requires PCPs, dentists, and Specialists to conduct affirmative 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 (3) attempts to contact the member. Attempts may include, but are not limited to: written attempts, telephone calls, and home visits. At least one (1) such attempt must be a follow-up telephone call.

Provider Types That May Serve As PCPs

Providers who may serve as primary care providers (PCP) 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 that practice under the supervision of the above specialties.

The PCP may practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (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 health care needs, multiple disabilities, or with 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.

The PCP to member ratio shall not exceed the following limits:

Practitioner Type	Ratio
General/Family Practitioners	One per 1,000 members
Pediatricians	One per 1,000 members
Internists	One per 1,000 members

Notification can 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 his/her panel unless the PCP has reached his/her 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 other non-members.

Member Selection or Assignment of PCP

Arkansas Total Care members will be directed to select a participating Primary Care Provider at the time of enrollment. In the event an Arkansas Total Care member does not make a PCP choice, Arkansas Total Care will usually assign the member a PCP based on:

1. **A previous relationship with a PCP.** If a member has not designated a PCP within the first 30 to 60 days of being enrolled in Arkansas Total Care, Arkansas Total Care will review and assign the member to the most recent PCP who has submitted claims for the member within the last 90 days.
2. **Geographic proximity of PCP to member residence.** The auto-assignment logic is designed to select a PCP for whom the members will not travel more than the required access standards.
3. **Appropriate PCP type.** The algorithm will use age, gender, and other criteria to identify an appropriate match, such as children assigned to pediatricians.

Members are advised to contact the Member Services Department at 1-866-282-6280 to change his or her PCP.

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 Arkansas Total Care Member Services detailing the intent to withdraw care. The letter must include information on the transfer of medical records as well as emergency and interim care.

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 which 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 the following 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 an arranging for care
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the DHS data specifications
- Maintaining continuity of each member's healthcare
- When needed, effectively communicate with the member by using (free of charge to the member):
    - Sign language interpreters for those who are deaf or hard of hearing
    - Oral interpreters for those individuals with 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 Behavioral Health Services covered through the Behavioral Health MCOs
- Allow 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

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 must should:

- Maintain contact and open communication with the member's referring PCP;
- Obtain required authorization from the Medical Management Department, if applicable, 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 receipt of 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; and
- Actively participate in and cooperate with all quality initiatives and programs.

Hospital Responsibilities

Arkansas Total Care has established a comprehensive network of hospitals to provide services to members. Hospital services and hospital-based providers must be qualified to provide services under the program. All services must be provided in accordance with applicable state and federal laws and regulations and 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 www.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 by our secure provider portal, fax, or by phone; and
- Adhere to the standards set Timeframes 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 our 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, within 15 calendar days of the receipt of the termination notice from the Provider, provided that such notice from the Provider was timely.

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:

1. Arkansas Total Care will conduct appointment accessibility surveys telephonic 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.
    - On-Site: Tier 1 Providers
    - Telephonic – All other Providers
2. Arkansas Total Care will assess all PCPs and providers with a minimum of 50% of current enrollment in each geographical region and randomly audit to ensure the following services are available.
3. Arkansas Total Care will also survey their top 5 specialties to ensure specialty access standards are being met. The state may determine what specialties are to be audited, and health plan should comply with those requirements. If the State does not determine which specialties to audit, Arkansas Total Care will select their top 5 specialties for survey.

The table below depicts the appointment availability for members:

Service Type	Time Frame
Emergency Care—Medical, Behavioral Health, Substance Abuse	24 hours a day, 7 days a week
Behavioral Health Service and Developmental Disability Service Mobile Crisis Service Mobile Crisis Response	24 hours a day, 7 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 hours/7 days a week 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

Provider Phone Call Protocol

PCPs and specialist providers must:

- Answer the member's telephone inquiries on a timely basis;
- Schedule appointments in accordance with 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 cancelled and no-show appointments;
- Identify special member needs while scheduling an appointment (e.g., 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; and
- Document after-hours calls in a written format in 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 his/her designee should contact the urgent care center or emergency department in order to notify the facility of the patient's impending arrival. Arkansas Total Care does not require prior-authorization for emergent care.

Arkansas Total Care will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

Provider Data Updates and Validation

Arkansas Total Care believes that providing easy access to care for our members is extremely important. When information (for instance address, office hours, specialties, phone number, hospital affiliations, etc.) 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, perform regular audits of our provider directories.

We need your support and participation in these efforts. CMS may also be auditing 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 health care services on an ongoing basis and must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours; and
- A member must be able to access his/her 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; 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 are answered by a recording telling callers to leave a message;
- Calls received after-hours are answered by a recording directing patients to go to an emergency room for any services needed; or
- 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, PCP, specialist providers, or covering professional 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.

Arkansas Total Care will monitor provider's compliance with this provision through scheduled and unscheduled visits and audits conducted by Arkansas Total Care staff.

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 to, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements. Providers are also contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential Provider and 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 or condition
- The provision of health care 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
- Many common identifiers (e.g. name, address, birth date, 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, and applicable contractual requirements. Arkansas Total Care' privacy policy conforms with 45 c.f.r. (code of federal regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information (PHI) (§164.520, 522, 524, 526, and 528).

Arkansas Total Care' policy also assists our personnel and Providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request including:

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 we're unable to verify his/her identity or authority to act as the member's authorized representative
- The documents requested are not part of the designated record set (e.g., 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 (e.g., accounting for certain disclosures)
- Accommodating the request would place excessive demands on us or our time and resources and is not contrary to HIPAA

ARKANSAS TOTAL CARE BENEFIT

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 Provider Services at 1-866-282-6280. A Provider Service Representative will be happy to assist you.

Arkansas Total Care covers, at a minimum, those core benefits and services specified in our Agreement with Arkansas State Medicaid 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 Community Independence Waiver services and Community & Employment Supports Waiver services, including therapy services and services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program for children.

State Plan Services

- Personal Care
- Primary Care Physician
- Durable Medical Equipment
- Occupational Therapy
- Speech Therapy
- Physician Specialists
- Pharmacy
- Hospital Services
- Physical Therapy
- Nursing services
- Family Planning
- Inpatient Psychiatric
- Outpatient Behavioral
- Health Counseling

Community & Employment Supports Waiver

- Respite
- Supported Employment
- Supported Living
- Community Transition Services
- Supplemental Support
- Specialized Medical Supplies
- Adaptive Equipment
- Environmental Modifications
- Consultation
- Crisis Intervention

Arkansas Community Independence Waiver

- Supportive Employment
- Planned Respite
- Emergency Respite
- Behavior Assistance
- Peer Support
- Family Support Partners
- Adult Rehabilitation Day Treatment
- Child & Youth Support Services
- Individual Life Skills Development
- Crisis Intervention
- Mobile Crisis Intervention
- Therapeutic Host Home
- Therapeutic Communities
- Supportive Housing
- Partial Hospitalization
- Community Reintegration Program
- Supportive Life Skills
- Group Life Skills Development

If a person is eligible to receive these services, Medicaid will still cover them; however, these services will not be managed by Arkansas Total Care.

- Nonemergency Medical Transportation (NET)
- Dental benefits in a capitated program
- School-based services provided by school employees
- Skilled nursing facility services (Limited Rehabilitation Stay is not considered an excluded skilled nursing facility service)
- Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices program, or a successor waiver for the elderly and adults with physical disabilities.

Sterilization

Sterilization procedures, such as tubal ligation and vasectomy, are covered when coordinated through a PCP and

delivered by a network Provider. As a Provider, you must counsel the member regarding alternative methods of birth control that are available. The sterilization procedure is permanent and the surgery cannot be 100% guaranteed to make him/her sterile. Inform the member that the signed consent can be withdrawn at any time and that he/she 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 he/she voluntarily signs 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. The form can be found on the website at ArkansasTotalCare.com.

Abortion

An abortion is only covered in cases where the mother's life is in danger or pregnancy is the result of rape or incest, or the woman suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition that manifests during pregnancy, which would, as certified by a physician, placed the woman in danger of death unless an abortion is performed.

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 Acknowledgement for Hysterectomy Form prior to performing the procedure. The consent form must accompany the claim to obtain payment. The form can be found on the website at ArkansasTotalCare.com.

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 it is medically necessary, or is a covered service, and provided to an eligible member.

Please visit our website at Arkansastotalcare.com or call Provider Services at 1-866-282-6280 for a complete listing of these services.

VERIFYING MEMBER BENEFITS AND ELIGIBILITY

Importance of Verifying Benefits, Eligibility, and Cost Shares

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. In the event a member receives care during which time they are not considered eligible the member shall be held liable for the cost of Covered Services received during the grace period. Claims will not be paid if it is determined the member is not eligible for dates of service.

Member Identification Card

All 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)

All new Arkansas Total Care members receive an Arkansas Total Care member ID card. Members will 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 services are required.

Methods to Verify Benefits, Eligibility, and Cost Shares

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

1. **Log on to our Secure Provider Web Portal** at ArkansasTotalCare.com. Using our secure Provider Portal, you can check member eligibility. You can search by date of service and either of the following: Member name and date of birth, or member Arkansas Total Care ID 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.

1. **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 automated system will prompt you to enter the member's Arkansas Total Care ID and the month of service to check eligibility.

2. **Call Arkansas Total Care Provider Services.** 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. Provider Services will need the member name, member Arkansas Total Care ID, and member date of birth to check eligibility.

Through Arkansas Total Care's Secure Provider Portal, PCPs are able to access a list of eligible members who have selected their services or were assigned to them. The list also provides other important information, including indicators for patients whose claims data show a gap in care. To view this list, log on to ArkansasTotalCare.com.

Eligibility changes can occur throughout the month and 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

24/7 Toll Fee Interactive Voice Response (IVR) Line at 1-866-282-6280	The automated system will prompt you to enter the member ID number and the month of service to check eligibility.
Provider Services at 1-866-282-6280	If you cannot confirm a member's eligibility using the secure portal or the 24/7 IVR line, call Provider Services. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will require the member name or member ID number and date of birth to verify eligibility.

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 will be 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 health care while at the same time 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 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 underutilization. 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 will result in denial of coverage.

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 which:

- 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 that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
- When specifically applied to a hospital confinement, it means that the diagnosis and treatment of the medical symptoms or conditions cannot be safely provided as an outpatient.
- Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity or the recipient and those functional capacities are appropriate of 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 Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the member.

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

Timeframes for Prior Authorization Requests and Notifications

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

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient service date
Emergent inpatient admissions	Notification within 24 hours or by the next day
Organ transplant initial evaluation	Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services.
Clinical trials services	Prior Authorization required at least 30 days prior to receiving clinical trial services.

Utilization Determination Timeframes

Authorization decisions are made as expeditiously as possible. Below is a list of specific timeframes utilized by Arkansas Total Care. In some cases it may be necessary for an extension to extend the timeframe below. You will be notified if an extension is necessary. Please contact Arkansas Total Care if you would like a copy of the policy for UM timeframes.

Type	Timeframe
Prospective/Urgent	72 hours
Prospective/Non-Urgent	5 business days
Concurrent/Urgent	24 hours

Services Requiring Prior Authorization

A list of services requiring prior authorization is available on our website at ArkansasTotalCare.com. To verify a service requires prior authorization, please visit the Arkansas Total Care website at ArkansasTotalCare.com/, and use the “Pre-Auth Needed?” tool under For Providers – Provider Resources, or call the Utilization Management Department with questions. Failure to obtain the required prior authorization or pre-certification may result in a denied claim or reduction in payment. Note: All out of network services require prior authorization, excluding emergency room services.

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 hospitalist services related to a procedure or hospital stay requiring a pre-authorization will be considered and will not require a separate pre-authorization.

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

Procedure for Requesting Prior Authorizations

Medical

Secure Portal

The preferred method for submitting authorizations is through the secure provider portal at ArkansasTotalCare.com/

The provider must be a registered user on 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. If the provider is not already a registered user on the secure provider portal and

needs assistance or training on submitting prior authorizations, the provider should contact his or her dedicated Provider Relation Specialist. Other methods of submitting the prior authorization requests are as follows:

Phone

Phone 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

Fax prior authorization requests utilizing the Prior Authorization fax forms posted on the Arkansas Total Care website at ArkansasTotalCare.com

Please note: faxes will not be monitored after hours and will be responded to on the next business day. Please contact our 24/7 Nurse Advice Line at 1-866-282-6280 for after hour urgent admissions, 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 utilized):

- 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;

The procedure code(s); Note: If the procedure codes submitted at the time of authorization differ from the services actually performed, it is **required** within 72 hours or prior to the time the claim is submitted that you phone Medical Management at 1-866-282-6280

- to update the authorization; otherwise, this may result in claim denials;
- Relevant clinical information (e.g. Past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed);
- Admission date or proposed surgery date if the request is for a surgical procedure;
- Discharge plans; and

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 services. 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, and
- 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; and
- 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 Authorizations

NIA provides an interactive website (www.RadMD.com) which should be used to obtain on-line authorizations. For urgent authorization requests please call 1-866-282-6280, and follow the prompt for radiology authorizations. For more information call our Provider Services department at 1-866-282-6280.

PHARMACY

Arkansas Total Care is committed to providing appropriate, high quality, and cost-effective outpatient medications as listed on the CMS Quarterly Drug Information File, when determined to be medically necessary to all Arkansas Total Care Participants. We work with Providers and Pharmacists to ensure 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 (PA) and/or have limitations on age, dosage and/or maximum quantities. Through an exception process, authorizations are granted for these medically necessary medications.

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

Working With the Pharmacy Benefit Manager (PBM)

Arkansas Total Care works with Envolve Pharmacy Solutions to administer pharmacy benefits, including the Prior Authorization process. Certain drugs require Prior Authorization to be approved for payment by Arkansas Total Care.

Pharmacy Prior Authorization

Drug Prior Authorization request can be submitted to Envolve Pharmacy Solutions through phone, fax or online. To ensure timeliness of our Participants' pharmacy needs, Arkansas Total Care has a strict twenty four (24) hour turnaround time requirement to process these requests.

Phone

- Prescribers may call Envolve Pharmacy Solutions to initiate a Prior Authorization by calling 1- 866-399-0928
- The Envolve Pharmacy Solutions Prior Authorization (PA) Help Desk is staffed with PA Triage Specialists 7 days a week, 365 days a year - 8am-9pm EST
- During regular business hours, licensed Clinical Pharmacists and Pharmacy Technicians are available to answer questions and assist Providers. A nurse advice line is available to assist Providers outside regular business hours.

FAX

- Prescribers may complete the Arkansas Total Care/Envolve Pharmacy Solutions Medication Prior Authorization Request form, found on the Arkansas Total Care website at ArkansasTotalCare.com
- Fax to Envolve Pharmacy Solutions at 1-866-399-0929
- Once approved, Envolve Pharmacy Solutions notifies the prescriber by fax
- When medical necessity criteria is 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

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Fax to Envolve Pharmacy Solutions at 1-866-399-0929
Once approved, Envolve Pharmacy Solutions notifies the prescriber by fax
When medical necessity criteria is 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 - Pharmacy

CoverMyMeds is an online drug prior authorization (PA) program through Envolve Pharmacy Solutions that allows prescribers to begin the PA process electronically. Prescribers locate the correct form, fill it out online, and then submit it to Envolve Pharmacy Solutions via fax. **CoverMyMeds** simplifies the PA submission process by automating drug prior authorizations for any medication.
CoverMyMeds can be found at https://www.covermymeds.com/epa/envolverx/

A pharmacy can provide up to a 72 hour supply of medically necessary outpatient medications by calling the Envolve Pharmacy Solutions Pharmacy Help Desk at 1-888-321-3120.

Pharmacy Claim Submission

For Envolve Pharmacy Solutions Pharmacy Paper Claim submissions, send correspondence to:

Attn: Envolve Pharmacy Solutions Pharmacy Claim Submission
5 E. River Park Pl, Suite 210
Fresno, CA 93720

Preferred Drug List (PDL)

The Arkansas Medicaid Preferred Drug List (PDL) can be found online at ArkansasTotalCare.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 Preferred Drug List 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 (PA).

A paper copy of the current PDL can be requested by calling Provider Relations department at number provided in the Key Contacts section of this manual.

Unapproved Use of Preferred Medication

Medication coverage under this program is limited to 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. Reimbursement decisions for specific non-approved indications will be made by Arkansas Total Care. Experimental drugs and investigational drugs are not eligible for coverage.

Prior Authorization Process

The Arkansas Medicaid PDL includes a broad spectrum of brand name and generic drugs. Clinicians are encouraged to prescribe from the Arkansas Medicaid PDL for their patients who are Participants of Arkansas Total Care. Some drugs will require PA (Prior Authorization). If a request for Prior Authorization is needed the information should be submitted by the physician/clinician to Envolve Pharmacy Solutions on the Arkansas Total Care/Envolve Pharmacy Solutions form: Medication Prior Authorization Request Form. This form should be faxed to Envolve Pharmacy Solutions at 1-866-399-0929. This document is located on the Arkansas Total Care website at ArkansasTotalCare.com. Arkansas Total Care will cover the medication if it is determined that:

1. There is a medical reason the Participant needs the specific medication.
2. Depending on the medication, other medications on the PDL have not worked.

Prior Authorization requests for specialty medications should be faxed 866-399-0929 Envolve PA help desk

All reviews are performed by a licensed clinical pharmacist using the State approved criteria. A licensed pharmacist can issue a medical denial determination. Once approved, Envolve Pharmacy Solutions notifies the prescriber/clinician by 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 Participant and the prescriber of medication alternatives in addition to provide information for the appeal process.

Envolve Pharmacy Solutions Contact Information:

Prior Authorization FAX: 1-866-399-0929
Prior Authorization Phone: 1-866-399-0928
Mailing Address: 5 E River Park Place, Suite 210, Fresno, CA 93720

72 Hour Emergency Supply of Medications

Federal law allows a pharmacy to dispense a72 hour emergency supply of medication. Arkansas Total Care will allow up to a 72 Hour supply of medication to any patient awaiting a prior authorization determination. The purpose 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 PA request is ultimately approved or denied. The pharmacy will contact the Envolve Pharmacy Solutions Pharmacy Help Desk at 1-888-321-3120 for a prescription override to submit the 72 hour medication.

Step Therapy

Some medications listed on the Arkansas Medicaid PDL may require specific medications to be used before you can receive the Step Therapy medication (ST). If Arkansas Total Care has a record that the required medication was tried first the ST medications are automatically covered. If Arkansas Total Care does not have a record that the required medication was tried, the Participant or physician/clinician may be required to provide additional information. If Arkansas Total Care does not grant an exception to the step therapy 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

- Immunizations are medical benefits that do not require Prior Authorization
- 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

Injectable Drugs

Injections as defined by CMS list of covered outpatient drugs as listed on the CMS Quarterly Drug Information File when determined to be medically necessary are approved benefits for our Arkansas Total Care Participants.

Specialty Pharmacy Program

Arkansas Total Care will contract on an equal basis with any pharmacy that is willing to comply with our terms, quality standards and reimbursement rates. Prior Authorization for specialty medications can be requested by faxing the Envolve number 866-399-0929

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum 31 day supply for each new or refill non-opioid. Opioid prescriptions are subject to the State criteria. A total of 75 percent (75%) of the days supplied for a non-controlled medication and 90 percent (90%) for controlled substances must have elapsed before the prescription can be refilled without a Prior Authorization approval. Dispensing outside the quantity limit (QL) or age limits (AL) 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 a Participant has a medical reason for getting a larger amount, he or she can ask for Prior Authorization. If Arkansas Total Care does not grant a Prior Authorization approval, we will notify the Participant and physician/clinician and provide 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 and for safety concerns 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. There is always consideration of the exception process for medically necessary treatments.

Mandatory Generic Substitution

Generic drugs have the same active ingredient, work the same as brand name drugs, and have lower copayments. If the Participant or physician/clinician feels a brand name drug is medically necessary, the physician/clinician can ask for an authorization. We will cover the brand name drug according to our clinical guidelines if there is a medical reason the Participant needs the particular brand name drug. If Arkansas Total Care does not grant authorization we will notify the Participant and physician/clinician and provide information regarding the appeal process.

Over-The-Counter Medications (OTC)

The pharmacy program covers all DHS approved OTC medications. All OTC medications must be written on a valid prescription by a licensed physician in order to be reimbursed.

Envolve Pharmacy Solutions Contacts

Prior Authorization

Telephone: 866-399-0928

Fax: 1-866-399-0929

Web: envolverx.com

7 days a week, 365 days a year - 8am-9pm EST.

Mailing Address

Envolve Pharmacy Solutions
5 E River Park Place, Suite 210
Fresno, CA 93720

When calling, please have Participant information, including Medicaid ID number, Participant date of birth, complete diagnosis, medication history, and current medications readily available. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific Participants to receive this specific drug.

If the request is denied, information about the denial will be provided to the Provider and the Participant.

Providers are requested to utilize the Preferred Drug List when prescribing medication to Arkansas Total Care Participants. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the provider to request a change to a product included in the Arkansas Medicaid Preferred Drug List.

In the event that a Provider or Participant disagrees with the decision regarding coverage of a medication, the Participant or the Provider, on the Participant's behalf, may submit an appeal, verbally or in writing.

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 (i.e. member was unconscious at presentation, member did not have their Arkansas Total Care ID card, or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined participant was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of request, not to exceed 90 calendar days from date of service. Presumptive eligibility rules apply.

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:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
2. Impairments of bodily functions, or
3. 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 Primary Care Practitioner (PCP) and/or Arkansas Total Care' 24 hour Nurse Advice Hotline for assistance; however, this is not a requirement to access emergency services. Arkansas Total Care contracts with emergency services 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'

Provider network and will not deny payment for treatment obtained under either of the following circumstances:

1. 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 Emergency Medical Condition; or
2. A representative from the Plan instructs the participant to seek emergency 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.

Utilization Review Criteria

Utilization management decision-making is based on appropriateness of care and service and 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 underutilization.

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

Medical Services	InterQual® Adult, Clinical Policies and Pediatric Guidelines
Behavioral Health Services	InterQual® Adult and Pediatric Guidelines
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. The criteria are available at www.RadMD.com.
Substance Use Disorder Services	Based upon the American Society for Addiction Medicine (ASAM) Patient Placement Criteria. The criteria are available at www.asam.org

Arkansas Total Care's Medical Director, or other health care 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 health care 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. An Arkansas Total Care Care Manager may also coordinate communication between the Medical Director and the requesting provider.

Care Management and Concurrent Review

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.

Care Coordination

Integrated Care Coordination is a collaborative process which assesses plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's medical and behavioral health needs, using communication and available resources to promote quality, cost effective outcomes. Service/Care Coordination and Care Management is member-centered, goal-oriented, culturally relevant, and logically managed

processes to help ensure that a member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner.

Arkansas Total Care's Care Coordination teams support physicians by tracking compliance with the Care Management plan and facilitating communication between the PCP, member, managing physician, and the Care Management team. The Care Manager also facilitates referrals and links to community providers, such as local health departments and school-based clinics. The managing physician maintains responsibility for the member's ongoing care needs. The Arkansas Total Care Care Manager will contact the PCP and/or managing physician if the member is not following the plan of care or requires additional services.

Arkansas Total Care will provide individual Care Management services for members who have high risk, high-cost, complex, or catastrophic medical and/or behavioral health conditions. The Arkansas Total Care Care Manager will work with all involved providers to coordinate care and provide referral assistance and other care coordination as required. The Arkansas Total Care Care Manager may also assist with a member's transition to other care, as indicated, when Arkansas Total Care benefits end.

Start Smart for Your Baby® (Start Smart) is a Care Management program available to women who are pregnant or who have just had a baby. Start Smart is a comprehensive program that covers all phases of the pregnancy, postpartum, and newborn periods. The program includes mailed educational materials for newly identified pregnant members and new mothers after delivery.

Telephonic Care Management by Program Specialist work with the member to create a customizable and integrated plan of care in order to promote healthcare as well as adherence to Care Management plans. Care Managers will coordinate with physicians, as needed, in order to develop and maintain a plan of care to meet the needs of all involved.

All Arkansas Total Care members with identified needs are assessed for Care Management enrollment. Members with needs may be identified via clinical rounds, referrals from other Arkansas Total Care staff members, via hospital census, via direct referral from Providers, via self-referral, or referral from other health professionals.

Care Management Process

Arkansas Total Care's Care Management for high risk, complex, or catastrophic conditions contains the following key elements:

- Conduct Health Risk Screenings to identify members who potentially meet the criteria for Care Management.
- Assess the member’s risk factors to determine the need for Care Management.
- Notify the member and his/her PCP of the member’s enrollment in Arkansas Total Care’s Care Management program.
- Develop and implement a treatment plan that accommodates the specific cultural and linguistic needs of the member.
- Establish treatment objectives and monitor outcomes.
- Refer and assist the member in enduring timely access to providers.
- Coordinate medical, behavioral health, residential, social, and other support services.
- Monitor care/services.
- Revise the treatment plan as necessary.
- Assess the member’s satisfaction with Complex Care Management services.
- Track plan outcomes.
- Follow-up post discharge from Care Management.

Refer a member to Arkansas Total Care Care Management: Providers are asked to contact the Medical Management Department to refer a member identified in need of Care Management intervention.

CLAIMS

The appropriate Center for Medicare and Medicaid Services (CMS) billing form is required for paper and electronic data interchange (EDI) claim submissions. The appropriate CMS billing forms usage 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 its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials. Reimbursement Policy can 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:

- 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, individually or batch.
- All claim submissions will be subject to 5010 validation procedures based on CMS Industry Standards.
- Member ID and date of birth combination must exactly match a participating Arkansas Total Care member.
- 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).
- 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 to their **highest number of digit**s available.
- National Drug Code (NDC) is 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, this criteria looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.
    - 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

- 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. (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 prior authorization processes were followed.
- Payment for services is contingent upon 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** means a claim for payment of health care expenses that is submitted on a CMS 1500 or a UB04 claim form, in a format required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with all required fields completed in accordance with Arkansas Total Care's published claim filing requirements.

Non-Clean Claim Definition

Non-clean or unclean claim definition- 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

Upfront Rejection

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.

Denial

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, however has been billed with **invalid** or **inappropriate** information causing the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found listed below with explanations in Appendix II.

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 final determination of the primary payer**.**

- **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 Explanation of Payment issued by Arkansas Total Care to the date received.
- **Coordination of Benefits** - Days are calculated from the date of Explanation of Payment from the primary payers to the date received.

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 dedicated Provider Relations Representative that the following information is current in our files:

1. Provider Name (as noted on current W-9 form)
2. National Provider Identifier (NPI) (if applicable)
3. Group National Provider Identifier (NPI) (if applicable)
4. Tax Identification Number (TIN)
5. Taxonomy code (This is a REQUIRED field when submitting a claim)
6. Physical location address (as noted on current W-9 form)
7. Billing name and address (as noted on 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. 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 Explanation of Payment (EOP). For more information on electronic filing, contact:

Arkansas Total Care c/o Centene EDI Department
1-800-225-2573, extension 6075525
or by e-mail at: 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 evidence of payments 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.

The Arkansas Total Care Payer ID is **68069**. For a list of the clearinghouses that we currently work with, please visit our website at ArkansasTotalCare.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 very 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 upon the provider's contract with his/her 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 upfront rejected 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 very important to review this report daily. The report shows rejected claims; these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements 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.

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

Invalid Electronic Claim Record Upfront Rejections/Denials

All claim records sent to Arkansas Total Care must first 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 received by Arkansas Total Care. In these cases, the claim must be corrected and re-submitted 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 re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 6075525, or via e-mail at EDIBA@Centene.com. If you are prompted to leave a voice mail, 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

Please refer to the EDI HIPAA Version 5010 Implementation section on our website for detailed information.

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 can 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. Provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review, e.g. complicated or unusual procedure. Provider is required to submit medical records with the claim.
- Claim for services requiring documentation and a Certificate of Medical Necessity, e.g. oxygen, motorized wheelchairs.

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Submitting Claims through clearinghouses Arkansas Total Care Payer ID number for all clearinghouses (Medical and Behavioral Health) is **68069**	We use Availity as our primary clearinghouse, which provides us with an extensive network of connectivity. You are free to use whatever clearinghouse you currently do as Availity maintains active connections with a large number of clearinghouses.
General EDI Questions:	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or (314) 505-6525 or via e-mail at EDIBA@Centene.com.
Claims Transmission Report Questions:	Contact your clearinghouse technical support area.
Claim Transmission Questions (Has my claim been received or rejected?):	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or via e-mail at EDIBA@Centene.com.
Remittance Advice Questions:	Contact Arkansas Total Care Provider Services or the secure provider portal.
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Provider Service in writing include an updated W9.

Important Steps to a Successful Submission of EDI Claims:

1. Select a clearinghouse to utilize.
2. Contact the clearinghouse regarding what data records are required.
3. Verify with Provider Services at Arkansas Total Care that the provider is set up in the Arkansas Total Care system prior to submitting EDI claims.
4. 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 are being transmitted to Arkansas Total Care and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Arkansas Total Care. Always review the acceptance and claims stats report for rejected claims. If rejections are noted, correct and resubmit.
5. Most importantly, all claims must be submitted with providers identifying the appropriate coding. See the CMS 1500 (02/12) and CMS 1450 (UB-04) Claims Forms instructions and claim form for details.

Online Claim 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 to Arkansas Total Care on the secure provider portal at ArkansasTotalCare.com.

You must request access to our secure site by registering for a user name and password. If you have technical support questions, please contact Provider Services.

Once you have access to the secure portal, you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims. Detailed instructions for submitting via secure provider portal are also stored on our website; you must log-in to the secure site for access to this manual.

Paper Claim Submission

The mailing address for first time claims **(for medical and behavioral health)**, corrected claims and requests for reconsideration:

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

The mailing address for non-claim related Complaints/Grievances and Medical Necessity Appeals is:
Arkansas Total Care
P.O. Box 25010
Little Rock, AR 72221

The mailing address for claim (for medical and behavioral health) claim disputes/claim appeals:

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 websites. 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 invalid and will be rejected. If a paper claim has been rejected, provider should correct the error and resubmit the paper claim as an original claims. If the paper claim passes the specific edits and is denied after acceptance, the provider should submit the denial letter with the corrected claim.

Acceptable Forms

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

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

Important Steps to Successful Submission of Paper Claims:

1 Providers must file claims using standard claims forms (UB-04 for hospitals and facilities; CMS 1500 for physicians or practitioners).

2 Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard and handwritten claim forms will be **rejected** back to the provider.

3 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, refer to Arkansas Total Care Taxonomy(PDF) located on our website: https://Arkansas Total Care.arhealthwellness.com/

4 Ensure all Diagnosis and Procedure Codes are appropriate for the age of the member.

5 Ensure all Diagnosis Codes are coded to their highest number of digits available

6 Ensure member is eligible for services during the time period in which services were provided.

7 Ensure provider has received authorization to provide services to the eligible member, when appropriate.

8 Ensure an authorization has been given for services that require prior authorization by Arkansas Total Care.

9 Providers billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form.

10 Ensure all paper claim forms are typed or printed with either 10 or 12 Times New Roman font. Do not use highlights, italics, bold text, ink stamps, or staples for multiple page submissions.

11 Ensure print is properly aligned on the form. Arkansas Total Care utilizes OCR software to convert paper forms to EDI transactions and information may not process correctly and result in a rejected claim.

Claims missing 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 from the date of the original explanation of payment 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 timeframe for contracted providers, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

1. A catastrophic event that substantially interferes with normal business operation of the provider, or 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.
2. 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 his or her Arkansas Total Care ID Card or information;
    - The provider can substantiate that he or she continually pursued reimbursement from the patient until eligibility was discovered; and
    - The provider has not filed a claim for this member prior to the filing of the claim under review.

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/claim appeal** – A provider disagrees with the outcome of the request for reconsideration. For ‘Medical Necessity Dispute Process’ see Automated Clinical Payment Policy Edits below for details.

Corrected Claims

Corrected claims must clearly indicate they are corrected in one of the following ways:

1. Submit a corrected claim via the secure provider portal. Follow the instructions on the portal for submitting a correction.
2. 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**
3. Submit a corrected paper claim to:

    Arkansas Total Care
    Attn: Corrected Claims
    PO Box 8020
    Farmington, MO 63640-8020

    - Upon submission of a corrected paper claim, the **original claim numbe**r 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 cancelled) in field 22 of the CMS 1500 and in field 4 of the UB-04 form.
    - Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected.

Request 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, 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 in the following ways:

1. Phone call to Provider Services
    - This method may be utilized 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 particular rate, but the payment amount did not reflect that particular rate.
2. Providers may utilize the Request for Reconsideration form found on our website (preferred method).
3. Providers may send a written letter that includes a detailed description of the reason for the request. In order 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 on a CMS 1500 form or field 64 on a UB-04 form. The corresponding frequency code should also be included with the original claim number (7 =

    replacement or corrected; 8 = voided or cancelled) in field 22 of the CMS 1500 and in field 4 of the UB-04 form.
4. A copy of the submitted claim is not necessary to be attached.

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

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

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

Claim Dispute

A claim dispute/claim appeal should be used only when a provider has received an unsatisfactory response to a request for reconsideration. If a dispute from is submitted and a reconsideration request is not located in our system, this will be considered a reconsideration and treated as outlined above.

A claim dispute/claim appeal must be submitted on a claim dispute/claim appeal form found on our website. The claim dispute form must be completed in its entirety. The completed claim dispute/claim appeal form may be mailed to:

Arkansas Total Care
Attn: Claim Dispute
PO Box 8020
Farmington, MO 63640-8020

A claim dispute/claim appeal will be resolved within 30 calendar days. A provider will receive a written letter detailing the decision to overturn or uphold the original decision. If the original decision is upheld, the letter will include the rationale for upholding the decision. Disputed claims are resolved to a paid or denied status in accordance with state law and regulation.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

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 EFT and ERA, or contact Provider Services.

Benefits include:

- **Elimination of paper checks** - all deposits transmitted via EFT to the designated bank account
- **Convenient payments & 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**
- **Reduce accounting expenses –** Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- **Improve cash flow –** Electronic payments can mean faster payments, leading to improvements in cash flow.
- **Maintain control over bank accounts** - You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- **Match payments to advices quickly –** You can associate electronic payments with electronic remittance advices quickly and easily.
- **Manage multiple Payers –** Reuse enrollment information to connect with multiple payers and assign to different payers to different bank accounts as desired.

For more information, please visit our provider home page on our website at https://ArkansasTotalCare.com/. If further assistance is needed, please contact our Provider Services Department at 1-866-282-6280.

Risk Adjustment and Correct Coding

Risk adjustment is a critical element of the Affordable Care Act (ACA) that will help ensure the long-term success of the Health Insurance Marketplace. 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:

1. Code all diagnoses to the highest level of specificity, which means assigning the most precise ICD code that most fully explains the narrative description in the medical chart of the symptom or diagnosis;
2. Ensure medical record documentation is clear, concise, consistent, complete, legible, and meets CMS signature guidelines (each encounter must stand alone);
3. Submit claims and encounter information in a timely manner;
4. Alert Arkansas Total Care of any erroneous data submitted and follow Arkansas Total Care's policies to correct errors in a timely manner;
5. Provide medical records as requested in a timely manner; and
6. Provide ongoing training to their staff regarding appropriate use of ICD 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 Marketplace product. Claims submitted with inaccurate or incomplete data will often 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 HCPCS Level II 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 a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of services.
- Code is inappropriate for the age of the member.
- Diagnosis code is missing digits.
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary.
- Code billed is inappropriate for the location or specialty billed.
- Code billed is a part of a more comprehensive code billed on same date of service.
- 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/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and 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.

For more information regarding billing codes, coding, and code auditing/editing, please contact Arkansas Total Care Provider Services or visit https://ArkansasTotalCare.com.

The clinical and payment policies are located under the "Provider Resources" link.

Clinical Lab Improvement Act (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 upfront rejected. Below are billing instructions on how and/or where to provide the CLIA certification or waiver number on the following claim type submissions:

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 laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self- performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4,

-Or-

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4.

***Note**

The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4.

Please refer to the 5010 implementation guides for the appropriate loops 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 CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

***Note**

An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self- performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, two separate claims should be submitted, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a **separate** claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Taxonomy Code Billing Requirement

Taxonomy numbers are required for **all** Arkansas Total Care claims. Claims submitted without taxonomy numbers will be upfront rejected 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 91 is as follows: Invalid or Missing Taxonomy Code. Please contact

Provider Services to resolve this issue. Below are three scenarios involving the Taxonomy Code Billing Requirement.

Scenario One: Rendering NPI is ***different*** than the Billing NPI CMS 1500 Form

Rendering Provider Taxonomy Number	Shaded portion of box 24J	2310B	PRV03 REF02
		2420A	PRV03 REF02
Group NPI	Box 33a	2010AA	NM109
Billing Provider Group Taxonomy utilizing the ZZ Qualifier (for the 2000A PROV02 = qualifier "PXC") e.g. box 33b ZZ208D00000X EDI PRV*PE*PXC*208D00000X	Box 33b	2000A	PRV03
Billing Provider Group FTIN(EI)/ SSN(SY)		2010AA	

Claim Reconsiderations Related To Code Editing And Editing

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

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

CODE EDITING

Arkansas Total Care uses HIPAA-compliant code auditing software to improve accuracy and efficiency in claims processing, payment, and reporting. 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 correct coding guidelines.

CPT and HCPCS Coding Structure

The Healthcare Common Procedure Coding System (HCPCS) is a set of health care 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 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 5-digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are updated (added, revised, and deleted) on an annual basis.

Level II HCPCS Codes: The Level II set of HCPCS codes 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 which 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 report, pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) 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 only be used 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 code 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, which allows for a high level of specificity in coding a wide range of health problems.

Revenue Codes

These 4-digit numeric codes are utilized 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, etc.

The following sources are utilized in determining correct coding guidelines for the software:

- Centers for Medicare & Medicaid Services (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 (such as 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 upon the code edit applied, the software will make the following recommendations:

Deny: Code editing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment 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 explanation of payment 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.

Code Editing Principles

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

Unbundling Edits

PTP Practitioner and Hospital Edits

CMS has designated certain combinations of codes that are generally not separately reimbursable on the same date of service. These are known as Procedure-to-Procedure (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 published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed 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 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. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0, 10 or 90-day global surgical period. Procedures assigned a 90-day global surgical period are designated as major procedures. Procedures assigned a 0 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 1-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 0-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.

Diagnostic Services Bundled to the Inpatient Admission (3-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 bundled into the inpatient admission, and therefore 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 to 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. Finally, the software analyzes multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician 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

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

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

Evaluates claims billed with a co-surgeon or team surgeon that normally do not require a co-surgeon/team surgeon. CMS guidelines define whether or not 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 or team surgeon.

Add-on and Base Code Edits

These rules analyze claims in which an add-on CPT code was billed without the primary service CPT code. Additionally, 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 rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, 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 not considered for reimbursement. CMS determines the readmission time interval as 30 days;

Viewing Claims Coding Edits

Code Editing Assistant

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 clicking "Claim Editing Tool" in the secure provider portal.

This tool offers many benefits:

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

The tool 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.

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 which may be used to determine if an edit is appropriate.

The code editing assistant can be accessed from the provider web portal.

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 this tool.

Claim Reconsiderations Related To Claim Editing

Claims reconsiderations resulting from claim editing are handled per the provider claims dispute process out-

lined in this manual. When submitting claims 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 this type of information:

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

THIRD PARTY LIABILITY

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

If third party liability 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 third party liability.

BILLING THE MEMBER –

Covered Services

Charges that Are Not the Responsibility of the Member

A member is not liable for the following charges:

A. A claim or portion of a claim denied for lack of medical necessity.

B. Charges in excess of the contracted allowable rate.

C. A claim or portion of a claim denied due to provider error.

D. A claim or portion of a claim denied because of errors made Arkansas Total Care.

E. A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed.

F. A claim or portion of a claim denied because a provider failed to obtain prior, concurrent or retroactive authorization for a service.

G. 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. Arkansas Total Care members are not responsible for deductibles, co-payments 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.

H. Arkansas Total Care pays the difference between the amount paid by private insurance and the Arkansas Total Care maximum allowed amount. 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:

A. Charges incurred during a time of ineligibility

B. 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

C. Charges for services which the member has chosen to receive and agreed to pay for as a private pay patient

Arkansas Total Care pays the difference between the amount paid by private insurance and the Medicaid maximum allowed 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 only bill Arkansas Total Care members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

1. the specific service(s) to be provided
2. a statement that the service is not covered by Arkansas Total Care
3. a statement that the member chooses to receive and pay for the specific service
4. 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

Member Rights

Providers must comply with the rights of members as set forth below:

1. To participate with providers in making decisions about their health care. This includes working on any treatment plans and making care decisions. The member should know any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any treatment without consent freely given by the member or the member's legally authorized surrogate decision-maker. The member must be informed of his/her care options.
2. To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly.
3. To receive the benefits for which the member has coverage.
4. To be treated with respect and dignity.
5. To privacy of their personal health information, consistent with state and federal laws, and Arkansas Total Care policies.
6. To receive information or make recommendations, including changes, about Arkansas Total Care's organization and services, the Arkansas Total Care network of providers, and member rights and responsibilities.
7. To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the member's primary care provider about what might be wrong (to the level known), treatment, and any known likely results. The provider must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs he/she will need to pay. This should be told to the member in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the member's approval for treatment unless there is an emergency and the member's life and health are in serious danger.
8. To make recommendations regarding the Arkansas Total Care member's rights, responsibilities and policies.
9. To voice complaints or appeals about: Arkansas Total Care, any benefit or coverage decisions Arkansas Total Care makes, Arkansas Total Care coverage, or the care provided.
10. To refuse treatment for any condition, illness or disease without jeopardizing future treatment, and to be informed by the provider(s) of the medical consequences.
11. To see their medical records.
12. To be kept informed of covered and non-covered services, program changes, how to access services, primary care provider assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Arkansas Total Care rules and guidelines. Arkansas Total Care will notify members at least 60 days before the effective date of the modifications. Such notices shall include the following:
    - Any changes in clinical review criteria,
    - A statement of the effect of such changes on the personal liability of the member for the cost of any such changes.
13. To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice.
14. To select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual preference, national origin, or religion. Sex discrimination includes, but is not limited to, discrimination on the basis of pregnancy, gender identity and sex stereotyping.

16. To access medically necessary urgent and emergency services 24 hours a day and seven days a week.
17. To receive information in a different format in compliance with the Americans with Disabilities Act, if the member has a disability.
18. To refuse treatment to the extent the law allows. The member is responsible for his/her actions if treatment is refused or if the provider's instructions are not followed. The member should discuss all concerns about treatment with his/her primary care provider or other provider. The primary care provider or other provider must discuss different treatment plans with the member. The member must make the final decision.
19. To select a primary care provider within the network. The member has the right to change his/her primary care provider or request information on network providers close to his/her home or work.
20. To know the name and job title of people providing care to the member. The member also has the right to know which physician is his/her primary care provider.
21. To have access to an interpreter when the member does not speak or understand the language of the area.
22. To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment.
23. To execute an advance directive for health care decisions. An advance directive will assist the primary care provider and other providers to understand the member's wishes about the member's health care. The advance directive will not take away the member's right to make his/her own decisions. Examples of advance directives include:

    - Living Will,
    - Health Care Power of Attorney,
    - "Do Not Resuscitate" Orders.

    Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive.

Member Responsibilities

1. To read his/her Arkansas Total Care contract in its entirety.
2. To treat all health care professionals and staff with courtesy and respect.
3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about his/her health. The member should make it known whether he/she clearly understands his/her care and what is expected of him/her. The member needs to ask questions of his/her provider, so he/she understands the care he/she is receiving
4. To review and understand the information he/she receives about Arkansas Total Care. The member needs to know the proper use of covered services.
5. To show his/her I.D. card and keep scheduled appointments with his/her provider, and call the provider's office during office hours whenever possible if the member has a delay or cancellation.
6. To know the name of his/her assigned primary care provider. The member should establish a relationship with his/her primary care provider. The member may change his/her primary care provider verbally or in writing by contacting the Arkansas Total Care Member Services Department.
7. To read and understand to the best of his/her ability all materials concerning his/her health benefits or to ask for assistance if he/she needs it.
8. To understand his/her health problems and participate, along with his/her health care providers in developing mutually agreed upon treatment goals to the degree possible.
9. To supply, to the extent possible, information that Arkansas Total Care and/or his/her providers need in order to provide care.
10. To follow the treatment plans and instructions for care that he/she has agreed on with his/her health care providers.
11. To understand his/her health problems and tell his/her health care providers if he/she does not understand his/her treatment plan or what is expected of him/her. The member should work with his/her primary care provider to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of his/her decision.
12. To follow all health benefit plan guidelines, provisions, policies, and procedures.
13. To use any emergency room only when he/she thinks he/she has a medical emergency. For all other care, the member should call his/her primary care provider.
14. To give all information about any other medical coverage he/she has at the time of enrollment. If, at any time, the member gains other medical coverage besides Arkansas Total Care coverage, the member must provide this information to Arkansas Total Care.
15. To pay his/her monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

1. To be treated by his/her patients, who are Arkansas Total Care members, and other healthcare workers with dignity and respect.

2. To receive accurate and complete information and medical histories for members' care.

3. To have his/her patients, who are Arkansas Total Care members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.

4. To expect other network providers to act as partners in members' treatment plans.

5. To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times.

6. To make a complaint or file an appeal against Arkansas Total Care and/or a member.

7. To file a grievance on behalf of a member, with the member's consent.

8. To have access to information about Arkansas Total Care quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.

9. To contact Provider Services with any questions, comments, or problems.

10. To collaborate with other health care professionals who are involved in the care of members.

11. To 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.

12. To collect member copays, coinsurance, and deductibles at the time of the service.

Provider Responsibilities

Providers must comply with each of the items listed below.

1. To help or advocate for members to make decisions within his/her scope of practice about his/her relevant and/or medically necessary care and treatment, including the right 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.
2. To treat members with fairness, dignity, and respect.
3. To not discriminate against members on the basis of race, color, gender, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high cost care.
4. To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
5. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service.
6. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
7. To allow members to request restriction on the use and disclosure of their personal health information.
8. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
9. To 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.
10. To 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.
11. To 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.
12. To respect members' advance directives and include these documents in their medical record.
13. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
14. To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately.
15. To follow all state and federal laws and regulations related to patient care and rights.
16. To participate in Arkansas Total Care data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of provider performance data.
17. To review clinical practice guidelines distributed by Arkansas Total Care.
18. To comply with the Arkansas Total Care Medical Management program as outlined herein.
19. To disclose overpayments or improper payments to Arkansas Total Care.
20. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.

21. To obtain and report to Arkansas Total Care information regarding other insurance coverage the member has or may have.
22. To give Arkansas Total Care timely, written notice if provider is leaving/closing a practice.
23. To contact Arkansas Total Care to verify member eligibility and benefits, if appropriate.
24. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
25. To provide members with information regarding office location, hours of operation, accessibility, and translation services.
26. To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
27. To provide hours of operation to Arkansas Total Care members which are no less than those offered to other commercial members.

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 and within an organization and at all service levels the organization engages in outside of the organization. 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 health care 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 the patient's culturally-based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. 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, reducing effectiveness of the entire healthcare process.

As part of Arkansas Total Care's Cultural Competency Program, providers must ensure that:

- members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them;
- medical care is provided with consideration of the members' primary language, race and/or ethnicity as it relates to the members' health or illness;
- office staff routinely interacting with members has been given the opportunity to participate in, and have participated in, cultural competency training;
- office staff responsible for data collection makes reasonable attempts to collect race and language specific information for each member. Staff will also explain race categories to a member in order assist the member in accurately identifying his/her race or ethnicity;
- 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, gender identity, sexual orientation, and other characteristics that may influence the member's perspective on health care;
- office sites have posted and printed materials in English and Spanish or any other non-English language which may be prevalent in the applicable geographic area; and
- an appropriate mechanism is established to fulfill the provider's 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.

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, gender identity, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- denying a member a covered service or availability of a facility; and
- providing an Arkansas Total Care member a covered service that is different or administered in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, 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 a disability from:

- 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.

Providers should ensure that their offices are as accessible as possible to persons 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 at the Provider's location and who seeks to participate in the Provider Network to determine whether the office is architecturally accessible to persons 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 terms of this paragraph, the Provider may participate in the Provider Network provided that the Provider: 1) Requests and is determined by Arkansas Total Care to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) Agrees, in writing, to remove the barrier to make the office or facility accessible to persons with mobility impairments within one hundred eighty (180) days after Arkansas Total Care has identified 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 Arkansas Child Maltreatment Act and Arkansas Adult Maltreatment Act. These laws have been established in order to detect, prevent, reduce, and eliminate, abuse, neglect, exploitation and abandonment of children and adults in need including Arkansas Total Care Arkansas Medicaid members. If you suspect elder abuse or the abuse of an adult with a disability call Adult Protective Services at 1-800-490-8505, available 24 hours a day.

Abuse is defined as one or more of the following acts: a) the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish b) the willful deprivation by a caretaker of goods or services necessary to maintain physical or mental health c) sexual harassment, rape, or abuse. Sexual abuse of a participant 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 physical or mental health.

Common Signs of Abuse:

- Bruises or broken bones
- Weight loss
- Memory loss
- Personality changes
- Social isolation
- Changes in banking habits
- Giving away assets such as money, property, etc.

Advance Directives

The Patient Self-Determination Act of 1990, effective December 1, 1991, requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members written information about the members' right to have an Advance Directive. An Advance Directive is a legal document through which a member may provide directions or express preferences concerning his or her medical care and/or to appoint someone to act on his or her behalf. Members can use Advance Directives when the member is unable to make or communicate decisions about his or her 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 his or her medical care.

In Arkansas, there are two types of Advance Directives:

- Living will or health care instructions
- Appointment of a Health Care Power of Attorney

Arkansas Total Care is committed to ensure that members are aware of and are able to avail themselves of their rights to execute Advance Directives. Arkansas Total Care is equally committed to ensuring that its 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 or not 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.

Arkansas Total Care is aligned with the HEDIS Care of Older Adults measure, which includes annual review of advanced care planning, medication review, functional status, and pain assessment. To do this, Arkansas Total Care will annually assess and document the Advance Directive status in the Case Management systems.

PCPs and Providers delivering care to Arkansas Total Care members must ensure adult participants receive information on Advance Directives and are informed of their right to execute Advance Directives. Providers must document such information in the permanent medical record.

Arkansas Total Care recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an Advance Directive and the member's response should be documented in the medical record.
- If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Advance Directive to the PCP's office and document this request in the member's medical record.
- An Advance Directive should be a part of the member's medical record and include mental health directives.

If an Advance Directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the Advance Directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

COMPLAINT PROCESS

Provider Complaint/Grievance and Appeal Process

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

Mailing Address

The mailing address for claim (for medical and behavioral health) claim disputes/claim appeals:

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

The mailing address for non-claim related Complaints/Grievances and Medical Necessity Appeals is:

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

A Complaint is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Arkansas Total Care's policies, procedure, or any aspect of Arkansas Total Care's functions. Arkansas Total Care logs and tracks all complaints whether received verbally or in writing. Arkansas Total care will attempt to resolve all complaints within 10 business days of receipt. If the complaint is not resolved within 10 business days of receipt, Arkansas Total Care will reach out to the member by the business day after the 10th business days of receipt and offer the option to enter the complaint as a grievance and complete the grievance process to resolve the matter. If that option is exercised, after a complete review of the complaint, Arkansas Total Care shall provide a written notice to the provider within 30 calendar days from the received date of Arkansas Total Care's decision. If the complaint/grievance 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 Provider Manual prior to filing a Complaint.

Authorization and Coverage Complaints

Authorization and Coverage Complaints must follow the Appeal process below.

An Appeal is the mechanism which allows providers the right to appeal actions of Arkansas Total Care such as a prior authorization denial, or if the provider is aggrieved by any rule, policy, procedure, or decision made by Arkansas Total Care. A provider has 60calendar days from Arkansas Total Care's notice of action to file the appeal. Arkansas Total Care shall acknowledge receipt of each appeal within 5 business days after receiving an appeal. 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 timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Arkansas Total Care demonstrates that there is need for additional information and how 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 or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that 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 timeframe 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 timeframe 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.

Member Complaint/Grievance and Appeal Process

To ensure Arkansas Total Care member's rights are protected, all Arkansas Total Care members are entitled to a Complaint/Grievance and Appeals 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 at https://ArkansasTotalCare.com/or by calling Arkansas Total Care at 1-866-282-6280.

If a member is displeased with any aspect of services rendered:

The member should contact our Member Services department at 1-866-282-6280. The Member Services representative will assist the member.

If the member continues to be dissatisfied, he/she may file a formal complaint/grievance. Again, our Member Services department is available to assist with this process. Information regarding this process can be found at https://ArkansasTotalCare.com/

1. A member may designate in writing to Arkansas Total Care that a provider is acting on behalf of the member regarding the complaint/grievance and appeal process.

Site reviews are performed at provider offices and facilities when the member complaint threshold is met. A site review evaluates:

- physical accessibility;
- physical appearance;
- adequacy of waiting and examining room space; and
- adequacy of medical/treatment record keeping.

Mailing Address

The mailing address for non-claim related Complaints/Grievances and Medical Necessity Appeals is:

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

PROVIDER DISPUTES

Arkansas Total Care maintains a Provider Dispute Resolution Process, which provides for informal resolution of Provider Disputes at the lowest level and a formal process for Provider Appeals. The resolution of all issues regarding the interpretation of Department of Health approved Provider Agreements must be handled between the Provider and Arkansas Total Care and does not involve the Department of Health; therefore, these are not within the scope of the Department's Bureau of Hearings and Appeals (BHA). Additionally, the Department's BHA or its designee is not an appropriate forum for Provider Disputes/Appeals with Arkansas Total Care.

Arkansas Total Care' Informal and formal processes for settlement of Provider Disputes includes the following:

- Acceptance and usage of the Department's definition of Provider Appeals and Provider Disputes
- Timeframes for submission and resolution of Provider Disputes/Provider Appeals
- Processes to ensure equitability for all Providers
- Mechanisms and time-frames for reporting Provider Appeal decisions to Arkansas Total Care' administration, QM, Provider Relations and the Department
- Establishment of an Arkansas Total Care' Committee to process formal Provider Disputes/ Provider Appeals which provides:
    - At least one-fourth (1/4th) of the members of the Committee must be composed of Health Care Providers/peers
    - Committee participants have the authority, training, and expertise to address and resolve Provider Dispute/Provider Appeal issues
    - Access to data necessary to assist committee participants in making decisions
    - Documentation of meetings and decisions of the Committee

PROVIDER APPEALS RIGHTS

161.200 Administrative Reconsideration 1-1-16

A. Within 30 calendar days after notice of an adverse decision/action, the provider may request administrative reconsideration. Requests must be in writing and include:

1. A copy of the letter or notice of adverse decision/action
2. Additional documentation that supports medical necessity

Administrative reconsideration does not postpone any adverse action that may be imposed pending appeal.

B. Requests for reconsideration must be submitted as follows:

1. In situations where the adverse decision/action has been taken by a reviewing agent, the request must be directed to that reviewing agent. Contact information for the department's reviewing agents can be found in Section V of this manual. General rules regarding due process are contained in Section I of each provider manual; but some administrative reconsideration and appeal processes are program-specific and are set forth in Section II of the applicable program manual.
2. When an adverse decision/action has been taken by the Division of Medical Services, the request for reconsideration must be directed to Office of Medicaid Inspector General (OMIG). **View or print the Office of Medicaid Inspector General contact information.** Within 20 calendar days of receiving a timely and complete request for administrative reconsideration, the Director of the Division of Medical Services will designate a reviewer, who did not participate in the initial determination leading to the adverse decision/action, who is knowledgeable in the subject matter of the administrative reconsideration, to review the reconsideration request and associated documents. The reviewer shall recommend to the Director that the adverse decision/action be sustained, reversed or modified. The Director may adopt or reject the recommendation in whole or in part.

A reconsideration request received within 35 calendar days of the written notice will be deemed timely. The request must be mailed or delivered by hand. Faxed or E-mailed requests will not be accepted.

No administrative reconsideration is allowed if the adverse decision/action is due to loss of licensure, accreditation or certification.

161.300 Administrative Appeals of Adverse Actions that are not Sanctions 9-15-09

In addition to sanction reconsiderations and appeal procedures set forth in Sections 160.000-169.000, providers may appeal any other decision of the Department of Human Services, its reviewers or contractors if that decision adversely affects a Medicaid provider or members with regard to receipt or payment of Medicaid-covered services. Such decisions and consequent actions are "non-sanction adverse actions."

Within 30 calendar days of receiving notice of non-sanction adverse action, the provider may appeal. An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions/ actions that the provider alleges are not supported by applicable laws, including state and federal laws and rules, applicable professional standards, or both. Mail or deliver the appeal to the Office of Appeals and Hearings, Arkansas Department of Human Services, P.O. Box 1437, Slot N401, 7th and Main Streets, Little Rock, AR 72203-1437.

161.400 Sanction Appeals 9-15-09

Within 30 calendar days of receiving notice of adverse decision/action, or 10 calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision/action, whichever is

later, the provider may appeal.

An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions/actions that the provider alleges are not supported by applicable laws; including state and federal laws and rules, applicable professional standards or both. Mail or deliver the appeal to the Director, Division of Medical Services, P.O. Box 1437, Slot S401, 7th and Main Streets, Little Rock, AR 72203-1437. No appeal is allowed if the adverse decision/action is due to loss of licensure, accreditation or certification.

161.500 Continued Services During the Appeal Process 9-15-09

The adverse action notice sent to the Medicaid member must comply with 42 CFR §431.230 entitled "Maintaining Services," which states in part:

> (a) When the department mails the 10-day or 5-day notice, as required, and the member requests a hearing before the date of action, the department may not terminate or reduce services until a decision is rendered after the hearing unless:
>
> > (1) It is determined at the hearing that the sole issue is one of federal or state law or policy; and
> >
> > (2) The department promptly informs the member in writing that services are to be terminated or reduced pending the hearing decision.

162.000 Notice of the Appeal Hearing 9-15-09

When an appeal hearing is scheduled, the Office of Hearings and Appeals shall notify the provider, or if the provider is represented by an attorney, the provider's attorney, in writing, of the date, time and place of the hearing. Notice shall be mailed not less than 10 calendar days before the scheduled date of the hearing. Hearings shall be conducted in accordance with DHS Policy 1098. The decision of the Office of Appeals and Hearings is the final agency determination.

162.100 Conduct of Hearing 9-15-09

A. The hearing shall be conducted by a hearing officer who is authorized by the Director of the Division of Medical Services to conduct such hearings.

B. Testimony shall be taken only under oath, affirmation or penalty of perjury.

C. Each party shall have the right to call and examine parties and witnesses, to introduce exhibits, to question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination. Each party has the right to impeach any witness regardless of which party first called him to testify. Each party has the right to rebut the opposing evidence.

D. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs regardless of the existence of any common law or statutory rule that might make improper the admission of such evidence over objection in civil or criminal actions.

E. The hearing officer may provide for discovery by any means permitted by the Arkansas Rules of Civil Procedure and may assess the expense to the requesting party.

F. The hearing officer may question any party or witness and may admit any relevant and material evidence.

G. The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. Before taking evidence, the hearing officer shall explain the issues and the order in which evidence will be received.

H. The provider shall have the burden of proving by a preponderance of the evidence that it delivered all billed services in accordance with all applicable requirements.

I. Except as provided in part H, the burden of producing evidence of a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

162.200 Representation of Provider at a Hearing 9-15-09

Individual providers may represent themselves. A partner may represent the partnership. A limited liability company or corporation may be represented by an officer or the chief operating official. A professional association may be represented by a principal of the association. Representatives must be courteous in all activities undertaken in connection with the appeal and must obey the orders of the hearing officer regarding the presentation of the appeal. Failure to do so may result in exclusion from the appeal hearing, or in the entry of an order denying discovery.

162.300 Right to Counsel 10-13-03

Any party may appear and be heard at any proceeding described herein through an attorney-at-law. All attorneys shall conform to the standards of conduct practiced by attorneys before the courts of Arkansas. If an attorney does not conform to those standards, the hearing officer may exclude the attorney from the proceeding.

162.400 Appearance in Representative Capacity 9-15-09

A person appearing in a representative capacity shall file a written notice of appearance on behalf of a provider identifying himself or herself by name, address and telephone number; and identifying the party represented. He or she shall have written authorization to appear on behalf of the provider. The Division of Medical Services shall notify the provider in writing of the name and telephone number of the division's representative.

163.000 Form of Papers 4-1-06

All papers filed in any proceeding shall be typewritten on legal-sized white paper using one side of the paper only. They shall bear a caption clearly showing the title of the proceeding and the docket number, if any.

The party and/or his authorized representative or attorney shall sign all papers, and all papers shall contain his/her address and telephone number. At a minimum, an original and two copies of all papers shall be filed with the Office of Hearings and Appeals.

163.100 Notice, Service and Proof of Service 9-15-09

A. All papers, notices and other documents shall be served by the party filing the same upon all parties to the proceeding. Proof of such service upon all parties shall be filed with the Office of Hearings and Appeals.

B. Service shall be made by delivering, in person or by mail, properly addressed with postage prepaid, one copy to each party entitled thereto. When any party or parties have appeared by an attorney, service upon the attorney shall be deemed service upon the party or parties.

C. Proof of service of any paper shall be by certificate of attorney, affidavit or acknowledgement.

D. Service by mail is presumptively complete upon mailing. When service is permitted upon an attorney, such service may be put into effect by electronic transmission, provided the attorney being served has facilities within his office to receive and reproduce verbatim electronic transmissions.

164.000 Witnesses 10-13-03

A party shall arrange for the presence of his or her witnesses at the hearing.

165.000 Amendments 4-1-06

At any time prior to the completion of the hearing, amendments to the adverse decision/action, the provider's notice of appeal, or both, may be allowed on just and reasonable terms to add or discontinue any party, change the allegations or defenses, or add new causes of action or defenses.

Where the Division of Medical Services seeks to add a party or a cause of action or change an allegation, notice shall be given pursuant to Section 154.000, "Notice of Violation," and Section 163.100, "Notice, Service and Proof of Service," to the appropriate parties except that the provisions of Section 161.200, "Administrative Reconsideration," and Section 162.000, "Notice of the Administrative Appeal Hearing," shall not apply.

Where a party other than the Division of Medical Services seeks to add a party or change a defense, notice shall be given pursuant to Section 163.100, "Notice, Service and Proof of Service."

The hearing officer shall continue the hearing for such time as he deems appropriate, and notice of the new date shall be given pursuant to Section 166.000, "Continuances or Additional Hearings."

166.000 Continuances or Additional Hearings 4-1-06

A. The hearing officer may continue a hearing to another time or place or order additional hearings on his or her own motion or upon showing of good cause at the request of any party.

B. When the hearing officer determines that additional evidence is necessary for the proper determination of the case, he or she may, at his or her discretion:

1. Continue the hearing to a later date and order one or both parties to produce additional evidence, or

2. Conclude the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to both parties, and each party shall have the opportunity for rebuttal.

Written notice of the time and place of a continued or additional hearing shall be given, except that when a continuance or additional hearing is ordered during a hearing, oral notice may be given to each party present.

167.000 Failure to Appear 4-1-06

If a party fails to appear at a hearing, the hearing officer may dismiss the appeal or enter a determination adverse to the non-appearing party. A copy of the decision shall be mailed to each party. The hearing officer may, upon motion, set aside the decision and reopen the hearing for mistake, inadvertence, surprise, excusable neglect, fraud, or misrepresentation.

168.000 Record of Hearing 10-13-03

The Division of Medical Services (DMS) shall tape-record the hearings, or cause the hearings to be tape-recorded. If the final DMS determination is appealed, the tape recording shall be transcribed, and copies of other documentary evidence shall be reproduced for filing under the Administrative Procedure Act.

169.000 Decision 4-1-06

A. At the conclusion of the hearing, the hearing officer shall take the matter under consideration and shall submit a proposed decision to the Director of the Division of Medical Services.

B. The proposed decision shall be in writing and shall contain findings of fact and conclusions of law, separately stated, and a proposed order.

C. The director may adopt the proposed decision, or he may reject the proposed decision and have a

decision prepared based upon the record, or he may remand the matter to the hearing officer to take additional evidence. In the latter case, the hearing officer, thereafter, shall submit to the director a new proposed decision.

D. The director's decision is the final agency determination under the Administrative Procedure Act. The director shall cause a copy of the decision to be mailed to the provider at the provider's last known address, or, if the provider was represented by an attorney, to the address provided by the attorney.

169.100 Recovery of the Costs of Services Continued During the Appeal Process 9-15-09

42 CFR §431.230 entitled "Maintaining Services," which states in part:

> (b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or member to recoup the cost of any services furnished the member, to the extent they were furnished solely by reason of this section.

Federal regulation does not distinguish between member-filed and provider-filed appeals.

Providers filing appeals shall be subject to the same recovery procedures as members. When both the provider and member appeal, liability shall be joint and several.

PROVIDER DUE PROCESS

190.001 The 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:

1. Appropriate level of care or coding,
2. Medical necessity,
3. Prior authorization,
4. Concurrent reviews,
5. Retrospective reviews,
6. Least restrictive setting,
7. Desk audits,
8. Field audits and onsite audits, and
9. 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: denial or partial denial of a claim or authorization of services.

F. Department:

1. The Arkansas Department of Human Services,
2. All of the divisions and programs of the Arkansas Department of Human Services, including the state Medicaid Program, and
3. 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 health care.

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:

1. Reducing, withholding or affecting in any other manner current or future payments to a provider, or
2. 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:

1. Utilization reviews,
2. Medical necessity reviews,
3. Professional reviews,
4. Field audits and onsite audits, and
5. 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:

1. Reviews for quality,
2. Reviews for quantity,
3. Utilization,
4. Practice patterns,

5. Medical necessity,

6. Peer review, and

7. 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:

1. Lack of medical necessity or failure to document medical necessity in a manner that meets professionally recognized applicable standards of care,

2. Failure to provide care of a quality that meets professionally recognized local standards of care,

3. Failure to obtain prior, concurrent or mandatory authorization if required by regulation,

4. Fraud,

5. A pattern of abusive billing,

6. A pattern of noncompliance, or

7. A gross and flagrant violation.

190.003 Administrative Appeals 12-1-05

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

1. A member may appeal on his or her own behalf.

2. A provider of medical assistance that is the subject of the adverse action may appeal on the member's behalf.

3. 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 they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

E. A Medicaid member may attend any hearing related to his or her care, but the department may not make his or her 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 himself or herself injured in his or her 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. §§ 2515-201 – 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 provider will have time to prepare for the appeal. 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, and

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 primary care physician 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 upon 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 upon conditions that later changed, thereby rendering the care medically unnecessary.

Recoupment based upon 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:

A. Intervening weekends or holidays,

B. Lack of cooperation by third parties,

C. Natural disasters, or

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 are 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 its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality improvement initiatives 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 services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. Arkansas Total Care requires all practitioners and providers to cooperate with all QI activities and allow Arkansas Total Care to use practitioner and/or provider performance data to ensure success of the QAPI program.

Arkansas Total Care will promote the delivery of appropriate care with the primary goal being to improve the health status of its 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 designation of adequate resources to support the interventions. Whenever possible, the Arkansas Total Care QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

QAPI Program Structure

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

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

- to enhance and improve quality of care;
- to provide oversight and direction regarding policies, procedures, and protocols for member care and services; and
- to offer guidelines based on recommendations for appropriateness of care and services.

This is accomplished through 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 QI, UM, and Credentialing and recredentialing programs.

The following standard sub-committees report directly to the Medical/Quality Management Committee-developed by the PASSE to oversee its QAPI strategic plan. To include clinicians that specialized in behavioral health, HCBS, and LTSS services and 1 consumer advisor:

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- Performance Improvement Team
- Provider Advocacy Committee

- Member Advisory Committee
- HEDIS Steering Committee
- Pharmacy and Therapeutics Committee
- Delegate Vendor Operations 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, but not limited to, the QIC, 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 the following: 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:

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulation
- 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
- Pharmacy
- 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 status through a variety of meaningful quality improvement 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:

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;
- To utilize Management Information Systems (MIS) in data collection, integration, tracking, analysis and reporting of data that reflects performance on standardized measures of health outcomes;
- To allocate personnel and resources necessary to:
    - support the quality improvement program, including data analysis and reporting;
    - meet the educational needs of members, providers, and staff relevant to quality improvement efforts;
- To seek input and work with members, providers, and community resources to improve quality of care;
- To oversee peer review procedures that will address deviations in medical management and health care practices, and devise action plans to improve services;
- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
- To recommend and institute "focused" quality studies in clinical and non-clinical areas, where appropriate;
- To conduct and report annual CAHPS surveys and certified HEDIS results for Arkansas Total Care members;
- To achieve and maintain NCQA accreditation;
- To monitor for compliance with regulatory and NCQA requirements.

Practice Guidelines

Evidence based preventive health and clinical practice guidelines, are provided to assist providers, members, medical consenters, and caregivers in making decisions regarding health care 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 health care professionals in the particular field, and needs of the 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 targeted mailings.

A complete listing of approved preventive health and clinical practice guidelines is available at https://ArkansasTotalCare.com/.

The full guidelines are available to print, or 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 death of a member. Arkansas Total Care employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors, or the BOD may advise the QI Department of potential quality of care issues. Adverse events may also be identified through claims based reporting and analyses. 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 in the QI Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

The Arkansas Total Care QIC reviews and adopts an annual QAPI Program and Work Plan based on managed care appropriate industry standards. The QIC 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 indicates 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 QI 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 QI 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 QIC activities, reporting, and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC 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.

Arkansas Total Care communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter, and the Arkansas Total Care website at https://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 the 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 simply cost differences.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. Purchasers of health care may use the aggregated 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 being used as evidence of preventive care from primary care office practices.

HEDIS Rate Calculations

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim 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 consists of both administrative data and a sample of medical record data. Hybrid data requires 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, ICD-10,and HCPCS codes can reduce the necessity of medical record reviews (see the HEDIS brochure (posted on https://Arkansas Total Care.arhealthwellness.com/) for more information on reducing HEDIS medical record reviews)*.* HEDIS measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c values, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who Conducts Medical Record Reviews (MRR) for HEDIS

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

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment, or health care 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 with Arkansas Total Care, which allows them to collect PHI on our behalf.

How can providers improve their HEDIS scores?

- ***Understand the specifications*** established for each HEDIS measure by engaging in educational trainings offered by the plan.
- ***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 is the most clean and efficient way to report HEDIS.
- ***Submit claims and encounter data correctly, accurately, and on time.*** If services rendered are not filed or billed accurately, then they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- ***Ensure chart documentation reflects all services provided.*** Keep accurate chart/medical record documentation of each member service, and document conversation/services.

Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure, where appropriate.

If you have any questions, comments, or concerns related to the annual HEDIS project or medical record reviews, please contact the Quality Improvement Department at 1-866-282-6280.

Provider Satisfaction Survey

Arkansas Total Care conducts an annual provider satisfaction survey, which includes questions to evaluate the provider experience with Arkansas Total Care and our services such as claims, communications, utilization management, and provider services. Behavioral health providers receive a provider survey specific to the provision of behavioral health services in the Arkansas Total Care network. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Arkansas Total Care, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

REGULATORY MATTERS

Medical Records

Arkansas Total Care providers must keep accurate and complete patient medical records which are consistent with 45 CFR 156, financial, and other records pertinent to Arkansas Total Care members. Such records enable providers to render the most appropriate level of health care service to members. They will also enable Arkansas Total Care to review the level and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Arkansas Total Care requires providers to maintain all records for members for at least 10 years after the final date of service, unless a longer period is required by applicable state law.

Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum: provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e. x-rays, laboratory tests). Medical records should be accessible at the site of the member's participating primary care provider. 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:

- Member's name, and/or medical record number must be on all chart pages.
- Personal/biographical data is present (i.e., 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.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in chart for adults.
- Evidence 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.

- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- 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 primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented, including follow up of outcomes and summaries of treatment rendered elsewhere, 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 over, appropriate notations concerning use of tobacco, alcohol, and substance use (for members seen three or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- 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.
- Confidentiality of member information and records are protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

Access to Records and Audits by Arkansas Total Care

Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit Arkansas Total Care or its designated representative access to Provider's Records, at 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, upon at least thirty (30) business days prior written notice by Arkansas Total Care or its designated representative, but not more than sixty (60) days following such written notice.

EMR Access

Provider will grant Arkansas Total Care access to Provider's Electronic Medical Record (EMR) system in order to effectively case manage Members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the Arkansas Total Care for this access.

Medical Records Release

All member medical records are confidential and must not be released without the written authorization of the member or his/her parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

All release of specific clinical or medical records for Substance Use Disorders must meet Federal guidelines at 42 CFR Part 2 and any applicable State Laws.

Medical Records Transfer for New Members

All PCPs are required to document in the member's 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 they are unable to provide addresses of the previous providers, then this should also 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 protected health information 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 and 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.

Still other laws at the State level place further restrictions on the release of certain information, such as behavioral health, communicable disease, etc.

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

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.hhs.gov, and then select "Regulations and Guidance" and "HIPAA – General Information;"
- 42 CFR Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: www.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 1-866-282-6280 or in writing (refer to address below) with any questions about our privacy practices.

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

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 please visit http://www.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 very 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 waste, abuse, and fraud 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 Billing and Claims section of this Manual. The Centene Special Investigation Unit (SIU) performs retrospective audits, which, in some cases, may result in taking actions against providers who commit waste, abuse, and/or fraud. These actions include but are not limited to:

- 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; and
- 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;
- diagnosis and/or procedure code not consistent with the member's age;
- use of exclusion codes;
- excessive use of units;
- misuse of benefits; and
- 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 waste, abuse, or fraud very seriously and investigates all reported issues.

WAF Program Compliance Authority and Responsibility

The Arkansas Total Care Vice President of Compliance and Regulatory Affairs 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 waste, abuse, and fraud.

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.

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:

1. knowingly presenting, or causing to be presented a false claim for payment or approval;
2. knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
3. conspiring to commit any violation of the False Claims Act;
4. falsely certifying the type or amount of property to be used by the Government;
5. certifying receipt of property on a document without completely knowing that the information is true;
6. knowingly buying Government property from an unauthorized officer of the Government; and
7. 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, please visit www.cms.hhs.gov.

STATE MANDATED REGULATORY REQUIREMENTS

Arkansas

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

AR-1 Continuity of Care. If the Payor becomes insolvent, each Participating Provider shall continue to provide services to Covered Persons for the duration of the period after the Payor's insolvency for which the premium payment has been made and until any Covered Persons that are inpatients at the time of the Payor's insolvency are discharged from the inpatient facilities. (ARK. CODE ANN. § 23-76-118(c)(2))

AR-2 Hold Harmless. In the event the Payor fails to pay for Covered Services as set forth in the Agreement, each Participating Provider agrees that no Covered Person is liable to the Participating Provider for any sums owed by the Payor. In addition, the Participating Provider agrees that the Participating Provider and any agent, trustee, or assignee of the Participating Provider shall not maintain an action at law against a Covered Person to collect sums owed to them by the Payor nor shall they make any statement, either written or oral, to any Covered Persons that makes demand for, or would lead a reasonable person to believe that a demand is being made for, payment of any amounts owed by the Payor. (ARK. CODE ANN. §§ 23-76-119(c)(1), 23-76-119(c)(3), 23-76-118(b))

AR-3 Network Access. Each Participating Provider authorizes Company to sell, lease, assign, convey, and otherwise grant access to Company's network and related contracted reimbursement rates to other entities, including, without limitation, Payors. (ARK. CODE ANN. § 23-63-113(b)(1))

For Providers and Contracted Providers in the State of Tennessee, Health Plan or Celtic Insurance Company, an Affiliate, may issue the Coverage Agreement that applies to a Covered Person. In such case the following provisions may apply to the Covered Person or the Participating Provider as applicable.

TN-1 Hold Harmless. Participating Provider agrees that the Agreement contains a hold harmless clause that relieves a Covered Person from any liability for services rendered by Participating Providers except for reasonably copayment and non-Covered Services. (TENN. CODE § 56-32-105(c))

TN-2 Network Access by Third Parties. Participating Provider agrees authorizes the Health Plan to enter into an agreement with third parties allowing each third party to exercise the Health Plan's and/or Payor's rights and responsibilities under the Agreement as if the third party were the Health Plan. (TENN. CODE § 56-60-105)

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 Provider-led Arkansas Shared Savings Entity (PASSE), and each provider of home and community based services ("HCBS provider.")

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.

Until PASSE HCBS providers are a registered and fully functional provider type in MMIS, the PASSE is responsible for the annual certification of CES Waiver Providers. All other provisions, except annual 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 Home and Community based PROVIDERS AND ANNUAL CERTIFICATION REQUIREMENTS
SECTION	200	Hiring Procedures and Personnel Record maintenance
SECTION	300	Incident Reporting
SECTION	400	Beneficiary and Legal Guardian Rights
SECTION	500	BENEFICIARY HEALTH AND SAFETY and legal rights

100 Organizational/Management Requirements and solicitation

Organizational Requirements

Annual Certification: The PASSE is responsible for the credentialing of PASSE home and community-based service (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 Home and Community Based Service 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.
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; and
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

1. The PASSE HCBS Provider must obtain and verify each of the following from an applicant prior to employment:
2. A completed job application that includes all the applicant's required current and up-to date credentials.
3. A signed criminal conviction statement.
4. 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 eighteen (18) if a beneficiary is to be permitted to stay overnight in an applicant's residence.
5. A signed declaration of truth of statement.
6. Completed reference checks.
7. A successfully passed drug screen.
8. 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 thirty (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

adult over the age of eighteen (18) that resides 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 adult over the age of eighteen (18) that resides 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 adult over the age of eighteen (18) residing in a residence where a beneficiary is approved and permitted to stay overnight.

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 e-mail 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 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 (2) hours (i.e. elopement and/or wandering), or where services are interrupted for more than two (2) hours.

8. Any event where a staff member threatens 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, 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 e-mail, PASSE HCBS providers are to also 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 you are in network at multiple PASSEs, the incident must be sent 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 the Department of Human Services.
In addition to sentinel events, the Department of Human Services will also 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 Timeframes

A. Immediate Reporting

Providers must report the following incidents to the DHS PASSE Quality Assurance unit emergency number (501) 371-1329 within one (1) hour of occurrence, regardless of hour 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

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 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 HCSB Incident Report Form via secure e-mail no later than two (2) 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 person that 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.

400 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: (i) informed of their rights; (ii) provided copies of the policies enumerating their rights prior to the initiation of services and at any other time upon request; and (iii) 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 person centered service plan ("**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 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.

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 their 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")

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 "time-out," in which a beneficiary is temporarily, 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 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.
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 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 (3) times in any thirty (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 it 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 over-the-counter 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.

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 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

C. 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 the Health Insurance Portability and Accountability Act ("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 (i.e., 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 (5) 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 ("PHI") or HIPAA polices or complaints must be retained for six (6) 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 thirty (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 only be performed 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; and
    - 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 (2) 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:

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 which 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 (i.e. law enforcement, poison control etc.)
6. First-Aid kit

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 (3) 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. 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, 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. Eighty (80) square feet per beneficiary in multi-sleeping rooms; one hundred (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 (4) 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 (8) beneficiaries.
    4. Must be well ventilated by natural or mechanical methods.

Home and Community Based Services (HCBS) Settings Requirements

All PASSE HCBS providers must meet the Home and Community-Based Services (HCBS) Settings 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:

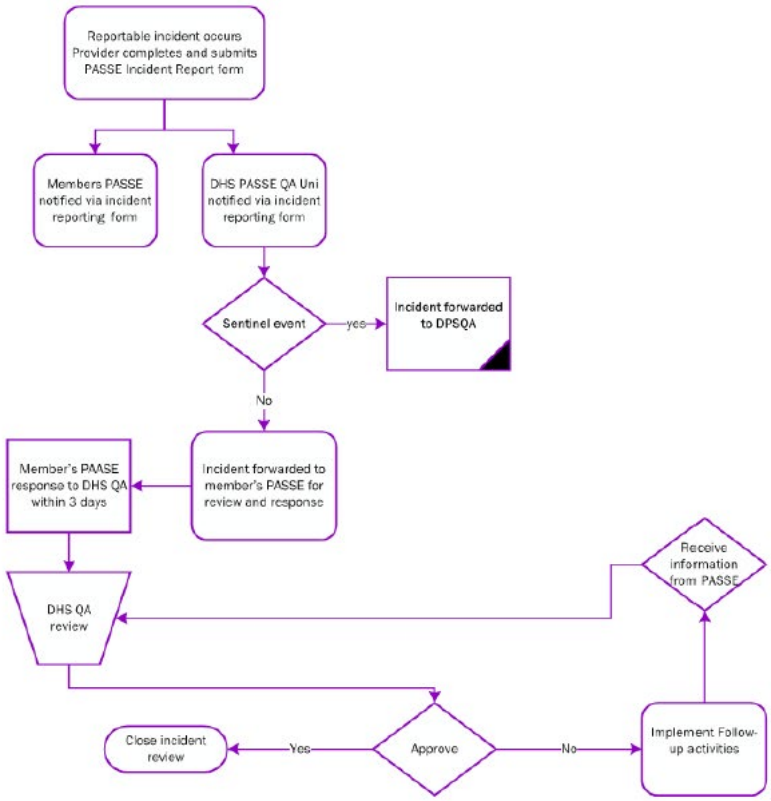
1. Be chosen by the beneficiary from among setting options including non-disability specific settings (as well as an independent setting), and an option for a private unit in a residential setting.
    a. Choice must be identified/included in the beneficiary's PCSP.
    b. Choice must be based on the 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 but not limited to, 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:
    i. Units have entrance doors lockable by the beneficiary, with only appropriate staff having keys to doors.
    ii. Beneficiaries sharing units have a choice of roommates in that setting.
    iii. 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 through 10 above must be justified in the beneficiary's PCSP. The following requirements must be documented in the beneficiary's PCSP:
    i. Identify a specific and individualized assessed need.
    ii. Document the positive interventions and supports used prior to any modifications to the PCSP.
    iii. Document less intrusive methods of meeting the need that have been tried but did not work.
    iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
    v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
    vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    vii. Include the informed consent of the beneficiary.
    viii. Include an assurance that interventions and supports will cause no harm to the beneficiary.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Innovation and Delivery System Reform

P.O. Box 1437, Slot S401 · Little Rock, AR 72203-1437
501-682-8292 · Fax: 501-682-1197



All reportable incidents must be reported to DHS Quality Assurance (QA) and the affected member's PASSE

DHS QA
Phone 501-371-1329 Fax 501-371-1474
Email dhs.dds.central@arkansas.gov

PASSE
Summit (APC LLC) 1-844-462-0022
Arkansasquality@anthem.com
Empower 866-261-1286
Incident.reporting@empowerhcs.com
Arkansas Total Care 866-262-6280
incident@ArkansasTotalCare.com.

ARKANSAS PASSE Incident Report Form

Type of report ____ **Initial Written** **Date/Time:** _____
____ **Follow-up** **Date:** _____
____ **Final** **Date:** _____

____ APC LLC dba Summit 1-844-462-0022 ArkansasQuality@anthem.com
____ Empower 866-261-1286 Incident.Reporting@empowerhcs.com
____ Arkansas Total Care 866-282-6280 incident@ArkansasTotalCare.com

Incident Date: _____ Incident Time: _____
Injured Person Name: _____
Address: _____
Phone Numbers: _____
Age or Date of Birth: _____ Gender _____ Race:_____ Legal Status: _____

Incident type
____ Death Suspected cause_____
_____ Suicidal behaviors ___Rape _____Maltreatment/Abuse/Exploitation ___ Neglect ___Verbal
___Physical ___Sexual ___Other _____ _____ Missing client _____injury
____Disturbance ___ Property destruction ___Theft _____ Arrest ___Other
_____

Does Incident/injury require medical attention Yes: _____ No: _____

Physician/Hospital Name: _____
Address: _____
Phone Numbers: _____

Designation of incident:

___Member to member ___Member to Staff ___ Self-inflected ___member to public ___Public to Member
___Other _____

Roles (relationship to subject) and Names of others involved

_____	_____	_____
Role	Name	Address and phone
_____	_____	_____
Role	Name	Address and phone

(Continue on next page as needed)

Notifications (enter method, date and time when communicated as appropriate)
___Adult Protective Services Hotline (1-800-482-8049) _____
___Child Abuse Hotline (1-800-482-5964) _____
___ DHS PASSE Incident report line (501-371-1329 fax 501-371-1474) _____
___DHS PASSE Ombudsman
___Next of Kin _____
___ Responsible Party (if different from above: _____
___ Law Enforcement
___ Other_____

PASSE Incident Report Form (Page 2)

Type of report
____ **Initial Written**
____ **Follow-up**
____ **Final**

Date of incident: _____
Time of incident: _____
Place of incident: _____

Clear, Concise description of incident

Should/Could incident have been prevented/anticipated? ___ Yes ___ No (if yes, please explain)

Findings/outcome/disposition (when appropriate include corrective action or preventive plans for future)

____ Pending investigation

___ Investigated with appropriate action/preventive plan attached

Additional information as needed:

Person submitting form: _____ Title: _____

PASSE: _____ Phone Number: _____ email: _____

HCBS Provider: _____ Contact: _____

Phone Number: _____ email: _____