

# provider office manual



An arch covers and protects all who stand beneath it.

**The strength of an arch comes from the sum of its parts.**

The strength of ArchCare Advantage comes from the connection of our staff, provider network and Nurse Practitioner/Care Managers working together to provide members with comprehensive, coordinated and compassionate care.

**An arch is used to provide an opening, passageway or entrance.**

**An arch is welcoming.**

The welcome begins when our Nurse Practitioner/Care Manager introduces our services and gets to know the member and their family. A Nurse Practitioner is specially trained to conduct thorough physical exams and manage your chronic health care conditions. He/she will prepare treatment plans and order tests, medications and other services. The Nurse Practitioner guides the member along the healthcare continuum to ensure that they get what they need, when they need it.

# TABLE OF CONTENTS

<b>How to Contact ArchCare Advantage</b>	6
<b>Introduction</b>	7
<b>Archcare Advantage Model of Care</b>	7
<b>Compliance with Contract, Regulations and this Manual</b>	10
<b>Member Rights</b>	12
• Member Right Timely, Quality Care and Receipt of Covered Services	12
• Privacy and Protection of Personal Health Information	12
• Information about the Plan	13
• Treatment with Dignity and Respect	13
<b>Provider Rights &amp; Responsibilities</b>	13
• Primary Care Physicians and Medical Team Members	14
• PCP Responsibilities	14
• Specialist Responsibilities	15
• Overall Physician and Provider Responsibilities	16
• Confidentiality	17
• HITECH Act	17
<b>Fraud and Abuse</b>	18
• Adhere to ArchCare Advantage’s HMO Compliance Policies	18
<b>Access and Availability</b>	19
<b>Advance Directives</b>	20
• Health Care Proxies	21
• Do Not Resuscitate (DNR)	21
• Living Wills	21
• Informed Consent	21
<b>Member Identification</b>	22
<b>Benefits</b>	23
• Covered Services	23
• ArchCare Advantage Benefits	23
• Exclusions	23
• Post-Stabilization, Emergency and Urgently Needed Services	24
• Renal Dialysis	25
• Medicare Part ‘B’, Covered Drugs and Supplies	25
• Questions or Concerns	25
<b>Prior Authorization Guidelines</b>	25
• How to obtain Prior Authorization	26
<b>Enrollment Eligibility and Enrollee Orientation</b>	26
<b>Disenrollement</b>	27
<b>Enrollee Appeals and Grievances</b>	28
<b>Submitting Grievances</b>	29
<b>Expedited Organization Determinations</b>	29
• Standard Medicare Appeals Process	29
• Grievances Filed Against a Provider	30
• Provider Responsibility	30

• Submission of Member Appeals	30
• 14 Day Extension	31
• Non Contracted Provider Appeals	31
<b>Credentialing</b>	32
• Physician and Health Care Provider Credentialing	32
• Facility Credentialing	32
• Skilled Nursing Facility Credentialing	32
• Delegated Credentialing	33
• Medical Record Review	33
• Adverse Credentialing Determination Appeals	34
• Requests for Additional Information	34
• Appeals Process for Providers	34
<b>Termination</b>	35
<b>Sanctions</b>	36
• Resolving Disputes	37
• Contract Concern or complaint	37
• Arbitration	37
<b>Data Collections</b>	37
<b>Protect Confidentiality of Patient Data</b>	38
<b>Medical Records</b>	38
<b>HIPAA and Releasing Information</b>	39
<b>Foreign Language Translation</b>	39
<b>Preventive Health Care Services</b>	39
• Women’s Health Services	40
• Vaccines	40
<b>Complex or Serious Health Condition</b>	40
• Health Risk Assessment	41
<b>Quality Improvement Program</b>	41
• Quality Improvement Organization (QIO)	41
• Participation of Providers with QI Activities	42
• Quality Improvement Activities	42
• Patient Safety	42
• Quality of Care Issues	43
• HEDIS Measures	43
• Adult Health Screening	45
• Clinical Practice Guidelines	45
<b>Private Contract “Opt Out”</b>	45
<b>CMS Enrollee Survey</b>	46
<b>Billing and Claims</b>	46
• Part A Covered Services and Reimbursement	47
• ArchCare Advantage Payment in Full/Member Held Harmless	47
• General Billing Requirements	48
• National Provider Identifier (NPI)	49
• Present on Admissions (POA)	49
• Facilities	49
• Skilled Nursing Facility (SNF) billing	50
• Coordination of Benefits (COB)	50
• Electronic Billing	51

• Paper Claim Submission	52
• Late Claim Submission	52
• Claim Inquiries	53
• Request for Review and Reconsideration of a Claim	53
• Explanation of Payment (EOP)	54
• Overpayments	54
• Notice of Overpayments Before Seeking Recovery	55
• If you Agree That We Have Overpaid You	55
• If You Disagree that We Overpaid You	55
• If You Fail to Respond to Our Notice of Overpayment	56
<b>Appendix</b>	
<b>A- Provider Addition/Change Request Form</b>	<b>57</b>
<b>B- Sample Explanation of Benefits (EOP)</b>	<b>58</b>
<b>C- Cultural Competency Self Review</b>	<b>58</b>

# **How to Contact ArchCare Advantage**

## **Administrative Office/Plan Address**

205 Lexington Avenue  
14<sup>th</sup> Floor  
New York, NY 10016

### **Providers:**

- Credentialing, Contract Status, Provider Information Changes, Training and Orientations

1-800-373-3177

Telephone

1-646-794-1400

Fax

### **Clinical Services**

- Pre-authorization requests can be obtained by:
  - Calling 1 – 800-373-3177, or
  - Fax 1-212-524-5163, or

Department e-mail [clinicalservices@archcare.org](mailto:clinicalservices@archcare.org)

### **Claims:**

1-866-479-5050

Telephone

### **Claims Submission Address**

ArchCare Advantage  
c/o TriState Benefit Solutions  
619 Oak Street  
Cincinnati, OH 45206

### **Electronic Claims (Payer ID 31144)**

To sign up for electronic billing with Emdeon or for more information visit [www.emdeon.com](http://www.emdeon.com) or call 1-866-924-4634 #4.

### **Member Services**

1-800-373-3177

Monday – Sunday 8am – 8pm

1-646-233-5745

Telephone

1-800-662-1220

Fax

TTY/TDD (Teletype)

Department e-mail [archcareadvantagememberservices@archcare.org](mailto:archcareadvantagememberservices@archcare.org)

**ArchCare Advantage Website:** [www.archcareadvantage.org](http://www.archcareadvantage.org)

### **Compliance Hotline**

*(Fraud and Abuse Prevention)*

1-800-443-463

Telephone

## **Introduction**

ArchCare Advantage will update the Provider Manual periodically and will make available electronic versions which can be viewed from our web site at [www.archcareadvantage.org](http://www.archcareadvantage.org). Information related to these updates may appear on the ArchCare Advantage web site, in our bi-annual provider newsletter and in other mailings. This manual provides the most current information on the ArchCare Advantage program and your responsibilities under this program.

## **Model of Care**

The ArchCare Advantage model of care management is a continuous, collaborative process with the member, their family, nursing facility staff, and the member's primary care and specialty physicians. This care management process consists of initial and recurrent assessments, planning, implementation, coordination, monitoring, and evaluation of options and services to meet the member's health care needs using available resources to promote quality, cost-effective outcomes. The chronically impaired member has access to a wide range of services from primary and preventive services to acute care. The ArchCare Advantage care management model integrates these services, develops a plan and manages transitions to ensure continuity of care across all settings.

The model of care is designed around a Master's prepared nurse practitioner (NP) or Physician Assistant (PA) care manager who has enhanced training and is licensed to assess, diagnose and treat acute and chronic health care problems. The nurse practitioner/physician assistant care manager, who is assigned to each member upon enrollment, is the single point of contact for all services and collaborates with the member's primary care physician and a team of health care providers in the nursing home as well as with hospital and community based providers.

The team of health care providers known as the Interdisciplinary Care Team (ICT) is composed of but not limited to, nurses including registered and licensed practical nurses, certified nursing assistants, social workers, dietitians (nutritionists), restorative health specialist (physical therapist, occupational therapist, speech pathologist), behavioral and/or mental health specialists (Psychiatrist, Psychologist) and pastoral care.

The NP/PA is the primary care coordinator who collaborates with the member's primary care physician and the ICT for the life of their enrollment in ArchCare Advantage. The NP care manager and ICT engage in ongoing care management at scheduled meetings and when there is a change of condition e.g. change in mental status or a return from the hospital, to coordinate and communicate clinical assessments and develop appropriate interventions that meet the member's needs.

Our Care Management Program (CMP) goals and objectives include to:

- Conduct initial and ongoing timely assessments and provide coordinated, cost effective, interventions to members in the nursing home;

- Assist the member to function at the highest level of consistent with their goals of care;
- Improve the quality of life while reducing avoidable hospital admissions and emergency department visits;
- Facilitate communication among members and their families, primary care physicians, the ICT and other health care providers;
- Maintain or improve the member's health status;
- Improve or maintain our members mobility and functional status, improve pain management, self-management and independence consistent with goals of care;
- Improve access to affordable care for all covered services including medical, mental health and social services;
- Improve coordination of care and transitions of care across healthcare settings and providers through an identified point of contact;
- Improve quality of life as self reported by members or family and satisfaction with health services;
- Assist and guide the member and their family through advance care planning, comfort and palliative care and end of life issues when appropriate.

NP/PAs receive initial orientation and ongoing training to ensure that they are well prepared to meet the needs of the members. Training includes; case based bedside teaching with the Medical Director supplemented by reading materials, weekly telephonic meetings dealing with clinical issues, case based interactive presentations addressed at common geriatric syndromes in nursing homes, e.g. dementia, depression, falls, urinary incontinence, acute change in condition, infections, nutritional issues, advance care planning, polypharmacy and attending geriatric conferences and didactic presentations. In addition, NP/PAs have access to an extensive self-study library of (e-Learning) which includes a wide range of clinical topics.

The ArchCare Advantage provider network was developed and is routinely monitored to ensure that it is sufficient to provide adequate access and availability to meets the needs of our members. The Provider Relations staff works closely with the care team to identify network needs e.g. specialists who will come to the nursing home to evaluate the member rather than have the member transported to the physician's office Providers are educated about the care management program, the special needs of the members and the benefits of a partnership with the ICT. The account manager and clinical manager provide in-service education to nursing facility staff and serve as a resource for clinical and administrative issues. The Provider Relations staff also develops supports and manages the business relationships with contracted providers.

Members are assessed upon enrollment to identify actual and potential problems that dictate the types of interventions and treatments necessary to achieve the desired outcomes. The assessment includes but is not limited to: health status, clinical history, physical examination; geriatric review of function; medication review, activities of daily living (ADL), instrumental activities of daily living (IADL), mental status including cognitive function, medication review as well as assessment of affective disorders e.g. depression, cultural and language preferences or limitations, and advance care planning. Members are continuously monitored and evaluated for an acute change of condition or



critical event e.g. a fall or unplanned hospital admissions or readmissions or emergency department visits. A social work assessment may be necessary to evaluate the psychological, social service and member's eligibility for financial entitlement.

Following the initial assessment, the NP/PA care manager formulates a care plan tailored to meet the member's functional, medical, behavioral, emotional needs. This care plan includes; goals and objectives and specific services and benefits to be provided with measurable outcomes. Members and their families are included in the development of the care plan which reflects their goals of care and care preferences. Coordination, communication and discussion between the NP/PA care manager, primary care physician and the members of the ICT occurs regularly through formal case conferences, team meetings, family meetings or informal consultation and shared electronic medical record. During ICT meetings, clinical supervisor meetings, medical director rounds and case conferences, assessment findings, specific problems or care needs and interventions treatments are discussed. These discussions present the team with the opportunity to monitor and reevaluate the care plan to confirm that the planned interventions remain appropriate to the member's condition and projected/desired outcomes.

A goal of the program is to reduce unnecessary utilization, service duplication and medical errors and incidents through assessment, planning and coordination of care to reduce transitions. The NP and the ICT manages and provides coordination and continuity of care across all settings. The NP/PA care manager enhances the communication of transitional care information with health care practitioners between sending and receiving facilities. Through collaborative working relationships with hospitals and other health care practitioners, the NP effectively monitors, plans and manages the member's return to the nursing home from the hospital.

Essential to the care planning process are the discussions with the member, their family and the NP/PA care manager regarding advance care planning including advance directives, health care proxy ,living wills, and medical orders for life sustaining treatment (MOLST) Honoring member and family preference is a critical element in the development of a quality advance care plan. An integral part of the care planning process includes documentation of the presence of an advance care plan or advance care planning discussion including goals of care. These discussions helps members and their families proactively communicate their wishes to the NP/PA care manager and re-evaluate them periodically based on changing preferences, health conditions or life changes.

The Care Management Program is evaluated on an on-going basis to monitor and assess performance and effectiveness of the care management process. Data is collected, analyzed and discussed monthly at the UM Committee and reported quarterly to the QIC. Data is used to ensure compliance with standards, evaluate staff performance, develop training materials and conduct staff training, improve processing workflow and when necessary revise policies and procedures. The Director of Clinical Services has oversight and reporting responsibility with final responsibility resting with the Medical Director.

### **Compliance with the Contract, Regulations, and this Manual**

ArchCare Advantage is subject to certain requirements as set forth by the Centers for Medicare and Medicaid Services (CMS) for this health plan and will disclose to CMS all information necessary to administer and evaluate the program, and establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. The ArchCare Advantage provider contract requires compliance with the contract and with federal regulations governing Medicare Advantage health plans and the plan's policies and procedures. Those requirements are set forth in the ArchCare Advantage provider contract, this manual and from time to time in provider newsletters and other communications and notices sent by ArchCare Advantage.

In accordance with ArchCare Advantage's Medicare Advantage Contract with CMS, the following items must be adhered to by each participating ArchCare Advantage provider.

- Providers understand that ArchCare Advantage is responsible for overall administration of the health plan including all final coverage determinations and monitoring of its contracted provider's compliance with state and federal regulations.
- ArchCare Advantage is responsible for all marketing of the health plan and providers are not authorized to act as agents of ArchCare Advantage in marketing. Only ArchCare Advantage-approved marketing materials may be provided to beneficiaries to explain the ArchCare Advantage program.
- Providers will comply with ArchCare Advantage Utilization/Medical Management Policies and Procedures.
- Providers will comply with ArchCare Advantage Quality Management Programs. ArchCare Advantage requires that all providers participate in periodic audits and/or site surveys for evaluating compliance with ArchCare Advantage Quality Management standards and regulatory requirements.
- Medical Records - ArchCare Advantage Providers must safeguard the privacy of any information that identifies a particular Member and must maintain Member records in an accurate and timely manner. Contracted providers must provide an ArchCare Advantage Medical Director or designee access to all ArchCare Advantage Members' charts and medical records for the purpose of determining or resolving eligibility, liability or appropriate care issues. Provider, as prescribed by State and federal law under HIPAA regulations, will maintain confidentiality of this information. ArchCare Advantage is concerned with protecting Member privacy and is committed to complying with the HIPAA privacy regulations. Generally, covered health plans and covered providers are not required to obtain individual Member consent or authorization for use and disclosure of Protected

Health Information (PHI) for treatment, payment and health care operations. Activities such as care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement fall into this category. If you have further concerns, please contact your Provider Relations Representative.

- No Balance Billing of Members with the exception of applicable co-payments, deductibles or coinsurance. An ArchCare Advantage contracted provider agrees not to impose any charges on any ArchCare Advantage Member for Covered Benefits shown in the Evidence of Coverage. Further, contracted providers agree to accept the ArchCare Advantage payment as payment in full and agree not to seek compensation from an ArchCare Advantage Member for services provided to that Member, even in the event of non-payment by ArchCare Advantage.
- Contracted providers agree to retain financial and medical records relating to ArchCare Advantage Members for a period of ten (10) years from the termination of the contract or such time as may be required by applicable state or federal law, regulation or customary practice.
- ArchCare Advantage Providers must give the U.S. Department of Health and Human Services, the U.S. Government Accounting Office and their designees the right to audit, evaluate, and inspect their financial records, contracts, medical records, member documentation and other relevant records. These rights will extend for ten (10) years beyond termination of the ArchCare Advantage Agreement and until the conclusion of any governmental audit that may be initiated that pertain to such records.
- ArchCare Advantage Providers must not discriminate against Members based on their health status. Further, Providers must ensure that Members are not unlawfully discriminated against based on race, color, creed, national origin, ancestry, religion, sex, marital status, age, physical or mental handicap, or in any other manner prohibited by state or federal law.
- ArchCare Advantage Providers must provide all covered benefits in a manner consistent with professionally recognized standards of health care.
- ArchCare Advantage Providers must cooperate with the plan's grievance and appeals procedures that protect beneficiary and member rights.
- ArchCare Advantage Providers have specific continuity of care obligations in the event that the ArchCare Advantage Agreement terminates for any reason, including a provider's request to end the agreement or if ArchCare Advantage becomes insolvent. In the event of insolvency, ArchCare Advantage Providers must continue to provide care to Members through the period in which their CMS payments have been made to ArchCare Advantage. Additionally, if the Member is hospitalized, services must be provided until termination of CMS' agreement with

ArchCare Advantage or, in the event of ArchCare Advantage' insolvency, through the date of the Member's discharge.

- ArchCare Advantage Providers may not encourage members to disenroll.

Providers should review the ArchCare Advantage contract for any additional sections or provisions not discussed in this section. In addition, the description of the contract provisions listed in this section does not constitute the complete disclosure of all requirements placed on providers contracted with ArchCare Advantage. Contracted providers should refer to their ArchCare Advantage contract for further information.

## **Member Rights**

ArchCare Advantage will inform Members of their rights and responsibilities through the Evidence of Coverage, provided to all Members once their enrollment in ArchCare Advantage is accepted and confirmed by CMS. ArchCare Advantage staff is responsible for ensuring that Members understand their rights and responsibilities. Furthermore, all staff members and contracted providers must respect and abide by a Member's rights and responsibilities as detailed below.

### **Timely, Quality Care and Receipt of Covered Services**

- Choice of a qualified and certified Medicare provider primary care physician, specialist and hospital provider.
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage, in the member's preferred language and in a way the member can understand.
- Timely access to care and coordinated specialist visits when medically necessary.
- Receive emergency services when the member, as a prudent layperson acting reasonably, would have believed that an emergency medical condition existed. Payment will not be withheld for emergent services under these circumstances.
- Fully and actively obtain information from providers and participate in decisions regarding their own health and treatment options.

### **Privacy and Protection of Personal Health Information**

- Confidential treatment of all communications and records pertaining to their care. Members have the right to access their medical records, and ArchCare Advantage must provide members with timely access to their records and any information that pertains to them. ArchCare Advantage will obtain written permission from the member or their authorized representative before medical records are made available to any person not directly concerned with the member's care or responsible for making payments for the cost of such care.

**Information about the Plan**

The member has the right to:

- make a complaint about any concerns or problems related to coverage or to care received, without fear of retaliation or unfair treatment because a complaint was made;
- request information about covered medical services.

**Treatment with Dignity and Respect**

- Always be treated with dignity, respect, and fairness and to have their right to privacy recognized.
- Exercise these rights regardless of a member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care. Members can expect these rights to be upheld by both ArchCare Advantage and the network providers.
- Refuse treatment or leave a medical facility, even against the advice of network providers (providing the member accepts the responsibility and consequences of the decision). If the member makes a decision to leave a network Nursing Home, they will be informed that such a decision may leave them ineligible for continued enrollment in ArchCare Advantage.
- Complete advance care directives including health care proxy, living will, and medical orders for life sustaining treatments (MOLST) or other directive about how they want their care to be handled, in the event that they are unable to make decisions for themselves. This information will be provided to their network providers.
- Extend these rights to any person who may have legal responsibility to make decisions on their behalf regarding their medical care.

## **Provider Rights & Responsibilities**

ArchCare Advantage will not discriminate against any healthcare professional acting within the scope of his/her license or certification under state law regarding participation in the network, reimbursement or indemnification, solely on the basis of the practitioner's license or certification. Nor will ArchCare Advantage discriminate against healthcare professionals who serve high-risk members or who specialize in the treatment of costly conditions.

ArchCare Advantage providers will be given written notice of material changes to the participation rules and requirements in this Provider Manual at least 30 days before the changes are implemented. These communications will be circulated in newsletters or special mailings.

### **Primary Care Physicians and Clinical Services Team Members**

Primary Care Physicians (PCP) are Internists, Geriatricians, Family Practitioners, General Practitioners and Pediatricians. Nurse Practitioners and Physician Assistants work collaboratively with the primary care physician to enhance, coordinate and improve the care of the ArchCare Advantage member.

#### **PCP responsibilities include:**

- Providing coverage for their practice 24 hours a day, 7 days a week with a published after hours telephone number, pager or answering service.
- The management of medical care provided to Members who have chosen or been assigned to the physician and team as their Primary Care Physician. A PCP is expected to provide all necessary care required by a Member that is within the scope of his or her practice and expertise. The PCP should refer a Member to a specialist or other provider only when he or she is not able to provide the specialty care.
- Coordinate the services a Member may need that can be effectively provided within the nursing facility.
- Coordinate all referrals for specialty care.
- Obtain Pre-authorization for the following services:
  - All out of network services
  - All elective inpatient Hospitalizations
  - Ambulatory Surgery
  - PET Scans
  - Air Fluidized beds (Pressure Reducing Support Surfaces – Group 3)
  - Alternating Pressure Mattresses and Low-Air Loss Mattresses (Pressure Reducing Support Surfaces-Group 2)
  - Radiation Therapy
  - Power Mobility Assistive Equipment (Scooter/Power-Operated Vehicle, Power Wheelchair)
  - Hyperbaric Oxygen Treatment
  - Home Health
- Notify the ArchCare Advantage assigned Care Manager or the ArchCare Advantage Clinical Services department at (1-800) 373-3177 of any Member's acute change in condition.
  - ❖ Notification within one business day for Critical changes in condition such as falls, loss of consciousness and other conditions as listed in the system-wide Policy and Procedure "Acute Change in Condition" revised 5/4/2012.
  - ❖ Notification within 48 hours of change in condition which may include but not be limited to the following:
    - Suspect, abnormal, unconfirmed x-ray results
    - Need to discontinue treatment for reasons other than one due to adverse consequences
  - ❖ Notification within 3 calendar days of change in condition which may include:
    - Decrease in food intake of 25%
    - Decrease in frequency of BM of 2 days duration
  - ❖ Notification within 4-7 calendar days of change in condition which may include:
    - Need to remove a pre-existing cyst which is now producing symptoms.

- Need to perform non emergent procedure/treatment needing elective scheduling of such procedure
- Notify the ArchCare Advantage assigned Care Manager or the ArchCare Advantage Clinical Services department at (1-800) 373-3177 of any potential Member transition (e.g. transition from home to Emergency Room, or home to hospital) as soon as the potential transition is identified.
- Coordinate a member's care needed from specialty physicians or other healthcare providers by referring to providers in the ArchCare Advantage network of providers.
- Except in emergency and urgent situations and for renal dialysis services for those members temporarily out of the service area, if services are not available within the ArchCare Advantage network of providers, then the Primary Care Physician must contact ArchCare Advantage' Medical Management team to obtain prior authorization to refer a Member to a nonparticipating provider prior to the care being rendered. Please call 1-800-373-3177 to request authorizations.
- Provide direction and follow-up care for those Members who have received emergency services.
- PCP's and their care team are responsible for all Members who select them, including members whom the PCP has not yet seen.

## **Specialist Responsibilities**

The role of the ArchCare Advantage participating specialist is to provide consulting expertise, as well as specialty diagnostic, surgical and other medical care for ArchCare Advantage Members. ArchCare Advantage expects a participating specialist to support the role of a PCP in coordinating and managing a Member's health care by discussing the consultation and recommendations with the PCP preferably before the provision of services, providing only those specific services for which a referral has been issued, and promptly returning the Member to the PCP as soon as medically appropriate. Open, prompt communication with the PCP concerning follow-up instructions, circumstances of further visit requirements, medications, lab work, x-rays, etc. are essential to the coordination of care.

### **The ArchCare Advantage Specialist's responsibilities include:**

- Specialists must provide coverage for their practice 24 hours a day, 7 days a week with a published after hours telephone number, pager or answering service.
- Specialists should order all laboratory testing, radiology studies or other diagnostic testing through a contracted, in-plan facility unless an emergency situation clearly indicates emergency laboratory or radiology services are indicated. ArchCare Advantage has specific, contracted laboratory and radiology service providers.
- Specialists are encouraged to “Fast Track” the member through his/her office on the day of their scheduled appointment. “Fast Track” includes the following components:
  - 1) When the member gets to the office, the member will be escorted immediately back to an exam room and be seen by the specialist.
  - 2) The transportation attendant will also wait for the member during this “fast tracking” so the member will not have to wait in the waiting area after the appointment and the office staff will not have to call for the transportation company to return to pick-up the member.
- Obtain Pre-authorization for the following services:
  - All out of network services
  - All elective inpatient Hospitalizations
  - Ambulatory Surgery
  - PET Scans
  - Air Fluidized beds (Pressure Reducing Support Surfaces – Group 3)
  - Alternating Pressure Mattresses and Low-Air Loss Mattresses (Pressure Reducing Support Surfaces-Group 2)
  - Radiation Therapy
  - Power Mobility Assistive Equipment (Scooter/Power-Operated Vehicle, Power Wheelchair)
  - Hyperbaric Oxygen Treatment
  - Home Health



### **Overall Physician and Provider Responsibilities**

Providers shall provide to Members Medically Necessary Covered Services on an as needed basis, within the scope of providers licensing, training, experience and qualifications and consistent with accepted standards of medical practice and the terms and conditions of this Agreement. In providing covered services, providers shall at all times comply with ArchCare Advantage requirements, including but not limited to the Utilization Management and Quality Improvement process. ArchCare Advantage shall have the sole discretion to determine if services provided are covered services.

Providers shall immediately notify ArchCare Advantage, in writing, if their ability to practice medicine is restricted or impaired in any way, they have been sanctioned by either Medicare or Medicaid, or if their license to practice their respective profession is revoked, suspended, restricted, requires a practice monitor or is limited in any way, or if any adverse action is taken, or an investigation is initiated by any authorized Local, State or Federal agency, or of any new or pending malpractice actions, or of any reduction, restriction or denial of clinical privileges at any affiliated hospital.

- Providers shall comply with all ArchCare Advantage administrative, patient referral, quality assurance, utilization management, and reimbursement procedures.
- Providers shall not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, and disability, place of residence, health status, or source of payment and shall observe, protect, and promote the rights of members as members and any other category protected by law.
- Providers shall cooperate and participate in all ArchCare Advantage peer review functions, including quality assurance, utilization review, administrative, and grievance procedures as established by ArchCare Advantage.
- Providers shall comply with all final determinations rendered by ArchCare Advantage peer review programs, or external arbitrators for grievance and appeals procedures consistent with the terms and conditions of the Provider's agreement with ArchCare Advantage.
- Providers shall notify ArchCare Advantage in writing of any change in office address, telephone number, or office hours. A minimum of thirty (30) days advance notice is requested.
- Providers shall notify ArchCare Advantage at least ninety (90) days in advance, in writing, of any decision to terminate their relationship with ArchCare Advantage or as required by the provider's agreement with ArchCare Advantage.
- Providers shall not under any circumstances, including non-payment or insolvency of ArchCare Advantage, bill, seek or accept payment from ArchCare Advantage members for covered services with the exception of co-payments.

- Providers agree to maintain standards for documentation of medical records and confidentiality for medical records as defined in the Medical Records section of this manual.

### **Informed Consent**

The provider will adhere to all federal and state law requirements for obtaining informed consent for treatment. Properly executed consents must be included in the medical record for all procedures that require informed consent.

### **Confidentiality**

All Protected Health Information (PHI), as this term is defined by the Health Insurance Portability and Accountability Act of 1996 (45 CFR § 164.501), related to services provided to members shall be confidential pursuant to Federal and State laws, rules and regulations. PHI shall be used or disclosed by the provider only for a purpose allowed by or required by Federal or State laws, rules, and regulations.

Medical records of all ArchCare Advantage members shall be confidential and shall only be disclosed to and by provider's personnel as necessary to provide medical care and quality, peer, or complaint review of medical care under the terms of the applicable program contract as required in accordance with applicable laws and regulations.

### **HITECH Act**

The Health Information Technology for Economic and Clinical Health (HITECH) Act, was passed as part of the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

Enacted in part to assist healthcare providers who are, or will be, utilizing electronic health records (EHR) systems, the HITECH Act addresses consumer access to their EHR, increases application of HIPAA privacy standards to business associates of covered entities, and implements a tiered system of civil monetary penalties for HIPAA violations.

Under the HITECH Act, business associates are now responsible for complying with the provisions and regulations of HIPAA and are directly answerable to the government for HIPAA breaches. Business associates are now also directly liable for civil and criminal penalties. This increased statutory liability for business associates under HIPAA will likely result in the necessity of updating business associate and vendor lists as well as re-negotiating business associate agreements. In addition, business associates will most likely incur costs associated with bringing themselves into direct HIPAA compliance. The Secretary of the Department of Health and Human Services (HHS) will ultimately issue guidance regarding these safeguards.

The HITECH Act also expands the notification requirements due to breaches of an individual's PHI. Both covered entities and business associates are now obligated to notify individuals of breaches of their PHI. In cases where more than 500 "residents of a State or jurisdiction" have had their PHI breached, "prominent media outlets" serving that area must also be notified. Individuals should be notified in writing or e-mail if that is their preferred method of contact, and be provided with basic information about the breach, such as:

- when the breach happened, when the event was discovered, and a brief statement about what happened;
- what type of PHI was breached;
- things that the individual can do in order "to protect themselves from potential harm resulting from the breach";
- what corrective actions and investigation the covered entity is doing to prevent future breaches and mitigate losses; and
- contact information for the individual to use in case of any questions.

In addition to disclosure accounting, the individual is also entitled to receive a copy of his or her electronic health record, if they request; this information may be sent to the individual, or another person designated by individual.

For more information about the HITECH Act, please visit the CMS website at [www.cms.gov](http://www.cms.gov).

## **Fraud and Abuse**

### **Adhere to ArchCare Advantage's HMO Compliance Policies:**

ArchCare Advantage HMO operates a comprehensive compliance program that actively investigates allegations of fraud, abuse and waste on the part of providers and members. Fraud and abuse are broadly defined as intentional deception or misrepresentation that results in an unauthorized benefit, payment or inappropriate care. The following are some examples of fraudulent, abusive, and unacceptable practices that are prohibited by ArchCare Advantage HMO:

- Submission of false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled (i.e. up coding or unbundling of charges).
- Billing for services not rendered or billing in advance of care.
- Knowingly demanding or collecting any compensation in addition to claims submitted for covered services (except where permitted by law).
- Ordering or furnishing inappropriate, improper, unnecessary or excessive care services or supplies.
- Failing to maintain or furnish, for audit and investigative purposes, sufficient documentation on the extent of care and services rendered to members.

- Offering or accepting inducements to influence members to join the plan or to use or avoid using a particular service.
- Submitting bills or accepting payment for care, services or supplies rendered by a provider who has been disqualified from participation in the Medicare or Medicaid programs.

Providers must comply with federal laws and regulations designed to prevent fraud, waste and abuse, but not limited to, applicable provisions of federal criminal law, the False Claims Act, the anti-kickback statute, and the Health Insurance Portability and Accountability Act administrative simplification rules, applicable state and federal law, including, but not limited to, Title VI of The Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act and all other laws applicable to recipients of federal funds from which payments to providers under this Agreement are made in whole or in part, and all applicable Medicare laws, regulations, reporting requirements, and CMS instructions.

Confirmed cases of fraud and abuse are reported to the appropriate state agency. Providers who suspect fraud, waste and abuse on the part of another provider or a member should contact the ArchCare Compliance Hotline at 1-800-443-0463. Remember, you may report anonymously as ArchCare Advantage HMO abides by a zero-tolerance against non-compliance.

## Access and Availability

ArchCare Advantage is available in a defined service area approved by CMS. The current service areas are:

- Bronx (Bronx County)
- Brooklyn (Kings County)
- Dutchess County
- Manhattan (New York County)
- Orange (Orange County)
- Queens (Queens County)
- Staten Island (Richmond County)
- Westchester (Westchester County)

Within this service area, ArchCare Advantage must offer a uniform benefit package and maintain a network of contracted physicians to meet access standards. Accessibility of services is measured by the timeliness of appointments for routine, urgent and emergency care. Each provider/practitioner must, at a minimum, meet the following standards of access and availability for all ArchCare Advantage members:

- Primary care providers and specialists provide coverage for their practice 24 hours a day, 7 days a week with a published after hours telephone number, pager or answering service.

- For emergency services: Available immediately or triage to Emergency Department.

- Urgent care services – service is provided within 24 hours. Urgent Care as defined by the Centers for Medicare & Medicaid Services (CMS), means those covered services provided when an enrollee is temporarily absent from the service area or the continuation area when such services are medically necessary and immediately required:
  - As a result of an unforeseen illness, injury or condition; and
  - It was not reasonable given the circumstances to obtain the services in plan.
- Non – urgent symptomatic services – service is provided within 24-48 hours.
- Routine, follow-up or preventive care is provided within 2 weeks.
- Extended visits (i.e. comprehensive exam, preventative care appointment, etc.) service is provided 4 weeks of request.
- Average waiting time in the office is equal to or less than thirty minutes.

#### Telephone Access.

- Arrange for an answering system after hours that members can access through the usual office protocol.
- Response to emergency phone calls should be within thirty (30) minutes
- Response to urgent phone calls should be within one (1) hour
- Provide 24 hour physician coverage through another ArchCare Advantage participating provider to ensure the urgent and emergency needs of members can be met 24 hours per day, 7 days per week
- TTY will be provided by calling 1-800-662-1220.

After-hours access shall be provided to ensure:

- Response to emergency phone calls within 30 (thirty) minutes
- Response to urgent phone calls within 1 (one) hour
- Life threatening emergencies should be referred to the appropriate health care facility.

## Advance Directives

ArchCare Advantage is required to maintain written policies and procedures regarding advance directives. Our written policies must include any limitations on implementation of an advance directive due to a matter of conscience. We must clarify whether any conscientious objections are raised by ArchCare Advantage, or by individual physicians or health care providers, and describe the range of medical conditions or procedures affected by the conscientious objection. If you have a conscientious objection relating to the implementation of an advance directive, please contact Customer Service at 1-800-373-3177.

ArchCare Advantage is required to inform all enrollees of their rights with respect to advance directives. In our enrollee materials, we encourage all ArchCare Advantage members to discuss their wishes with the Primary Care Physician or ArchCare Advantage Nurse Practitioner. Physician and health care providers must document in a prominent part of the Member’s current medical record whether or not the enrollee has executed an

advance directive. The provision of care cannot be conditioned, and a Member may not be otherwise discriminated against, based on whether or not the Member has executed and advanced directive. ArchCare Advantage uses the Medical Orders for Life Sustaining Treatment or MOLST (Medical Orders for Life Sustaining Treatment) approved by New York State.

ArchCare Advantage is not required to provide care that conflicts with an advance directive, nor are we obligated to implement an advance directive if, as a matter of conscience, we object. Any enrollee complaints regarding noncompliance with an advance directive may be filed with the appropriate state survey and certification agencies.

### **Health Care Proxies**

New York State law allows people to appoint someone they trust to decide medical care and treatment if they lose the ability to decide for themselves. These decisions include termination or withholding of life support systems, artificial nutrition and hydration. The proxy document may include special instructions, limits of authority and an expiration date and may provide for the appointment of an alternative representative. An adult with capacity may revoke his or her proxy at any time.

### **Do Not Resuscitate (DNR)**

Every patient is presumed to consent to cardio-pulmonary resuscitation in the event of cardiac arrest unless a Do Not Resuscitate (DNR) order has been written by the attending physician in compliance with the member or member's proxy's wishes. A non hospital DNR order may be issued by a hospitalized patient to take effect after hospitalization or may be issued by a physician in his or her office for a person who is not a patient in or resident of a hospital or nursing home.

### **Living Wills**

Living wills are documents which attempt to express a person's health care decision with the expectation that doctors and hospitals will follow these wishes in the event that the member becomes unable to give directions. Living wills, in order to be effective, require reference to: the withdrawal of nourishment or hydration; withholding breathing assistance; cardiopulmonary resuscitation; dialysis, etc. The living will should specify, to the extent possible, the circumstances under which withholding or withdrawal of such treatments should occur. It should also specify alternative treatment desired such as relief of pain, even if such treatment would shorten the duration of life.

### **Informed Consent**

Any competent adult, age 18 or over has the right to accept, decline, terminate or withdraw medical treatment, even life-saving and life sustaining treatment, and can refuse nutrition or hydration.

A member is entitled to be advised (unless previously requested otherwise) of an existing medical condition, the prognosis of the medical condition, the possible treatments which are professionally sound for the medical condition, and the probable benefits and risks

associated with each treatment before the member makes a decision regarding acceptance or refusal of medical care.

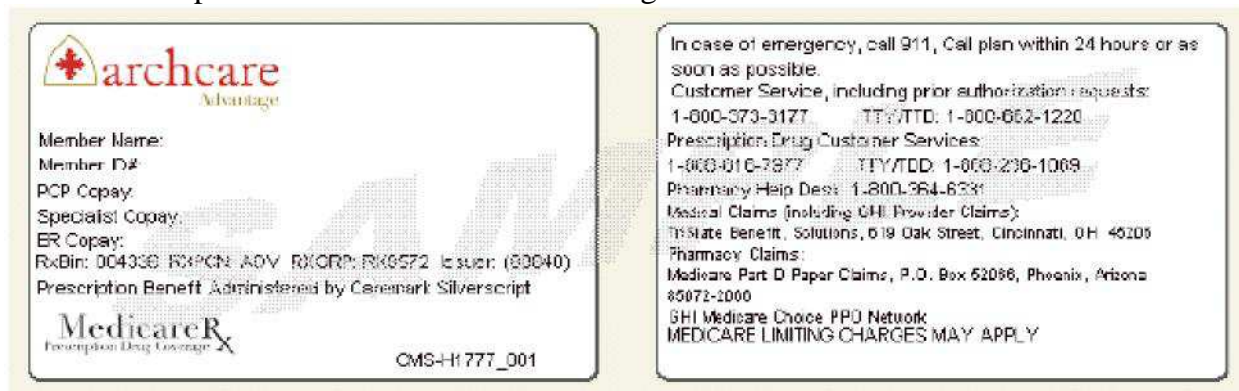
## Member Identification

Every ArchCare Advantage member receives a member identification card to present to physicians and providers when seeking health care services.

Providers should always verify member eligibility prior to the appointment. If the enrollee does not have an identification card, please call Member Services at 1-800-373-3177 to verify eligibility. Enrollees may use a copy of their enrollment form as interim proof of enrollment.

The ArchCare Advantage enrollee will receive their identification card and letter that will display the enrollee's name and member ID number. This card identifies the enrollee as an ArchCare Advantage enrollee. Medicare will not be responsible for claims for this enrollee while they continue to be enrolled. During that time, all claims need to be submitted to ArchCare Advantage at the address listed on the "How to Contact Us" page.

Below is a sample of the 2010 ArchCare Advantage member ID card:



ArchCare Advantage will make available a preliminary roster of current members for their respective Nursing Home to the Nurse Practitioners prior to the first of every month. PCPs will receive the final monthly electronic Member eligibility file no later than the 15<sup>th</sup> day of each month. In the event the 15<sup>th</sup> day falls on a non-business day or holiday, it will be made available on the next business day. Included in the roster will be all current Nursing Home ArchCare Advantage membership, rejections, disenrollments and cancellations. In addition, PCPs can also verify eligibility via Customer Service. In the event that Provider fails to verify Member eligibility, Provider shall be solely responsible for the cost of services rendered to persons not eligible for such services. Provider agrees to keep all such Member information confidential and shall afford such information the protections it customarily affords to its own proprietary information.



Verification of eligibility shall not be construed as a guarantee of payment in the event that ArchCare Advantage later becomes aware, that an individual was not in fact a Member eligible for Covered Services at the time verification was provided by ArchCare Advantage. ArchCare Advantage shall not be liable to Provider for any services rendered to persons not eligible or authorized to receive services as required under the applicable Health Benefit Plan. In the event Provider's claim is denied due to the ineligibility of an individual under a Health Benefit Plan, then Provider may bill the individual for the services rendered at Provider's usual and customary fee for such services.

## Benefits

### **Covered Services**

ArchCare Advantage includes all Medicare Part A, Part B and Part D covered services as well as additional and supplemental benefits. Coverage determinations are made in conjunction with Centers for Medicare and Medicaid Services (CMS) national coverage decisions and published covered decisions of local carriers and intermediaries. New coverage decisions are communicated to contracted physicians and other health care providers via the bi-annual ArchCare Advantage Newsletter.

A general list of covered services is included in the ArchCare Advantage Summary of Benefits. All services must be provided in accordance with professional recognized standards of health care.

For a more detailed listing, contact Provider Services at 1-800-373-3177.

### **ArchCare Advantage Benefits**

ArchCare Advantage benefits are available to members when care is received from contracted network providers. The only exceptions to this are for emergency, post-stabilization care, or urgently needed health services. In order to be covered when the enrollee requires medical care, other than for services listed as exceptions above, the enrollee must use an ArchCare Advantage contracted physician or health care provider.

Except for emergency, post-stabilization care, out-of-area renal dialysis or urgently needed health services, members will be fully responsible for services provided by a non-contracted physician or health care providers. In those situations, the enrollee should submit payment directly to the physician or health care provider and not ArchCare Advantage.

### **Exclusions**

Certain services and/or service categories are excluded from coverage under ArchCare Advantage. For a complete list of exclusions, contact Customer Services and ask for the

2010 Evidence of Coverage. In addition to the specific excluded services, ArchCare Advantage may deny coverage if:

- The service is not medically necessary or
- The service is not a Medicare covered benefit .

**Post-Stabilization, Emergency and Urgently Needed Services.**

Inpatient and outpatient emergency health services are covered both inside and outside the service area. In the event of an emergency, members should seek immediate care, or call 911 for assistance. Prior authorization is not required for emergency care, and ArchCare Advantage may not deny payment if an ArchCare Advantage contracted physician or health care provider instructs an enrollee to seek emergency services.

ArchCare Advantage provides coverage for the treatment of an emergency medical condition, which is defined by CMS as a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such 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:

- Placing the health of the individual in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part

ArchCare Advantage includes coverage for post-stabilization care. In-area post-stabilization care is defined as a non-emergency services needed to ensure that the enrollee remains stabilized after an emergency. The attending physician or health care provider determines when the condition is no longer an emergency and the enrollee is considered stabilized for discharge back to the nursing home in which the member resides or transfer. Continuation of care after the condition is no longer an emergency will require coordination with ArchCare Advantage. Post-stabilization care is covered:

- If automatically approved because ArchCare Advantage did not respond to the request by the physician or health care provider of post-stabilization services for prior authorization within one hour after ArchCare Advantage was asked to approve post-stabilization care, or
- If automatically approved because ArchCare Advantage could not be reached for prior authorization despite reasonable efforts.

Such automatic approval of post-stabilization care continues to be covered until ArchCare Advantage has responded to the request and arranged for discharge or transfer.

Urgently needed health services are covered when enrollees are temporarily outside of the ArchCare Advantage service area. Urgently needed services are also covered when obtained from any physician or health care provider within the ArchCare Advantage service area in extraordinary cases when a network provider is unavailable or inaccessible due to an unusual event.

Members are encouraged to notify ArchCare Advantage as soon as possible after receiving post-stabilization, emergency or urgently needed health services. ArchCare Advantage contracted physicians or health care providers are required to notify ArchCare Advantage if a member is admitted to the hospital. The Primary Care Physician should work with the attending physician to coordinate transfer to an in area contracted facility as soon as it is medically appropriate to do so.

#### **Renal Dialysis Services**

ArchCare Advantage provides coverage for renal dialysis services both in the service area and while an enrollee is temporarily outside of the service area for up to 6 months.

#### **Medicare Part B, Covered Drugs and Supplies**

ArchCare Advantage provides coverage for Medicare Part B covered drugs and certain supplies. This includes but not limited to prescription drugs such as immuno-suppressants, oral anticancer drugs with an injectable equivalent, nebulization solutions and anti-emetics (in conjunction with oral anticancer drugs) and glucose monitoring related supplies such as glucose test strips, lancets and devices, and calibrator solutions.

#### **Questions or Concerns**

You or your patient may contact the ArchCare Advantage Customer Service Department at 1-800-373-3177 for further clarification of covered benefits.

This list does not signify coverage for benefits. Coverage is determined in accordance with the enrollees Evidence of Coverage (Member Handbook). If you have questions about a patient's benefit coverage, please call Customer Service.

To contact the ArchCare Advantage Care Management Team please call 1-800-373-3177

## **Prior Authorization Guidelines**

Prior authorization is designed to promote the utilization of medically necessary services, to prevent unanticipated denials of coverage, to ensure that participating providers are utilized, and that all services are provided at the appropriate level of care for the member's needs. Please see below for a summary of services that require referral and prior authorization.

Member benefit plans change annually, so we advise that providers review benefit and authorization requirements or call ArchCare Advantage prior to providing services.

### **How to Obtain Prior Authorization**

ArchCare Advantage Providers can call or fax all prior authorization requests into the Utilization Management (UM) Department Care Coordinator 24 hours per day, 7 days per week.

**Telephone:** 1-800-373-3177

**Fax:** 1-646-794-1400

The following information will be required for Prior authorization processing:

- Member Name
- Date of Birth and/or Social Security Number
- Facility Name
- Requesting Provider
- Referral Provider
- Diagnosis
- Requested Service with CPT code(s) and ICD-9 code(s)
- Clinical Information for medical necessity including patient progress notes, labs and imaging as appropriate

Pre-Authorization is required for the following services only:

- All out of network services
- All elective inpatient Hospitalizations
- Ambulatory Surgery
- PET Scans
- Air Fluidized beds (Pressure Reducing Support Surfaces – Group 3)
- Alternating Pressure Mattresses and Low-Air Loss Mattresses (Pressure Reducing Support Surfaces-Group 2)
- Radiation Therapy
- Power Mobility Assistive Equipment (Scooter/Power-Operated Vehicle, Power Wheelchair)
- Hyperbaric Oxygen Treatment
- Home Health

## **Enrollment Eligibility and Enrollee Orientation**

CMS determine eligibility requirements and compliance is essential. The following guidelines are used to determine ArchCare Advantage enrollee eligibility:

A completed ArchCare Advantage application form must be submitted to ArchCare Advantage. ArchCare Advantage will submit to CMS for processing and approval. The applicant signature and date are required. If applicable, a legal representative such as a court appointed guardian or Power of Attorney, may execute, and date the application form.

Each applicant must be enrolled in Medicare Parts A and B programs and live in an ArchCare Advantage contracted Skilled Nursing Facility for 90 days or longer.

The applicant agrees to abide by the enrollment rules disclosed during the enrollment process. Applicants with End Stage Renal Disease (ESRD) are not eligible to enroll in ArchCare Advantage. However, if a member develops ESRD after enrollment in the plan, they may remain enrolled in the plan.

If an applicant does not meet eligibility requirements they will receive a letter explaining that they do not meet the eligibility requirements to enroll with ArchCare Advantage. The original application will be retained at the plan indefinitely with the appropriate letter.

When an applicant does meet the eligibility requirements, an acknowledgement letter will be sent along with an ID card.

### **Member Orientation**

Once the enrollment application has been processed and eligibility has been verified the enrollee will receive a letter stating the effective date of coverage and a packet of information about ArchCare Advantage, including the Evidence of Coverage.

## **Disenrollment**

Enrollees may only disenroll from the plan during certain times of the year. In some cases, an enrollee can disenroll during other times as well. Contact the plan for details.

Disenrollment requests received during valid times of the year will be effective the first day of the following month. In certain circumstances, CMS regulatory guidelines permit ArchCare Advantage to terminate an enrollee's coverage. These terminations are considered involuntary disenrollments. Examples of an involuntary disenrollment include:

- Permanent move out of the geographic service area;
- Loss of entitlement to Medicare Part A or B benefits;
- "For cause" or "fraud and abuse" as defined in the Medicare Advantage regulations;
- Disruptive behaviors as defined by CMS;
- Medicare Advantage plan termination or service area reduction;
- First of the month if enrollee is no longer a resident at a Contracted Facility;
- Death

ArchCare Advantage may disenroll an enrollee if the individual's behavior is documented to be disruptive, unruly, abusive, or uncooperative to the extent that his or her continued enrollment in ArchCare Advantage seriously impairs our ability to furnish services either to the individual or to other enrollees. CMS must approve all involuntary disenrollments. If you encounter any instances of this type of behavior, please notify us

by calling the Customer Service Department. ArchCare Advantage will investigate all complaints and when indicated, contact CMS.

ArchCare Advantage will properly communicate all involuntary disenrollments to the enrollee. This includes providing the enrollee with a written notice in accordance with the timelines set out in CMS's Medicare Managed Care Manual (MMCM). The Primary Care Team and the skilled nursing facility will be notified monthly on the current roster of eligible enrollees.

ArchCare Advantage must notify CMS whenever an enrollee is disenrolled, so Medicare benefits assignment can be transferred back to the beneficiary.

## Enrollee Appeals and Grievances

The Plan maintains a member complaint system that includes grievance and appeals processes for ArchCare Advantage members that includes Part C (Medical Benefit) as well as Part D (Pharmacy benefit).

An **appeal** is a request for review of an action taken by or on behalf of the Plan. A member, a member's representative with the member's written consent, or a provider acting on behalf of the member and may file an appeal.

Examples of actions include but are not limited to the following:

- Denial or partial authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The denial or partial authorization of a requested medication;

A **grievance** is any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which the Plan or delegated entity provides health care services regardless of whether any remedial action can be taken. A member or a member's representative, acting on behalf of the member and with the member's written consent, may file a grievance.

Possible reasons for grievances include but are not limited to the following:

- Quality of care or of services provided;
- Rudeness of the provider; or
- Failure to respect a member's rights.

The Plan ensures that decision-makers on grievances and appeals are not involved in previous levels of review or decision-making. These decision-makers include health care professionals with clinical expertise in treating the member's condition or disease. ArchCare Advantage utilizes a pool of physicians/Peer Reviewers to render decisions on appeals & quality of care grievances when applicable.

### **Submitting Grievances**

A member or provider acting on behalf the member and with the member's written consent may file a grievance either verbally or in writing within 60 calendar days after the date of the occurrence that initiated the grievance. A verbal request may be followed up with a written request, but the time frame for resolution begins the date the plan receives the verbal filing. If the member wishes to appoint another person as their representative, he/she must complete an Appointment of Representative Form or an equivalent document. The member and the person who will be representing the member must sign the statement.

The Plan ensures that punitive action is never taken against a provider who files a grievance on a beneficiary's behalf or supports a member's grievance. The Plan will make a determination on a grievance within the following time frames:

- Expedited Request: 24 hours
- Standard Request: 30 calendar days

The Plan gives members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. Members will be provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

### **Request for Expedited Grievance Determination**

The member, member's representative or a provider may file a request for an expedited grievance determination verbally or in writing. A verbal request can be filed by calling Customer Service. A written request may be mailed or faxed directly to the Grievance Department at:

ArchCare Advantage  
Appeals & Grievances Dept.  
155 East 56<sup>th</sup> Street, 2<sup>nd</sup> Floor  
New York, NY 10022  
Fax: 646-794-1400

A determination on the expedited request is made within 24 hours of receipt of the expedited request. A request for an expedited grievance determination can be made if the Plan:

- Extends the timeframe to make an organization determination or reconsideration
- Refuses to grant a request for an expedited organization determination or reconsideration.

### **Request for Standard Grievance Determination**

A grievance will be investigated as expeditiously as the member's case requires, based on the member's health status, but no later than 30 calendar days from the date the oral or written request is received unless extended as permitted under 42 CFR 422.564(e)(2). The determination will be made and a closure letter will be sent to the member within this time frame as well. The closure letter will include the results and date of the grievance resolution.

### **Grievances Filed Against a Provider**

If a member files a grievance against a provider in reference to the quality of care or service provided, the Plan will fax and mail a request to the provider for response.

### **Provider Responsibility**

The provider is given 10 business days to respond and, when applicable, submit medical records for review. If a provider has not responded within 10 business days, a second fax and certified letter is sent giving an additional five business days. Continued failure to respond will be interpreted as an indication that the provider does not disagree with the member's issue. The case is then subject to further investigation by the Quality Improvement department. If the provider does respond, the medical records are reviewed to determine if a possible quality issue exists. If the clinical reviewer believes there may be a potential quality of care issue, it is forwarded to the Medical Director for further review. The Medical Director may elect to contact the provider or request additional documentation. If the Medical Director feels there is a potential quality of care issue, the case is referred to the Peer Review Committee. The Peer Review Committee will render a decision and the Provider notified of the decision. If no quality issue is identified, the case is entered into the Plan's log for tracking and trending purposes.

### **Submission of Member Appeals**

Any party to an action appropriate for appeal (including a reopened and revised determination), including a member, a member's authorized representative or a contracted or non-contracted physician or provider to the Plan, may request that the determination be reconsidered. Providers do not have appeal rights through the member appeals process. The member, member's representative or provider (with member's written consent) may file a request for an expedited, standard, pre-service or retrospective medical benefit appeal determination. The member, member's representative (with member's written consent), or provider may file a request for an expedited, standard, medication appeal determination. An expedited request must come from the provider in order to be automatically processed as expedited. The Plan will not take, or threaten to take, any punitive action against any provider acting on behalf or in support of a member in requesting an appeal or an expedited appeal. The Plan gives members reasonable assistance in completing forms and other procedural steps for an appeal, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability. Members are provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. If the request for reconsideration is submitted after 60 calendar days, then good cause must be shown in order for the Plan to accept the late request. Examples of good cause include but are not limited to the following:

- The member did not personally receive the adverse organization determination notice or he/she received it late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The member had incorrect or incomplete information concerning the reconsideration process;



- The member lacked capacity to understand the time frame for filing a request for reconsideration.

Any questions regarding the filing of an appeal or the status of an appeal should be directed to the Customer Service Department. A member of the Customer Service, Provider Relations or Appeals teams will be in contact with the provider within two business days of the inquiry. A party may request a standard medical benefit reconsideration by filing a signed written request with the Plan. Except in the case of an extension of the filing time frame, a party must file the request for reconsideration within 60 calendar days from the date of the notice of the action or denial.

**14-Day Extension**

Each of the appeal or grievance determination periods noted above or in the table below may be extended by as many as 14 calendar days, if the member requests an extension or if the Plan justifies a need for additional information and documents how the extension is in the interest of the member. If an extension is not requested by the member, the Plan will provide the member with written notice of the reason for the delay.

Grievances and appeals must be resolved and notification provided to the member or representative, as expeditiously as the member’s condition requires but, no later than the time frames specified in the table below:

Type	Part C	Part D
Expedited Grievance	24 hours	24 hours
Expedited Appeal	72 hours	72 hours
Standard Grievance	30 calendar days	30 calendar days
Standard Appeal	30 calendar days	7 calendar days
Good Cause Extension	Up to 14 Calendar days	Up to 14 Calendar days

**Non-Contracted Provider Appeals**

A non-contracted provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of beneficiary liability statement, which provides that the provider will not bill the enrollee regardless of the outcome of the appeal. Physicians and suppliers who have executed a waiver of beneficiary liability are not required to complete the CMS-1696 unless a copy is requested by ArchCare Advantage. However, the time-frame for acting on a reconsideration request commences when the properly executed waiver of liability form is received.

All physician and health care providers providing health services to ArchCare Advantage members must be credentialed in accordance with ArchCare Advantage policies and procedures. Under CMS regulation, the credentialing process and approval must be completed by any network provider administering care to an ArchCare Advantage member. Re-credentialing will occur every three years thereafter for all contracted physicians, other health care providers, facilities, and hospitals.

The following items are required along with the provider credentialing applications in order to complete the credentialing process:

### **Physician and Health Care Providers**

- Current Curriculum Vitae
- Work history
- Current valid State license to practice
- Valid DEA & CDS (controlled dangerous substances) certificates
- Education and Training
- Copy of Insurance Certificate
- Board Certification status
- Hospital admitting privileges
- Disclosure Statement and Signed Attestation
- Verification of “Opt Out” or Private Contract from Medicare participation
- History of professional liability claims that resulted in settlements or judgments paid by the or on behalf of practitioner

### **Facility Credentialing**

- Medicare and/or Medicaid license
- Copy of New York State Operating License
- Copy of Insurance Certificate
- Copy of any accreditations and/or surveys

### **Skilled Nursing Facility Credentialing**

- Medicare, Medicaid or JCAHO accreditation
- Copy of License
- Copy of Insurance Certificate
- Copy of last 3 years of federal and state surveys including any sanctions

The credentialing process is considered complete when the credentialing committee approves the credentialing application. Once the credentialing process has been completed, and an executed contract is received and countersigned, the physician or health care provider will be considered participating. The physician or health care provider will use their NPI (National Provider Identification) number as their “provider number”.

### **Delegated Credentialing**

ArchCare Advantage offers delegated credentialing for large groups of health care providers. ArchCare Advantage delegates the credentialing function to groups that meet ArchCare Advantage and National Committee for Quality Assurance (NCQA) standards and state and federal law. The decision by ArchCare Advantage to delegate the credentialing function results from a review of the group's credentialing policies and procedures and an on-site audit of the group's credentialing files. The ArchCare Advantage Credentialing Committee reviews the resulting delegation report and makes a determination to approve, defer or grant provisional delegated status for the group. If provisional status is granted, this is followed by a reassessment within a specified period of time and a final decision to approve or defer. Groups granted "delegated status" are required to sign a delegated credentialing agreement with ArchCare Advantage.

### **Medical Record Review**

As part of the re-credentialing process Primary Care Physicians and mid level practitioners (e.g. NPs and PAs), that have more than 50 ArchCare Advantage enrollees under their care, will have 5% of their ArchCare Members records reviewed to meet the ArchCare re-credentialing criteria. The medical record review will be audited for the following items:

- Identifying information on the member
- Identification of all physician and health care providers participating in the member care and information on services furnished by these physician and health care providers
- Is there a completed problem list?
- Are all entries signed/ initialed?
- Are all entries dated?
- Is the record legible?
- Are allergies/adverse reactions prominently displayed?
- Is there evidence of an advanced directive in the enrollee's chart?
- Is there evidence of prescribed medications, including dosages and dates of initial or refill prescriptions?
- Is there evidence of past medical history, physical examination treatments, treatments necessary and possible risk factors for the enrollee relevant to the particular treatment?
- Are problems from previous visits addressed?
- Is the reason for referral addressed?
- Evidence of follow up for abnormal test results?
- Evidence of presenting complaints, diagnoses and treatment plan?

Prior to your date for recredentialing, a provider relations representative will contact your office to schedule time to review the medical records.

### **Provider Information**

Providers are responsible for contacting ArchCare Advantage to report any changes in their practice. It is essential that ArchCare Advantage maintain an accurate provider

database in order to ensure proper payment of claims and capitation, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members. Any changes to the following list of items must be reported to ArchCare Advantage within 30 (thirty) days of the change, using our Provider Change Request Form attached in the appendix of this manual:

- Provider's name and Tax ID number(s)
- Provider's address, zip code, telephone or fax
- Provider's billing address
- Languages spoken in the provider's office
- Wheelchair accessibility
- Provider's NY license (e.g., revocation, suspension)
- National Provider Identification Number (if applicable)
- Provider's board eligibility/board certification status
- Hospital affiliation status

Please use the "Provider Addition/Change Request" form found on page 46.

### **Adverse Credentialing Determination Appeals**

As a network provider, you have the right to:

- Review information submitted to your credentialing application.
- Correct erroneous information collected during the credentialing process.
- Be informed of the status of your credentialing or re-credentialing application.
- Be notified of these rights.

### **Requests for Additional Information**

If ArchCare Advantage receives information from an outside source that differs substantially from information you have provided us, we will contact you directly as soon as the discrepancy is noted and request your clarification in writing within 10 business days. Requests should be made in writing to:

ArchCare Advantage  
Attention: Credentialing Department  
155 East 56<sup>th</sup> Street  
2<sup>nd</sup> Floor  
New York, N.Y. 10022

### **Appeals Process for Providers Terminated or Rejected from the ArchCare Advantage Provider Network**

A provider has the right to appeal a Peer Review and Credentialing Sub-Committee decision that has negatively impacted the provider. ArchCare Advantage complies with all state and federal mandates with respect to appeals for providers terminated or rejected from the ArchCare Advantage Provider Network. ArchCare Advantage notifies the provider in writing of the reason for the denial, suspension and termination. Terminated or rejected providers may submit a request for an appeal as outlined in the letter of

rejection/termination sent by ArchCare Advantage. In addition, the request for appeal must be received by ArchCare Advantage within ten (10) days of the date of the rejection/termination letter. Upon receipt of the letter by ArchCare Advantage, the appeal is forwarded to the ArchCare Advantage Peer Review Committee for review and further processing ArchCare Advantage will ensure that the majority of the hearing panel members are peers of the affected physician.

## **Termination**

### **Physician and Health Care Provider Termination**

ArchCare Advantage or its participating providers may decide to terminate or elect not to renew a provider agreement. Termination procedures are subject to the provisions of the provider agreement. If there are conflicts between the provisions in this Provider Manual and any provider agreement, the terms of the provider agreement will apply.

All providers who wish to terminate their contractual relationship with ArchCare Advantage are bound by the applicable provisions of the individual or group provider agreement or hospital agreement that may govern the termination of an ArchCare Advantage provider. All providers voluntarily terminating their participation with ArchCare Advantage must give ninety (90) days prior written notice of the termination. ArchCare Advantage will not accept any verbal notification as sufficient to initiate the termination process.

Provider shall complete any course of treatment to any individual Member, in accordance with the terms of his/her agreement, for whom treatment was ongoing on the date of termination, unless ArchCare Advantage makes reasonable and medically appropriate provision for the assumption of such services by another participating provider. For those members confined to an inpatient facility, provider shall also complete any course of treatment in progress until a medically appropriate discharge or transfer is made, or completion of the course of treatment is made, whichever first occurs, provided that the confinement or course of treatment was commenced during the paid premium period.

Members with a primary care provider who is to be terminated by ArchCare Advantage or chooses to terminate their participation in the ArchCare Advantage plan will be contacted within 30 days and advised of the change in provider status. Members will be given the opportunity to select another primary care provider who sees members at the facility. If a provider is not selected, one will be chosen on their behalf. Members always have the right to select a new primary care provider by contacting ArchCare Advantage.

For information, regarding contracted physicians or health care providers including facilities termination; please refer to your provider agreement. Requests should be made in writing to:

ArchCare Advantage

Attention: Credentialing Department  
155 East 56<sup>th</sup> Street  
2<sup>nd</sup> Floor  
New York, N.Y. 10022

You may also contact Provider Relations at 1-800-373-3177.

## **Sanctions**

Upon written notification from CMS – by letter or the lists published by the Office of Inspector General (OIG) and Government Accountability Office (GAO) – of a physician's or other health care provider's exclusion from original Medicare, ArchCare Advantage will send a letter to the physician or provider stating the physician or provider will be removed from the ArchCare Advantage list of contracted physicians and providers. Except for post stabilization, emergency and urgently needed care; no payments will be made to the physician or provider after the exclusion effective date. Members are notified that the physician or other health care provider is no longer contracted and are advised to select a new Primary Care Physician or health care provider, if appropriate.

Members with claims pending for items or services from an excluded physician or provider, or member's submitting claims for items or services from an excluded physician or provider for the first time, will receive a letter notifying the enrollee of the following:

- The enrollee is accessing a sanctioned physician or provider.
- Payments to a Medicare-excluded physician or provider are prohibited.
- Payments will not be made for items or services rendered after the date of exclusion or after notification to the enrollee (whichever date is later).

Participating physicians and other healthcare providers are also prohibited from employing or contracting with an individual who is excluded from participation in Medicare, or with an entity that employs or contracts with such an individual, for the provision of health care, utilization review, medical social work or administrative services.

### **Reinstatement**

Upon reinstatement by CMS, the physician or provider is responsible for notifying ArchCare Advantage and apply for reinstatement.

## **Resolving Disputes**

### **Contract concern or complaint**

If you have a concern or complaint about your agreement with us, send a letter containing the details to:

ArchCare Advantage  
Provider Relations Department  
155 East 56<sup>th</sup> Street  
2<sup>nd</sup> Floor  
New York, New York 10022

A provider relations associate will investigate and resolve your complaint. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described below and in our agreement. If your concern or complaint relates to a matter which is generally administered by certain ArchCare Advantage procedures, such as the credentialing or Care Coordination process, we will follow the procedures set forth in those departments to resolve the concern or complaint. After following those procedures, if either party remains dissatisfied, an arbitration proceeding may be filed as described below and in our agreement.

If ArchCare Advantage has a concern or complaint regarding our agreement with a provider, a letter containing the details will be sent to the provider within thirty (30) days of the date the complaint is received. If we cannot resolve the complaint through informal discussions, an arbitration proceeding may be filed as described below and in our agreement.

#### **Arbitration**

ArchCare Advantage will conduct any arbitration proceeding under your agreement under the auspices of the American Arbitration Association, as further described in our agreement. For more information on the American Arbitration Association guidelines, visit their Web site at [www.adr.org](http://www.adr.org). In the event that a customer has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing customer appeals outlined in the customer's benefit contract or handbook.

## **Data Collection**

All Medicare Advantage organizations are required to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data related to costs, utilization, complaints, grievances and quality, and such other matters as CMS and New York State requires from time to time. As an ArchCare Advantage contracted physician or health care provider, you are required to submit all data necessary to fulfill these obligations in a timely manner. You are required to certify in writing at the time of submission to ArchCare Advantage or its designee, that all data including, but not limited to, encounter data and other information that CMS may specify, is truthful, reliable, accurate and complete.

## **Protect Confidentiality of Patient**

**Data**

ArchCare Advantage members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates that need that information to fulfill our obligations and to facilitate improvements to our enrollees' health care experience. We require our affiliates and business partners to protect privacy and abide by privacy law. ArchCare Advantage requires that all physician and health care providers comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for privacy and protection of enrollee data. If an enrollee requests specific medical record information, we will refer the enrollee to you as the holder of the medical records.

## **Medical Records**

In accordance with the Health Insurance Portability and Accountability Act and federal and state privacy regulations, confidentiality and accuracy of an enrollee's medical record must be maintained at all times. ArchCare Advantage requires that all physicians and health care providers comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for privacy and protection of member data. The privacy of any information that identifies a particular member must be safeguarded. Information from or copies of a member's medical record may only be released to authorized individuals. In addition, only authorized individuals can make amendments to a member's medical record. Physicians and other health care providers must ensure that unauthorized individuals cannot gain access to or alter a member's medical record. Original medical records may only be released in accordance with state laws, court orders or subpoenas, and timely access by members to the information that pertains to them must be ensured. Additionally, physicians, other health care providers and ArchCare Advantage must abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, and other health and member information. Disclosures of member's health information should be limited to the minimum amount necessary to achieve the purpose of the disclosure.

In addition, for members residing in a nursing home, medical records are maintained at the nursing home. ArchCare Advantage providers will document all services rendered to the member. The medical records will be accessible to ArchCare Advantage and appropriate state and federal authorities, or their delegates, involved in assessing the quality of care or investigating member's grievance or complaints.

A complete medical record must be maintained for each member for whom the practitioner has provided health care services and in accordance with accepted professional practice standards as well as state, and federal requirements. Records must have documentation of all services provided directly by the practitioner who provides primary care services and be retained and kept confidential by the provider for at least ten (10) years from the later of (1) the final date of the applicable Medicare Advantage Plan contract period, (2) completion of an audit, or (3) a date determined by CMS. Additionally, there must be prominent documentation in the medical record



demonstrating whether or not a member has executed an advance directive. ArchCare Advantage, CMS, or any Federal agency, and their designees, must have access to member medical records.

## **HIPAA and Releasing Information**

ArchCare Advantage is concerned with protecting enrollee privacy and is committed to complying with the HIPAA privacy regulations. All medical records shall be confidential and shall not be released without the written consent of the member or a responsible member's legal guardian, health care proxy or power of attorney. 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. Generally, covered health plans and covered providers are not required to obtain individual enrollee consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities such as care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement fall into this category. If you have further concerns please contact Customer Service at 1-800-373-3177.

## **Foreign Language**

Physician and health care providers are contractually bound to provide appropriate assistance to enrollees that may have a limited English proficiency or reading skills. If the physician or health care provider is unable to accommodate the member, the physician or health care provider must contact ArchCare Advantage for assistance by calling Customer Service at 1-800-373-3177. Please see the Promoting Cultural and Linguistic Competency Self Check List (Appendix C).

## **Preventive Health Care Services**

ArchCare Advantage provides members direct access to preventive health care services. ArchCare Advantage members may access any of the following services directly from a contracted physician or health care provider without a referral:

### **Women's health services:**

All female ArchCare Advantage members may seek care directly from women's health specialists (e.g., gynecologist) within ArchCare Advantage's provider network for women's routine and preventive health care services, including self-referral for mammography. Preventive health services are defined as breast exams, mammograms, pap smears and pelvic exams.

- ArchCare Advantage does not require referrals or authorization for use of women's health specialists/services from participating in-network providers

- An ArchCare Advantage member may choose to have these services provided or coordinated by their PCP or ArchCare Advantage nurse practitioner.
- Whenever possible, the ArchCare Advantage enrollee's Primary Care Team will provide direct care, or will attempt to arrange for preventive health services such as breast exams, mammograms and pap smears to be performed at the enrollee's residence.
- Institutionalized female ArchCare Advantage enrollees may need to go outside their facility to obtain the services of women's health specialists and to obtain preventive health services from these specialists. ArchCare Advantage makes no guarantee that contracted specialists can or will provide their services at locations other than their specified clinics.

**Vaccine:**

ArchCare Advantage members may receive a seasonal influenza, H1N1, or pneumococcal vaccination from any qualified physician or health care provider, including the licensed medical professionals employed by the resident's skilled nursing facility. ArchCare Advantage does not require enrollees to obtain a referral or prior authorization. There is no co-payment for these services.

## Complex or Serious Medical Condition

ArchCare Advantage is required to have in place CMS approved policies and procedures in order to identify members with complex or serious medical conditions and to assess, diagnose and monitor those conditions on an ongoing basis. A treatment plan must be established and implemented that is appropriate to the condition, and allows direct access visits to participating specialists to accommodate the treatment plan. The treatment plan must be time-specific and be updated periodically by the Primary Care Physician. ArchCare Advantage Nurse Practitioner staff will work closely with providers to identify enrollees with complex or serious medical conditions and to develop appropriate treatment plans and monitor them on an ongoing basis. ArchCare Advantage will utilize a comprehensive history/physical examination including a Health Risk Assessment developed for our members who reside in Skilled Nursing Facilities.

**Health Risk Assessment**

The health status of our enrollees is very important. ArchCare Advantage takes an active role in determining the health status of its enrollees, including identifying any complex and serious conditions that an enrollee may have. Within 30 days of enrollment, the new enrollee receives an initial assessment and appropriate interventions are initiated.

## Quality Improvement Program in ArchCare Advantage

The goal of the ArchCare Advantage Quality Improvement Program is to ensure the delivery of high quality, cost effective care to the frail and elderly population we serve through structured oversight and coordination among all areas of the organization as well as delegated entities and providers of services.

The Plan's Quality Improvement Program serves to improve the health of its members through emphasis on health maintenance, education, diagnostic testing and treatment. The Quality Improvement Program incorporates activities to assess the accessibility, availability, efficiency, safety, efficacy, appropriateness, effectiveness and continuity of patient care and services delivered by health care providers and the Plan itself. The Quality Improvement department will assess for practitioner adherence to the guidelines of care and documentation, as required by regulatory agencies. Assessment information will include, but not be limited to medical record documentation, health screening rates and disease management care.

### **Quality Improvement Organization (QIO)**

ArchCare Advantage is required to participate in specific reviews and tasks applicable to the Medicare QIO Programs geared toward improving care for beneficiaries enrolled in managed care. Providers contracted with the Plan are required to participate in all quality improvement functions and tasks required by the QIO. These activities may include but are not limited to:

- Compliance with request for medical records for quality improvement studies and audits
- Cooperation with quality improvement initiatives related to QIO collaborative projects
- Cooperation with QIO efforts to improve care for chronic disease and/or preventive care measures
- Compliance with requests for information and recommendations formulated by the QIO in the process of reviewing/resolving beneficiary and/or provider complaints.

The QIO, on behalf of Medicare (CMS) may also perform annual audits. Providers will be required to copy office records for these audits. It is very important that any time a copy of a record is requested the entire record is sent.

### **Provider Participation with QI Activities**

In accordance with regulatory contract guidelines, the Plan and its providers contractually agree to participate in quality improvement projects and medical record review activities including but not limited to:

- Copying and providing office/facility records as needed for quality-review and reporting activities (HEDIS, Quality Improvement Projects, annual medical record review)
- Maintaining member medical records in compliance with ArchCare Advantage Medical Record Standards
- Cooperating in quality of care investigations and quality improvement studies as may be required by regulatory agencies

### **Quality Improvement Activities**

The following are Quality Improvement activities performed by the plan on an ongoing basis:

- Preventive Health Maintenance
- Development and review of Clinical Practice Guidelines
- Disease Management Initiatives
- HEDIS® Reporting
- Referrals for quality issues
- Tracking and trending of complaints or referrals to identify potential
- Medical Record Content Reviews (See **Medical Records Standards** section for specific documentation standards and requirements)
- Medicare Quality Improvement Projects
- Chronic Care Improvement Programs
- Assessment of Member and Provider satisfaction
- Monitoring continuity of care
- Monitoring transitions

### **Patient Safety**

ArchCare Advantage is committed to offering a network of providers that ensures the safe delivery of clinical care to enrollees. Through execution of standardized internal processes and collaborative participation of network providers, the Plan seeks to promote the implementation of best patient safety practices.

The strategies of the Plan are to:

- Inform members and providers regarding the Plan's expectations for patient safety
- Engage the provider community in adopting processes to promote safe clinical practices
- Assist members to be participants in the delivery of safe health care
- Formally recognize and support patient safety best practices

The Plan addresses key elements of patient safety, such as the extent of coordination of care between providers, medical record review findings, clinical practice guideline adherence, adverse event and quality of care complaint tracking/trending, pharmaceutical management practices and member interactions. Through tracking and trending of relevant Plan metrics, the Plan can identify opportunities for improvement and facilitate education of target practitioner and/or the provider community at large in order to prevent or reduce the potential for patient safety incidents.

### **Quality-of-Care Issues**

*Quality-of-Care referrals* are defined as complaints and adverse outcomes related to the quality of care delivered. Referrals may be generated by the Appeals, Grievance, Risk Management, Provider Relations, Customer Service or Utilization Management departments or may be identified through routine record review. Occurrences considered potential quality of care issues include but are not limited to the following:

- Unplanned re-admission for the same or similar diagnosis in less than 30 days
- Falls
- Serious complication of anesthesia
- Transfusion error or serious transfusion reaction
- Medication error or adverse drug reaction with serious potential for harm
- Care or lack of care which could have resulted in a potentially serious complication

Potential quality-of-care issues are referred for peer review. In the event the peer reviewer/panel feels there is a possible quality-of-care issue, the physician is asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered. Peer review findings are categorized as follows:

1. Substantiated – there is evidence of a deviation in the standard of care
2. Unsubstantiated – there is no evidence of a deviation from the standard of care

Once that determination is made, the outcome is classified as either “adverse event” or “no adverse event”. Results of peer review activity will be reported to the Peer Review Sub-committee, to the Quality Improvement Committee, to the Board of Managers and when applicable to State or Federal regulatory agencies as appropriate.

### **HEDIS® Measures**

The following HEDIS® indicators are reviewed and reported on an annual basis. Throughout the year, initiatives involving physician and members will be undertaken as necessary to achieve an improvement in outcomes.

- a. Colorectal Cancer Screening
- b. Care of Older Adults
- c. Glaucoma Screening in Older Adults
- d. Use of High Risk Medication in the Elderly
- e. Osteoporosis Management in Older Women who had a Fracture
- f. Potentially Harmful Drug Disease Interaction in the Elderly
- g. Antidepressant Medication Management

Below is a brief description of the above measures:

#### **a. Colorectal Cancer Screening**

Members ages 50-75 who have had appropriate screening for colorectal cancer.

Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement year. Regardless of FOBT type, guaiac (gFOBT) or immunochemical (iFOBT)
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- Colonoscopy during the measurement year or the nine years prior to the measurement year

**b. Care for Older Adults**

The percentage of adults 65 years and older who had each of the following during the measurement year:

- Advance care planning
- Medication review
- Functional status assessment
- Pain screening

**c. Glaucoma Screening in Older Adults**

The percentage of Medicare members 65 years and older, without a prior diagnosis of glaucoma or glaucoma suspect, who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions.

**d. Use of High-Risk Medications in the Elderly**

- The percentage of Medicare members 65 years of age and older who received at least one high risk medication
- The percentage of Medicare members 65 years of age and older who received at least two different high risk medications

**e. Osteoporosis Management in Women Who Have Had a Fracture**

Women 67 and older, who suffered a fracture and who received either a bone mineral density (BMD) test or prescription treatment for osteoporosis, within six months of the date of the fracture.

**f. Potentially Harmful Drug-Disease Interactions in the Elderly**

The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a contraindicated medication, concurrent with or after the diagnosis. Report each of the three rates separately and as a total rate.

- A history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents
- Dementia and a prescription for tricyclic antidepressants or anticholinergic agents
- Chronic renal failure and prescription for non-aspirin NSAIDs or Cox-2 Selective NSAIDs
- Total rate (the sum of the three numerators divided by the sum of the three denominators)

**g. Antidepressant Medication Management**

The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on treatment for:

1. The effective acute phase of 84 days (12 weeks)
2. The effective continuation phase of at least 180 days (6 months)

### **Adult Health Screening**

An adult health screening performed by a provider to assess health status is required of all Medicare Advantage members, within 90 days of the member joining the plan. The adult member should receive an appropriate preventive health assessment and intervention as indicated or upon request.

### **Clinical Practice Guidelines**

Clinical Practice Guidelines based on the health needs and opportunities for improvement are identified as part of the quality improvement program. The clinical guidelines are reviewed, revised and adopted on a yearly basis, utilizing nationally recognized, evidenced based sources. The guidelines are developed with input from community/network physicians and reviewed and approved annually by the Peer Review Subcommittee, the Quality Improvement Committee and the Board of Managers.

## **Private Contracts “Opt Out”**

ArchCare Advantage, a Medicare Advantage organization, may not pay, directly or indirectly, on any basis, for services (other than post stabilization, emergency or urgently needed services) furnished to a Medicare enrollee by a physician or other health care provider who has filed an affidavit with the Medicare carrier agreeing to furnish Medicare covered services to Medicare beneficiaries only through private contracts with the beneficiaries. ArchCare Advantage verifies, with the local Medicare intermediary, the Opt Out or Private Contract list during credentialing and re-credentialing to ensure that our contracted providers are not included on the list.

Upon written notification from the carrier of a physician’s or other health care provider’s decision to “opt out” of the Medicare program, Provider Relations will send a letter to the physician or other health care provider stating that the physician or provider will be removed from the list of ArchCare Advantage contracted physicians and providers. No payments will be made to the physician or provider for two years after the effective date of the affidavit.

In addition, ArchCare Advantage will send a letter to each ArchCare Advantage member assigned to the physician or provider notifying the enrollee that the physician or provider is no longer contracted and advising the enrollee to select a new Primary Care Physician, if appropriate.

Members with claims pending for services from a physician or provider who has “opted out” of Medicare, or members submitting claims from physicians or providers who have “opted out” of Medicare will receive a letter containing the following information:

- The member is accessing a physician or provider who has “opted out” of Medicare.
- Payments by ArchCare Advantage, a Medicare Advantage organization are prohibited.

- The services are not covered, the current claim(s) will not be paid by ArchCare Advantage and the physician or provider must have entered into a private contract with the member in order to receive payment from the member.
- Payments will not be made for items or services rendered after the date of the physician “opt out.”

Physicians and health care provider are responsible for notifying ArchCare Advantage when their affidavit has expired if they desire to apply for reinstatement.

## **CMS Enrollee Survey**

CMS requires all Medicare Advantage contractors to participate in a beneficiary satisfaction survey. ArchCare Advantage surveys the member or their legal representative annually. ArchCare Advantage polls the member’s representative to determine satisfaction with the Primary Care Services, customer service, sales and written information.

ArchCare Advantage will make the summarized data available on request to the physician or health care provider of the member.

## **Billing and Claims**

All participant ArchCare Advantage providers are required to submit claims/encounters for services reimbursed fee-for-service and for services provided under a capitation model of care. Encounter data is essential for claims processing and utilization reporting as well as for complying with the reporting requirements of CMS, New York State and other governmental and regulatory agencies. It is essential that this information be submitted in a timely and accurate manner.

Payment for services rendered is subject to verification that the member was enrolled in ArchCare Advantage at the time the service was provided and the provider’s compliance with ArchCare Advantage medical management and prior authorization policies at the time of service.

- Providers should verify member eligibility at the time of service to ensure that the member is enrolled in ArchCare Advantage. Failure to do so may affect claims payment. Note, however, that member’s may retroactively lose their eligibility with ArchCare Advantage after the date of service. Therefore, verification of eligibility is not a guarantee of payment by ArchCare Advantage.
- Claims submitted for services rendered without proper authorization (as appropriate) will be denied for ‘failure to obtain authorization’. No payment will be made.



Payment is made directly to the participating hospital for all employed providers who are covered by the hospital's participation agreement with ArchCare Advantage and who practice in hospital outpatient departments and hospital owned community-based sites. For all other providers, payment is made directly to the provider or to the designated payee.

In certain cases, a managed care plan member may change health plans during the course of a hospital stay. When this occurs, provider should bill the health plan to which the member belonged at the time of admission to the hospital.

### **Part A Covered Services and Reimbursement**

ArchCare Advantage arranges for services covered under the Part A stay of a members benefit to be provided by the Skilled Nursing Facility. Services which are covered under Part A are to be billed to the skilled nursing facility where the member resides.

Exclusions to the above are:

1. Blood and blood products
2. Ambulance transportation
3. Artificial limbs and its components
4. Dialysis service and supplies
5. Ventilator equipment
6. Emergency room procedures
7. Diagnostic procedures provided in an outpatient hospital setting, limited to: cardiac cauterization, CT scans, MRI, MRA, radiation therapy, angiography, venous procedures, lymphatic procedures, ambulatory surgery involving the use of an emergency room
8. Hospice care
9. Vaccinations
10. Chemotherapy

ArchCare Advantage will only reimburse for services, to eligible members, covered under Part B to in network providers.

### **ArchCare Advantage Payment in Full / Member Held Harmless**

Pursuant to the provider contract, participating providers are prohibited from seeking payment, billing or accepting payment from any member for fees that are the legal obligation of ArchCare Advantage, including in the event that ArchCare Advantage becomes insolvent or denies payment on a claim, regardless of the reason. Participating providers must refund all amounts incorrectly collected from ArchCare Advantage members or from others on behalf of the member. ArchCare Advantage is not financially responsible for reimbursing non-covered services provided to members.

**Except for permitted co-payments, co-insurance, and deductibles, all payments for services provided to ArchCare Advantage members constitute payment in full.**

**Providers may not balance bill members for the difference between their actual charges and the reimbursed amounts, except for deductibles, copayment, or coinsurance, as applicable.**

### **General Billing Requirements:**

ArchCare Advantage adjudicates and pays all claims/encounters pursuant to CMS regulations applicable to Medicare Advantage Plans.

Providers should submit all claims/encounters within forty-five (45) days of the date of service for prompt adjudication and payment. However, claims for services that are submitted later than the time period set forth in the provider's agreement with ArchCare Advantage will not be paid except under certain circumstances. In no event will ArchCare Advantage pay claims submitted more than one hundred eighty (180) calendar days after the date of service.

Prior to being adjudicated, all claims/encounters are reviewed for completeness and correctness of the data elements required for processing payments, reporting, and data entry into the claims adjudication processing system. If the following information is missing from the claim/encounter, the claim/encounter is not 'clean' and will be rejected.

- Tax identification number
- National Provider Identifier (NPI)
- Member's name, ID number and date of birth.
- **For paper claims:** the Provider's name, ArchCare Advantage ID number, Tax ID number, and address.
- **For Electronic claims:** the Provider's name, National Provider Identifier, Tax ID number, and address.
- Date of service and applicable CMS two-digit place of service code.
- Applicable and current procedure code.
- Charge amount for the service rendered.
- Bill all applicable ICD-9 diagnosis codes – coded to highest specificity.
- CMS 1500 (837P) claims or UB-04 (837I) submitted electronically must include ArchCare Advantage's Payer Id Number **31144** on each claim.
- Service unit(s)
- Revenue codes (UB-04 / 837I).
- Bill type (UB-04 / 837I).
- Value codes (UB-04 / 837I)
- POA indicator (UB-04 / 837I)

CMS 1500 (837P) should be used by providers other than facilities. The UB-04 (837I) form should be used by facilities.

### **National Provider Identifier (NPI)**

Effective May 23, 2007, all providers (as applicable) should have acquired an NPI to transmit healthcare information to ArchCare Advantage via HIPAA standard transactions.

### **Present on Admission (POA)**

The POA indicator applies to diagnoses codes for certain healthcare claims. POA indicator reporting is mandatory for claims involving inpatient admission to general acute care hospital or other facilities. It clarifies whether a diagnosis was present at the time of admission.

Please refer to the instructions provided by CMS regarding identification of the POA for all diagnosis codes for inpatient claims submitted on the UB-04 and ASCX12N 837 institutional (837I) forms.

ArchCare Advantage requires POA indicators for all primary and secondary diagnosis codes as well as the external cause of injury codes; regardless of the manner in which claims are submitted (i.e. paper or electronic) for dates of service on or after October 1, 2008.

### **Facilities:**

- Submit inpatient and outpatient facility claims on the UB-04 or on electronic media (837I).
  - Report the name, NPI and ArchCare Advantage provider ID number of the attending provider in field 76. (ArchCare Advantage provider ID number is not required on electronic transactions.)
  - Include the ArchCare Advantage authorization number on claims submitted for inpatient services. Claims will be matched to prior authorization data in ArchCare Advantage's system and processed in accordance with applicable ArchCare Advantage policies and procedures.
- Professional services that are not part of the facility claims should be billed on a CMS 1500 form or on the electronic media format (837P).

### **Skilled Nursing Facility (SNF) Billing:**

All services that the member receives under Part 'A' must be billed on the UB-04 claim form (also known as CMS-1450) except for excluded services and services covered under Part 'B'.

- Use Type of Bill Code 021X, (FL 4)
- Report all appropriate occurrence codes, (FL 31- FL 36)

- Report all appropriate conditions codes, and value codes, (FL 18- FL 28, & FL39 a-d – FL 41 a-d)
- Report appropriate accommodation code (FL 42) corresponding to the level of service authorized (level I through V):
  - Sub acute care – level I
  - Sub acute care – Level II
  - Sub acute care – Level III
  - Sub acute care – Level IV
  - Intensive Health Services – Level V
- Report all applicable revenue codes for ancillary services, as appropriate (FL 42),
- Report all applicable HCPCS/ RATE / HIPPS codes (FL 44)
- Report service units (FL 46), and
- Report total charges (FL 47) for each line item reported on the claim.

All ICD-9CM codes must be current and the full IC-9-CM diagnosis code, including all five digits where applicable, must be reported.

Skilled Nursing Facility services may be billed after 30 days of care, and every 30 days thereafter, using type of bill code 0213.

Skilled Nursing Facility Providers must bill continuing claims in sequence for each member in an inpatient stay that extends beyond 30 days of care.

Please refer to the instructions on the “Uniform Billing Editor” for billing information required to generate a ‘clean’, accurate, and complete claim form and the “Medicare Claims Processing Manual”, Chapter 6 – SNF Inpatient Part ‘A’ Billing and SNF Consolidated Billing.

### **Coordination of Benefits (COB)**

Coordination of benefits (COB) ensures that the proper payers are held responsible for the cost of healthcare services. ArchCare Advantage follows all standard guidelines for COB. Members are asked to provide information about other insurance plans under which they are covered.

ArchCare Advantage is always the secondary payer in the following circumstances:

- Workers compensation,
- Automobile medical, and
- No-Fault or liability auto insurance.

ArchCare Advantage does not pay for services provided under the following circumstance when there is COB:

- The Department of Veterans Affairs (VA) or other VA facilities (except for certain emergency hospital services), and

- When VA-authorized services are provided at a non-VA hospital or by a non-VA physician.

ArchCare Advantage will use the same guidelines as CMS for determination of primary and secondary payer. As a result, ArchCare Advantage is the secondary payer for all of the cases listed above as well as for the following:

- Most Employer Group Health Plans (EGHP)
- Most EGHPs for disabled members

All benefits payable under an EGHP in the case of individuals who are entitled to benefits solely or partly on the basis of end state renal disease (ESRD) during a period of thirty (30) months. (This applies to all services, not just ESRD. If the individual entitlement changes from ESRD to over sixty-five (65) or disability, the coordination period will continue.)

### **Electronic Billing**

ArchCare Advantage utilizes Emdeon (WebMD) clearinghouse for all electronic claims. Claims submitted electronically must include:

1. ArchCare Advantage Payer ID number **31144** on each claim.
2. Complete **ArchCare Advantage Member ID Number** (see member ID card or monthly enrollment roster).
3. A National Provider Identifier (NPI) should reside in:
  - 837 Professional (CMS 1500) – Loop 2310B Rendering Provider Secondary ID, Segment / Element NM109. NM108 must qualify with an XX (NPI).
  - 837 Institutional (UB04) – Loop 2010AA Billing Provider, Segment / Element NM109. NM108 must qualify with an XX (NPI).

To sign up for electronic billing, providers must contact their software vendor and request that their ArchCare Advantage claims be submitted through Emdeon. Providers can also direct their current clearinghouse to forward claims to Emdeon. Please call 1-513-569-5049 to setup electronic billing.

Providers are encouraged to review claim submission errors and resubmit corrections.

### **Paper Claim Submission**

All paper claims should be submitted to:

ArchCare Advantage  
c/o TriState Benefit Solutions  
619 Oak Street  
Cincinnati, OH 45206

## Late Claim Submission

In certain circumstances, ArchCare Advantage will process claims submitted after the time period required under the provider’s agreement with ArchCare advantage.

**Please note that ‘unclean’ claims that are returned to the provider for necessary information are adjudicated according to the original date of service. They do not fall into the category of exceptions to the time period required.**

The following situations allow for special handling of claims. Claims must be submitted with a written explanation and appropriate documentation showing the date the claim came within the provider’s control.

Reason for Delay	Time Frame for Submission
Litigation involving payment of the claim.	Within sixty (60) calendar days from the time the submission came within the provider’s control.
Medicare or other third party processing delays affecting the claim.	Within sixty (60) calendar days from the time the submission came within the provider’s control.
Original claim rejected or denied due to a reason unrelated to the <b>180</b> – day rule.	Within sixty (60) calendar days of the date of notification (submit with original EOP)
Administrative delay (enrollment process, rate changes) by NYSDOH or other State agencies.	Within sixty (60) calendar days from the time of resolution (submit with documentation substantiating the delay.).
Delay in member eligibility determination.	Within sixty (60) calendar days from the time of notification of eligibility (submit with documentation substantiating the delay.)
PRO denial / reversal	Within sixty (60) calendar days from the time of notification (submit with documentation substantiating the delay).
Member’s Enrolment with ArchCare Advantage was not known on the date of service.	Within sixty (60) calendar days from the time the member’s enrollment is verified. Providers must make diligent attempts to determine the member’s coverage with ArchCare Advantage.

## Claim Inquiries

Providers may call 1–866–479-5050 to inquire on claim status.

## Requests for Review and Reconsideration of a Claim

Please note that the process described here does not apply to utilization management determinations concerning medical necessity. **See appropriate section (page 30) for information on medical management appeals.**

A provider may be dissatisfied with a decision made by ArchCare Advantage regarding a claim determination. Some of the common reasons include, but are not limited to, incorrectly processed or denial of a service / claim, the untimely submission of claims, or failure to obtain prior authorization.

Providers who are dissatisfied with a claim determination made by ArchCare Advantage must submit a written request for review and reconsideration with all supporting documentation to ArchCare Advantage within sixty (60) calendar days from the date on the provider's Explanation of Payment (EOP), to the following location.

ArchCare Advantage  
c/o Tristate Benefit Solutions  
619 Oak Street  
Cincinnati, OH 45206

All written requests for review and reconsideration must include a copy of the EOP, the claim, supporting documentation, and a written statement explaining why you disagree with ArchCare Advantage's determination as to the denial or payment.

Examples of other information and supporting documentation that should be submitted with your written requests for review and reconsideration include:

- Provider's name, address and telephone number.
- Member's name and ArchCare Advantage identification number
- Date(s) of service.
- ArchCare Advantage's claim number.
- A copy of the original claim or corrected claim, if applicable.
- A copy of the EOP from another insurer or carrier along with supporting medical records to demonstrate medical necessity.
- Contract rate sheet to support payment rate or fee schedule.
- Evidence of eligibility verification (copy of ArchCare Advantage member ID card).
- Evidence of timely filing – Insurance Carrier Rejection Report. (Please note: ArchCare Advantage **does not** accept copies of certified mail or overnight mail receipts, or documentation from internal bill practice software as proof of timely filing.)

ArchCare Advantage will investigate all written requests for review and reconsideration and issue a written explanation stating that the claim has been either reprocessed or the initial denial has been upheld within **45** calendar days from the date of receipt of the provider's request for review and reconsideration.

ArchCare Advantage will not review or reconsider claim determinations which are not appealed according to the procedures set forth above. If a provider submits a request for

review and reconsideration after the **60** calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services irrespective of the merits of the underlying dispute if the request for review and reconsideration is not timely filed. In such cases providers may not bill members for services rendered.

All questions concerning request for review and reconsideration should be directed to the ArchCare Advantage Provider Relations department at 1-800-373-3177.

### **Explanation of Payment (EOP)**

The EOP describes how claims for services rendered to ArchCare Advantage members were reviewed. It details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim. Please see Appendix A for a sample of the EOP.

### **Overpayments**

ArchCare Advantage periodically reviews payments made to providers to ensure the accuracy of claim payment pursuant to the terms of the provider contract or as part of its continuing utilization review and fraud control programs. In doing so, ArchCare Advantage may identify instances when we have overpaid a provider for certain services. When this happens, ArchCare advantage provides notice to the provider and recoups the overpayment consistent with Section 3224-b of the New York State Insurance Law.

ArchCare Advantage will not pursue overpayment recovery efforts for claims older than twenty-four (24) months after the date of the original payment to a provider unless the overpayment is:

- based upon a reasonable belief of fraud, intentional misconduct or abusive billing;
- required or initiated by the request of a self-insured plan or,
- required by a state or federal government program.

In addition, if a provider asserts that ArchCare Advantage has underpaid any claim(s) to a provider, ArchCare Advantage may offset any underpayments that may be owed against past overpayments made by ArchCare Advantage dating as far back as the claim underpayment.

### **Notice of Overpayments Before Seeking Recovery**

If ArchCare Advantage has determined that an overpayment has occurred, ArchCare Advantage will provide thirty (30) days written notice to the provider of the overpayment and request repayment. This notice will include the member names, service dates, payment amounts, proposed adjustment and a reasonably specific explanation of the reason for the overpayment and the adjustment. In response to this notice, the provider may dispute the finding or remit payment as outlined below.



### **If you Agree That We Have Overpaid You**

Upon receipt of a request for repayment, providers may voluntarily submit a refund check made payable to ArchCare Advantage within 30 calendar days from the date the overpayment notice was mailed by ArchCare Advantage. Providers should further include a statement in writing regarding the purpose of the refund check to ensure the proper recording and timely processing of the refund.

#### **Refund check should be mailed to:**

ArchCare Advantage  
Attn: Provider Relations  
155 E. 56th Street, 2<sup>nd</sup> Floor  
New York NY 10022

### **If You Disagree that We Overpaid You**

If a provider disagrees with ArchCare Advantage's determination concerning the overpayment, the provider must submit a written request for an appeal within 30 calendar days from the date the overpayment notice was mailed by ArchCare Advantage and include all supporting documentation in accordance with the provider appeal procedure.

If upon reviewing all supporting documentation submitted by a provider, ArchCare Advantage determines that the overpayment determination should be upheld, providers may initiate arbitration pursuant to their provider agreement. ArchCare Advantage will proceed to offset the amount of the overpayment prior to any final determination made pursuant to binding arbitration.

If upon reviewing all supporting documentation submitted by a provider, ArchCare Advantage determines that the overpayment determination should be upheld, providers may initiate arbitration pursuant to their provider agreement. ArchCare Advantage will proceed to offset the amount of the overpayment prior to any final determination made pursuant to binding arbitration.

### **If You Fail to Respond to Our Notice of Overpayment**

If a provider fails to dispute a request for repayment concerning an overpayment determination made by ArchCare Advantage within 30 calendar days from the date the overpayment notice was mailed by ArchCare Advantage, the provider will have acknowledged and accepted the amount requested by ArchCare Advantage.

ArchCare Advantage will offset the amount outstanding against current and future claim remittance(s) until the full amount is recovered by ArchCare Advantage.

APPENDIX - A

## ArchCare Advantage HMO Provider Addition/Change Request Form

**INSTRUCTIONS:** Type or print your information on this form. If a question does not apply, write "N/A" in the field. A separate form will be needed *for each Provider*.

Check the appropriate box:

Change of Information\*  Credentialing Request

Date of Request	
Practice Name	
Provider Name	
Specialty	
Board Certification	<input type="radio"/> Yes <input type="radio"/> No
Tax ID	
NPI	
Primary Office Location	
Secondary Office Location	
Nursing Home	<input type="radio"/> San Vicente de Paul Walsh <input type="radio"/> Kateri <input type="radio"/> Mary Manning <input type="radio"/> Carmel Richmond <input type="radio"/> Ferncliff <input type="radio"/> None
Provider Signature	

\*Requests for change of demographic information will be reflected in ArchCare Advantage within 48 hours. A

In receiving this form from the physician or entity, ArchCare Advantage relies on the truth of all the following statements:

- All information entered is accurate and complete, and that if any of that information changes, Provider will notify ArchCare Advantage of any such change within 30 days.
- By submitting this form, Provider agrees to abide by all Medicare statutes, rules, and policies.

representative will contact you within that time frame to advise when the change has taken effect.

Please submit request form to:

ArchCare Advantage HMO  
Attn: Provider Relations Department  
155 East 56<sup>th</sup> Street, 2<sup>nd</sup> Floor  
New York, N.Y. 10022  
Fax: 212-794-1400



## APPENDIX - C

**PROMOTING CULTURAL and LINGUISTIC COMPETENCY  
Self-Assessment Checklist  
for Personnel Providing Primary Health Care Services**

**Directions:** Please select A, B, or C for each item listed below.

- A = Things I do frequently
- B = Things I do occasionally
- C = Things I do rarely or never

**PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES**

- \_\_\_\_\_ 1. I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.
  
- \_\_\_\_\_ 2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures and languages of individuals and families served by my program or agency.
  
- \_\_\_\_\_ 3. When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the culture and ethnic backgrounds of individuals and families served by my program or agency.
  
- \_\_\_\_\_ 4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

## APPENDIX - C

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Tawara D. Goode\*Georgetown University Center for Child and Human Development\*Adapted from *Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Supports to Children with Special Health Care Needs and their Families* \* June 1989. (Revised 1993, 1996, 1997, 1999, 2000 & 2002, & 2004). Page 1

## COMMUNICATION STYLES

5. When interacting with individuals and families who have limited English proficiency I always keep in mind that:
- \_\_\_ \* limitations in English proficiency is in no way a reflection of their level of intellectual functioning.
  - \_\_\_ \* their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
  - \_\_\_ \* they may neither be literate in their language of origin nor in English.
- \_\_\_ 6. I use bilingual/bicultural or multilingual/multicultural staff, and/or personnel and volunteers who are skilled or certified in the provision of medical interpretation services during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.
- \_\_\_ 7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words so that I am better able to communicate with them during assessment, treatment or other interventions.
- \_\_\_ 8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment, health promotion and education or other interventions.
- \_\_\_ 9. For those who request or need this service, I ensure that all notices and communiqués to individuals and families are written in their language of origin.
- \_\_\_ 10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.
- \_\_\_ 11. I understand the principles and practices of linguistic competency and:
- \_\_\_ \* apply them within my program or agency.
  - \_\_\_ \* advocate for them within my program or agency.
- \_\_\_ 12. I understand the implications of health literacy within the context of my roles and responsibilities.
- \_\_\_ 13. I use alternative formats and varied approaches to communicate and share information with individuals and/or their family members who experience disability.

- \_\_\_\_\_ 27. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.
- \_\_\_\_\_ 28. I understand that grief and bereavement are influenced by culture.
- \_\_\_\_\_ 29. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
- \_\_\_\_\_ 30. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.
- \_\_\_\_\_ 31. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally diverse groups served by my program or agency.
- \_\_\_\_\_ 32. I keep abreast of the major health and mental health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.
- \_\_\_\_\_ 33. I am aware of specific health and mental health disparities and their prevalence within the communities served by my program or agency.
- \_\_\_\_\_ 34. I am aware of the socio-economic and environmental risk factors that contribute to health and mental health disparities or other major health problems of culturally and linguistically diverse populations served by my program or agency.
- \_\_\_\_\_ 35. I am well versed in the most current and proven practices, treatments, and interventions for the delivery of health and mental health care to specific racial, ethnic, cultural and linguistic groups within the geographic locale served by my agency or program.
- \_\_\_\_\_ 36. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, and linguistically diverse groups.
- \_\_\_\_\_ 37. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

**How to use this checklist**

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health, mental health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health and mental health care delivery programs.

## VALUES & ATTITUDES

- \_\_\_ 14. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
- \_\_\_ 15. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.
- \_\_\_ 16. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that show cultural insensitivity, racial biases, and prejudice.
- \_\_\_ 17. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
- \_\_\_ 18. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).
- \_\_\_ 19. I accept and respect that male-female roles may vary significantly among different cultures (e.g. who makes major decisions for the family).
- \_\_\_ 20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).
- \_\_\_ 21. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.
- \_\_\_ 22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.
- \_\_\_ 23. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.
- \_\_\_ 24. I understand that the perception of health, wellness, and preventive health services have different meanings to different cultural groups.
- \_\_\_ 25. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.
- \_\_\_ 26. I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.