Provider Manual

Provider Services: 844-462-0022

https://provider.summitcommunitycare.com

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How to apply for participation
If you're interested in applying for participation with Summit Community Care, please visit **https://www.summitcommunitycare.com/provider** or call Provider Services at **844-462-0022**.

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1 Introduction

Welcome to the Summit Community Care network provider family! We are pleased you've joined our network, which consists of some of the finest healthcare providers in the state.

The **Provider-Led Arkansas Shared Savings Entity (PASSE)** is a Medicaid program to address the needs of people with intensive behavioral health and intellectual and developmental disabilities service needs. The PASSE program is designed to improve people's health and let them take a more active role in their treatment with the support of comprehensive care coordination. PASSE enrollment population includes only:

- Individuals receiving services through the *1915(c) Home and Community Based Services Community and Employment Support (CES)* waiver;
- Individuals who are on the *CES* waiver waitlist;
- Individuals who are in private developmental disability Intermediate Care Facilities (ICFs); and
- Individuals with a behavioral health diagnosis have received an Independent Assessment that determines they need services in Tiers 2 or 3.
- Eligibility for coverage is determined through the Arkansas Department of Human Services (DHS).

Summit Community Care provides holistic care coordination to connect primary care physicians with specialty behavioral health providers and developmental disability service providers to create a complete plan of care for each member. Our Care Coordinators work with members, as well as their families, guardians (where applicable), providers, natural support systems, and community resources to deliver person-centered, fully integrated health and support services across their lifespan providing opportunities to lead meaningful and productive lives in their communities.

Using this manual

The purpose of this provider manual is to highlight and explain the program's elements and to serve as a useful reference for providers who participate in the https://provider.summitcommunitycare.com/Arkansas-provider/manuals-and-guides the Summit Community Care plan.

An electronic version of this manual is on our website at https://provider.summitcommunitycare.com/Arkansas-provider/manuals-and-guides. With the electronic version, you can click on any topic in the Table of Contents and be taken directly to that topic. Each chapter may also contain cross-links to other chapters, to our website or to outside websites containing additional information. Click on any link, and you will be redirected to that site. Please note some of the included website addresses are operated by a third party. These links are provided for your convenience and reference only; we do not control such sites and do not necessarily endorse them. We are not responsible for their content, products, or services.

Updates and changes

This manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. If there is an inconsistency between information contained in the manual and the agreement between you or your facility and Summit Community Care, the agreement governs.

To ensure providers are up to date with information required to work effectively with Summit Community Care and our members, we provide frequent communications to providers in the form of newsletters, e-mail alerts, fax, online postings, and other mailings. If there is a material change to the provider manual, we will make all reasonable efforts to notify you in advance of such a change through the methods noted above. As such, the most recently published information should supersede all previous information and be considered the current directive. Archives of all postings can be found on the provider website at: Archives (summitcommunitycare.com). Providers can sign up to receive email alerts on the home page of the provider's website.

This manual is not intended to be a complete statement of all policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications.

This manual does not contain legal, tax, or medical advice. Please consult your own advisors for advice on these topics.

2 Care coordination

Effective care coordination that delivers holistic services and supports to members across provider types and systems of care is key to the success of the PASSE program. The PASSE program defines care coordination as:

Ensuring that services are coordinated with specialty providers (BH and DD services, as appropriate). The PASSE must provide care coordinators who will work with the beneficiary's providers to ensure continuity of care across all services. *Act 775* of the 2017 Arkansas Regular Session defined care coordination as including the following activities:

1. Health education and coaching;
2. Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;
3. Assistance with social determinants of health, such as access to healthy food and exercise;
4. Promotion of activities focused on the health of a patient and their community, including without limitation outreach, quality improvement, and patient panel management; and
5. Coordination of Community-based management of medication therapy

Summit Community Care will assign every member in the program a qualified, conflict-free Care Coordinator who will be responsible for the total plan of care for the member, including, but not limited to the following:

- Behavioral Health Treatment Plan
- Person Centered Service Plan for Waiver Members
- Primary Care Physician Care Plan
- Individualized Education Program
- Individual Treatment Plans for developmental clients in day habilitation programs
- Management Plan
- Nutrition Plan
- Housing Plan
- Any existing Work Plan
- Justice system-related plan
- Child welfare plan or
- Medication

The Care Coordinator does not replace provider services but, instead, partners with providers to facilitate comprehensive care delivery to the member. The Care Coordinator is responsible for obtaining copies of all assessments, treatment, and service plans, coordinating related services and supports to prevent duplication of services, and identify any service gaps for the member, as well as provide any identified health education and health coaching resources.

The Summit Community Care coordinator will also provide case management under the concurrent *1915(c) Home and Community Based Services Community* and *Employment Support (CES) Waiver* for members who are *Waiver* participants, including:

1. Coordinating and arranging all CES waiver services and other state plan services;
2. Identifying and accessing needed medical, social, educational, and other publicly funded services (regardless of funding source);
3. Identifying and accessing informal community supports needed by members and their families;
4. Monitoring and reviewing services provided to members to ensure all plan services are being provided and to ensure the health and safety of the member;
5. Connecting with resources to aid in crisis intervention;
6. Providing guidance and support to meet generic needs;
7. Referrals for resources;
8. Monitoring services provided to ensure quality of care and case reviews which focus on the member's progress in meeting goals and objectives established on existing case plans;
9. Providing assistance relative to obtaining waiver Medicaid eligibility and ICF/IID level of care eligibility determinations;
10. Assisting with the submission of timely (advanced) and comprehensive behavior and assessment reports, continued plans of care, revisions as needs change and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;
11. Arranging for access to advocacy services as requested by the member; and
12. Providing assistance upon receipt of DDS or DHS notices or denials, including education regarding the reconsideration and appeal process.

Our approach uses case management teams with multifunctional expertise to assist community-based Care Coordinators, members, families, representatives and members' interdisciplinary teams in the development and implementation of person-centered service plans. We also serve as an ongoing resource in meeting member needs to support health, well-being, independence, and community living — such as employment and participation in community activities — in the most integrated setting. This approach optimizes person-centered service delivery with a continuous process of communicating, coordinating, delivering, monitoring, and assessing services, support, and progress toward achieving member goals.

The core components of the care coordination model include:

- Matching our members to the right community-based Care Coordinator by carefully considering:
  - Member diagnoses;
  - Complexity of medical, behavioral health or IDD conditions;
  - Intensity of service and support needs; and
- Identification of a community-based Care Coordinator on our team with appropriate experience, knowledge and skills, person-centered planning through partnership and collaboration with members, their providers, their families and/ or natural supports and other member-identified interdisciplinary team participants who will consider members holistically using discovery and assessment results to ensure medical, behavioral, social, vocational, and educational needs are

addressed to maximize health, well-being and independence in the development of a comprehensive, person-centered service plan.

- Coordination and collaboration across member systems of care to align resources based on need, integrate services, reduce duplication of efforts, improve continuity of care and services, and increase cost efficiencies.
- The continuous process of delivering, monitoring, and assessing interventions designed to meet the members' goals — defined in person-centered service plans and other care/treatment plans as part of their system of care — to maximize individual health, well-being, and quality of life.
- Technology and innovations to:
  - Improve member and natural support experiences;
  - Expand the tools to enable collaboration among multiple stakeholders;
  - Enhance our members' ability to self-direct services and supports;
  - Provide real-time member information; and
  - Improve provider and system performance.
- Ongoing stakeholder engagement at the member and system levels to build consensus, implement innovative solutions for issues and concerns, and facilitate continuous program improvements to better serve members.

A core responsibility within our model is embracing person-centered service planning. We communicate an array of options available to our members, supporting and promoting their informed decision-making and their well-being. Our approach promotes member engagement in all aspects of care and services, including interdisciplinary team development, use of support, and choice of specific providers. From our experience, we know fully informed members make effective decisions that promote health and safety and are suited to their preferences. This is a cornerstone to improving member experience, adherence to the service plans and overall outcomes.

Continuity of care

Summit Community Care is responsible for providing ongoing treatment and patient care to new members until an initial evaluation is performed and until a new plan of care is developed.

The following steps are taken to ensure members continue to receive necessary health services at the time of enrollment into Summit Community Care:

- Appropriate service referrals to specialty care providers will be provided in a timely manner.
- Authorization for ongoing specialty services will not be delayed while members await their initial PCP visit and comprehensive assessment. Services comparable to those the member received upon enrollment into Summit Community Care will continue during this transition period.
- If, after the member receives a comprehensive assessment, Summit Community Care determines a reduction in or termination of services is warranted, Summit Community Care will notify the member of this change at least 10 days before it is implemented. This notification will tell the member that they have the right to formally appeal to Summit Community Care or to DHS by calling us or the state at 800-482-8988. In addition, the notice will explain that if the member files an appeal within 10 days of notification and requests to continue receiving services, Summit Community Care will continue to provide these services until the appeal is resolved. You will also receive a copy of this notification.

3 Primary care providers (PCP), specialty care providers and long-term services and support/home and community-based services (LTSS/HCBS) providers

Roles of the PCP, specialty care and LTSS providers

The primary care provider (PCP) is a board-certified or eligible network provider responsible for the complete care of their patient, our member. This practice holds true whether functioning as the provider of that care or by referral to the appropriate provider within the network. PCPs may include the following specialties:

- General practitioners
- Family practitioners
- Internists
- Pediatricians
- Obstetricians/gynecologists (OB/GYNs) (for pregnant women only)
- Osteopaths
- Nurse practitioner
- Specialists designated as PCPs (with the approval of the Summit Community Care)

The Specialty Care Provider is a network provider responsible for providing specialized care for members, usually upon appropriate referral from a PCP within the network. In addition to sharing many of the same responsibilities to members as the PCP, the specialty care provider provides services that include:

- Allergy and immunology services
- Burn services
- Community behavioral health (e.g., mental health and substance abuse) services
- Cardiology services
- Clinical nurse specialists, psychologists, clinical social workers — behavioral health
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- OB/GYN services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Perinatal services
- Pediatric services
- Psychiatry (adult) services
- Psychiatry (child and adolescent) services
- Trauma services
- Urology services

A Long-Term Services and Supports/Home and Community Based Services (LTSS/HCBS) provider is a network provider who delivers home and community-based services, under the *1915(c)* Home and Community Based Services Waiver, or under the *1915(i) Home and Community Based Services State Plan Amendment*. These services include:

1915(c) Home and Community Based Services Waiver:

- Supported employment
- Supportive living
- Adaptive equipment
- Community Transition Services
- Consultation
- Crisis Intervention
- Environmental Modification
- Supplemental Support
- Respite
- Specialized Medical Supplies

***1915(i) HCBS* services:**

- Behavior Assistance
- Adult Rehabilitative Day Services
- Peer Supports
- Family Support Partners
- Supportive Life Skills Development
- Child and Youth Support Services
- Supportive Employment
- Partial Hospitalization
- Mobile Crisis Intervention
- Therapeutic Host Home
- Therapeutic Communities
- Residential Community Reintegration
- Planned and Emergency Respite Services

Providers may fulfill multiple roles for our members, requiring them to comply with the roles and responsibilities for each applicable provider-type.

Responsibilities of the participating provider

The participating provider shall:

- Manage the medical and healthcare needs of members, in collaboration with the Care Coordinator, including monitoring and following up on care provided by other providers; provide coordination necessary for referrals to specialists, including behavioral health providers and fee-for-service providers (both in and out-of-network); and maintain a medical record of all services rendered by the PCP and other providers.
- Provide 24-hour-a-day, 7-day-a-week coverage and maintain regular hours of operation that are clearly defined and communicated to members. Hours of operation provided to PASSE members

may be no less than the hours offered to commercial members or are comparable to Medicaid Fee for Service if the provider serves only Medicaid members.

- Provide services ethically, legally and culturally competently, meeting the unique needs of members with special healthcare needs.
- Ensure no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin or any other classifications protected under federal or state laws shall be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with Summit Community Care or in the employment practices of the provider. Ensure notices of nondiscrimination are posted in conspicuous places available to all employees and enrollees.
- Participate in the systems established by Summit Community Care that facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements.
- Implement policies and procedures for the provision of language assistance to members and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats such as auxiliary aids to any member and/or the member's representative who needs such services including but not limited to members with limited English proficiency, members who are hearing impaired and individuals with disabilities. Such services will be provided free of charge and be available in the form of in-person interpreters, sign language or access to telephonic assistance (e.g., the TTY universal line). Providers will also employ appropriate auxiliary aids and services free of charge.
- Participate and cooperate with Summit Community Care in any reasonable internal or external quality assurance, utilization review, continuing education, training, technical assistance, or other similar program established by Summit Community Care.
- Make reasonable efforts to communicate, coordinate and collaborate with specialty providers including developmental disability and behavioral health providers involved in delivering care and services to members.
- Participate in and cooperate with complaint and grievance procedures when notified by Summit Community Care of a member grievance.
- Not balance bill members.
- Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or to transition a pregnant member through postpartum care for pregnant members in their second and third trimester.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration (OSHA) standards.
- Meet the federal and state physical and mental accessibility standards and those defined in the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 applicable to his or her practice location.
- Support, cooperate and comply with the Summit Community Care Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
- Inform Summit Community Care if a member objects for religious reasons to the provision of any counseling, treatment or referral services.

- Treat all members with respect and dignity; provide members with appropriate privacy; and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse the release of such records as allowed under applicable laws and regulations.
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis.
- Give members the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options, including medication treatment options, regardless of whether benefits for such care are provided under the program.
- Advise members on treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to non-research-related care.

Primary Care Provider (PCP) Access and Availability

All providers are expected to meet the federal and state physical accessibility standards and those defined in the *Americans with Disabilities Act of 1990* and *Section 504 of the Rehabilitation Act of 1973*.

Healthcare services provided through Summit Community Care must be accessible to all members. Summit Community Care is dedicated to ensuring that:

- The PCP or another physician/nurse practitioner is available to provide medically necessary services.
- Covering physicians follow the referral/prior authorization guidelines.
- The automatic direction of a member to the emergency room when the PCP is **not** available never occurs.

We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

PCPs or extenders are required to adhere to the following access standards:

- Patient Load: 2,500 or less for physicians; half for physician extenders
- Appointment/wait times: usual and customary practice, not to exceed three weeks from date of a patient's request for regular appointments and 24 hours for urgent care; wait times shall not exceed 45 minutes

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

- Have the office telephone answered after-hours by an answering service that can contact the PCP or another designated network medical practitioner. All calls answered by an answering service must be returned by the PCP within 60 minutes.

- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP, directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Summit Community Care network medical practitioner who can return the call within 60 minutes.

The following telephone answering procedures are **not** acceptable:

- Office telephone is only answered during office hours
- Office telephone is answered after-hours by a recording that tells members to leave a message
- Office telephone is answered after-hours by a recording which directs members to go to an emergency room for any services needed
- Returning after-hours calls outside of 60 minutes

Procedures for becoming a PCP

See the **Provider Credentialing** section or contact Provider Services at **844-462-0022** for more information.

Submitting Provider demographic data requests and roster submissions through Roster Automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers*. **Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads.** If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

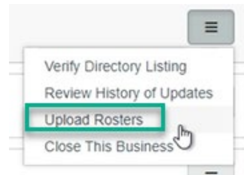
Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today:**

The resources for this process are listed below and available on our website. Visit https://provider.summitcommunitycare.com, then under For Providers, select Forms and Guides. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the Digital Tools category.

- **Roster Automation Rules of Engagement**: Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- **Roster Automation Standard Template:** Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).

- Upload your completed roster via the Availity PDM application.

Accessing PDM Application:
Log onto availity.com and select **My Providers > Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** (see screen shot below) and follow the prompts.



Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

***** Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
- Any specific state mandates or requirements for provider demographic updates

****** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Assignment and reassignment of a member

In-network PCPs receive a monthly panel listing identifying all Summit Community Care members assigned to them.

The Provider Inquiry Line is available 24 hours a day, 7 days a week at **844-462-0022**. This is an automated telephone tool that enables providers to verify member eligibility, prior authorization, and claims status. Providers can also log in to the secure website at **https://www.summitcommunitycare.com/provider** to verify member eligibility or call a Provider Services representative at **844-462-0022** to answer eligibility questions.

Procedure for selecting a PCP

Members have the right to select their PCP as well as a primary dental provider. Upon enrollment, the member may select a PCP from the directory or call Member Services at **844-405-4295** (**TTY 711**) for help to select a new provider. The member may consider the provider’s specialty, accessibility, gender, ethnic background, and languages spoken in the selection process. The member handbook includes a description of how to choose a PCP.

Summit Community Care issues a member ID card printed with the PCP's name and telephone number.

Default assignment of a PCP

The Summit Community Care provider network will be submitted to the Member Services department to assist new members in selecting a PCP. Members who do not select a PCP will be assigned to one using the enrollment information provided (e.g., geographic proximity to the provider, age and language).

Procedure for changing PCPs and other providers

Members have the right to change their PCPs at any time. The member may select a PCP from the directory or call Member Services at **844-405-4295** (**TTY 711**) for help to change his or her PCP. The member handbook includes a description of how to change a PCP. PCP change requests will be processed generally on the same day or by the next business day. Within 10 days, the member will receive a new ID card that displays the new PCP name and phone number.

If a provider is contacted by a member who is either assigned to another PCP or who does not yet have an assigned PCP, the provider should have the member contact our Member Services department at **844-405-4295** (**TTY 711**) to request a PCP change or to be assigned a PCP.

Responsibilities of specialty care providers

Specialist providers will only treat members who have been referred to them by network PCPs (with the exception of mental health and substance abuse providers and services that the member may self-refer to) and will render covered services only to the extent and duration indicated on the referral. Obligations of the specialists include the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Meeting eligibility requirements to participate in the Medicaid program
- Accepting all members referred to them if the referrals are within the scope of the specialist's practice
- Submitting required claims information
- Arranging for coverage with other network providers while off-duty or on vacation
- Verifying member eligibility and prior authorization of services (when required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis following a referral or routinely scheduled consultative visit
- Notifying the PCP and Summit Community Care and requesting prior authorization from Summit Community Care as appropriate when scheduling a hospital admission or any other procedure requiring Summit Community Care approval. Coordinating care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance abuse disorders
- Ensuring that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with Summit Community Care or in the employment practices of the provider
- Cooperate with Summit Community Care during discrimination complaint investigations and report discrimination complaints and allegations to Summit Community Care including allegations of discrimination

Specialty care access and availability

Summit Community Care will ensure access to specialty providers (specialists) for covered services.

Referral appointments to specialists (e.g., specialty provider services, hospice care, home healthcare, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate at the nearest facility available regardless of contract. Wait times shall not exceed 45 minutes.

All other services not specified here will meet the usual and customary standards for the community.

Specialty referrals

All specialty referral authorizations will comply with Section 6.3 of the Arkansas Department of Human services PASSE Contract.

To reduce the administrative burden on the provider's office staff, Summit Community Care has established procedures that are designed to permit a member with a condition that requires ongoing care from a specialist provider or other healthcare provider to request an extended authorization. The provider can request an extended referral authorization by contacting the member's PCP. The provider must supply the necessary clinical information that will be reviewed by the PCP to complete the authorization review.

On a case-by-case basis, an extended authorization will be approved. In the event of termination of a contract with the treating provider, the continuity of care provisions in the provider's contract with Summit Community Care will apply. The specialist provider may renew the authorization by submitting a new request to the PCP. Additionally, Summit Community Care requires the specialist provider or other healthcare provider to provide regular updates to the member's PCP. Should the need arise for a secondary referral, the specialist provider or other healthcare provider must contact Summit Community Care for coverage determination.

If the specialist or other healthcare provider needed to provide ongoing care for a specific condition is not available in the Summit Community Care network, the referring physician shall request authorization from Summit Community Care for services outside the network. Access will be approved to a qualified non-network healthcare provider within a reasonable distance and travel time at no additional cost if medical necessity is met.

Second opinions

A member, parent and/or legally appointed representative, or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion shall be provided at no cost to the member.

The second opinion must be obtained from a network provider (see provider directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Summit Community Care may also request a second opinion at its own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When Summit Community Care requests a second opinion, Summit Community Care will make the necessary arrangements for the appointment, payment and reporting. Summit Community Care will inform the member and the PCP of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

Responsibilities of LTSS/HCBS providers

The very nature of HCBS services is that LTSS/HCBS providers support members in their homes and in community settings, which makes them particularly suited to collaborating with Care Coordinators and other providers to support members in meeting their goals.

LTSS/HCBS providers will only deliver developmental disability and behavioral health HCBS services and support to members approved in the Person-Centered Service Plan or authorized by Summit Community Care. Obligations of the LTSS/HCBS providers include the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program, including program-specific requirements from the Division of Developmental Disabilities and the Division of Behavioral Health
- Meeting eligibility requirements to participate in the Medicaid program, as well as specific requirements applicable to
- Submitting required claims information
- Complying with program-specific documentation and service delivery requirements
- Where applicable, participate with the member's interdisciplinary team in developing and implementing the Person-Centered Service Plan

CES waiver compliance

All CES waiver service must be delivered in accordance with the waiver requirements and consistent with the Division of Disability Services CES Wavier Provider Manual or in our policies, which is included in the Appendix and incorporated herein.

Behavioral health, HCBS access standards

Service type	Maximum time for admission/appointment
Outpatient	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service

Service type	Maximum time for admission/appointment
Intensive Outpatient (may include day treatment adult, intensive day treatment children and adolescent or partial hospitalization)	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service
Outpatient Treatment Services (substance use)	Within 14 calendar days
Crisis Stabilization	Within four hours of referral

Behavioral health prior authorization

We require prior authorization for all elective behavioral health, inpatient admissions and certain outpatient services. We use our *Behavioral Health Medical Policies* and *Clinical UM Guidelines*. The following is a list of services that must be prior authorized:

- Inpatient admission
- Non-routine outpatient BH services (i.e., intensive outpatient)
- Routine outpatient BH services for out-of-network providers only
- Partial hospital programs
- Electroconvulsive therapy
- Psychological and neuropsychological testing

Cross-discipline coordination

Summit Community Care emphasizes the coordination and integration of physical and behavioral health and developmental disability services wherever possible. Key elements of the Summit Community Care model of coordinated care include:

- Ongoing communication and coordination between PCPs and specialty providers and LTSS/HCBS providers.
- The expectation that providers screen for co-occurring disorders including:
  - Behavioral health screening by PCPs.
  - Medical screening by behavioral health providers.
  - Screening of mental health patients for co-occurring substance use disorders.
  - Screening of consumers in substance use disorder treatment for co-occurring. mental health and/or medical disorders.
  - Screening tools for PCPs and behavioral health providers can be located at **https://www.summitcommunitycare.com/provider**.
- Referrals to PCPs or specialty providers, including LTSS/HCBS and other behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders
- Involving members, as well as caregivers and family members as appropriate, in the development of patient-centered treatment plans and service plans, including case management and disease management programs to support the coordination and integration of care between providers.
- Notification of a member's PCP when a member first enters behavioral healthcare and anytime there is a notable change in care, treatment or need for medical services, provided the provider has secured the necessary release of information. The minimum elements to be included in such correspondence are:
  - Patient demographics.
  - Date of initial or most recent behavioral health evaluation.

- Recommendation to see PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the member (e.g., EPSDT screen, complaint of physical ailments).
- Diagnosis and/or presenting behavioral health problem(s).
- Prescribed medication(s).
- Vital signs.
- Allergy/drug sensitivity.
- Pregnancy status.
- Behavioral health clinician's name and contact information.

We also recognize treatment and recovery can be complicated by comorbid conditions. Essential ambulatory care should continue unabated while a member is hospitalized; therefore, PCPs and specialty providers must communicate directly to ensure continuity of care.

- When a member being treated for a comorbid behavioral health or IDD condition is admitted for treatment of a physical health condition, the attending physician will try to secure a release of information and review the admission with the PCP. This is necessary to ensure essential treatment will continue unabated.
- When a member who is being treated for a comorbid physical health condition is admitted for treatment of a behavioral health or IDD condition, the attending physician will attempt to secure a release of information and review the admission with the behavioral health provider. This is necessary to ensure that essential treatment will continue unabated.

We require that PCPs, specialty providers and HCBS/LTSS providers share relevant case information in a timely, useful, and confidential manner. We require that the specialty providers be notified of the member's physical examination and laboratory and radiological tests within 24 hours of receipt for urgent cases and within five business days in non-urgent cases. This notification will be made by telephone with follow-up- in writing. The provider will obtain a release of information from any member or his or her legal representative (e.g., parent, guardian, or conservator) before releasing confidential health information. The release of information must contain, at a minimum, the following:

- Name and identification number of the member whose health information is being released
- Name of provider releasing the information
- Name of provider receiving the information
- Information to be released
- Period for which the authorization is valid
- Statement informing the signatory that he or she can cancel the authorization at any time
- Printed name of the signatory
- Signature or mark of the signatory
- Date of signature

A physical health provider who recognizes related behavioral health needs requiring treatment by a behavioral health provider will facilitate the member's access to a behavioral health service. A physical health provider who recognizes needed support or additional services regarding IDD needs requiring treatment by a specialized IDD provider will facilitate the member's access to such services. A non-network provider who recognizes related physical health needs requiring treatment by a physical health provider is expected to facilitate the member's access to a primary provider by contacting us.

For members hospitalized and receive behavioral and physical health services, primacy (i.e., the primary form of care) will be determined by the principal diagnosis, type of attending physician and location of

service. Either type of provider may initiate consultation with the other and coordinate further and/or ongoing care. A physical and behavioral health provider should exchange health information at the following junctures:

- When the member first accesses a physical or behavioral health service
- When a change in the member's health or treatment plan requires an alteration of the other provider's treatment plan (e.g., when a member who has been taking lithium becomes pregnant)
- When the member is admitted to or discharged from the hospital
- When the member discontinues care
- When a member is admitted, and a consultation is warranted

Information should contain at a minimum:

- Provider's name and contact information
- Member's name, date of birth, gender, ID number and contact information
- Reason for referral (initial contact only)
- Current diagnosis
- History of the presenting illness and other relevant medical and social histories (initial contact only)
- Level of suicide, homicide, physical harm, or threat
- Current treatment plan
- Special instructions (e.g., diagnostic questions to be answered, treatment recommendations)

The provider will maintain a copy of the release of information form and document care coordination in the member's medical record. We will coordinate inpatient behavioral health consultations and services and discharge planning and follow-up with the member's behavioral health provider (both network and non-network).

General provisions for all providers

The interactive voice response system

Summit Community Care provides an automated interactive voice response (IVR) system to better serve members and participating providers. This IVR technology allows Summit Community Care to provide more detailed enrollment, claims and authorization status information along with self-service features for members. These features allow each member to:

- Update his or her address and telephone number.
- Request a new member ID card.
- Search for and/or change his or her PCP name.

Summit Community Care recognizes that for you to provide the best service to members, accurate, UpToDate information must be shared. As a result, Summit Community Care offers an automated inquiry line for accessing claims status, member eligibility and prior authorization determination status 24 hours a day, 365 days a year.

The toll-free automated Provider Inquiry Line (844-462-0022) can be used to verify member status, claim status and prior authorization determination. This tool also offers the ability to be transferred to the appropriate department for other needs such as requesting new prior authorization, ordering referral forms or directories, seeking advice in case management, or obtaining a member roster. Detailed instructions for use of the Provider Inquiry Line are outlined below.

To access member eligibility information:
Electronic eligibility and benefits are available at **https://www.availity.com**. For manual calls to the Provider Inquiry Line:

1. Dial phone. After saying your NPI or provider ID and TIN for the prompt, you can say, **"member status," "eligibility"** or **"enrollment status."**
2. Be prepared to say the member's **Summit Community Care ID number**, **ZIP code** and **date of service**.
3. You can search by **Medicaid ID**, **Medicare ID** or **Social Security number**.
    a. Say, "**I don't have it"** when asked to say the member's Summit Community Care ID number, then say the ID type you would like to use when prompted.
4. The system will verify the member's eligibility and PCP name.

To review claim status:
Electronic claim status inquiry is available at **https://www.availity.com**. For manual calls to the Provider Inquiry Line:

1. Dial the phone and listen for the prompt.
    a. At the main menu, say, "**claims**."
    b. You can get the status of a **single claim** or the **five most recent claims**.
    c. You can speak to someone about a ***Payment Appeal Form*** or an ***EOP***.
2. Be prepared to say the **claim number.**
    a. If you don't have it, you can hear the **five most recent claims** by saying **recent claims.**

To review referral authorization status:

1. Dial the phone and listen for the prompt.
    a. At the main menu, say, "**authorizations**" or "**referrals**."
    b. Say "**authorization status**" to hear up to 10 outpatient or one inpatient authorization determination.
    c. Say "**new authorization**" to be transferred to the correct department based on the authorization type.
2. Be prepared to say the member's **Summit Community Care ID number**, **ZIP code**, **date of birth** and **date of service**.
    a. Say the admission date or the first date for the start of service in MM/DD/YYYY format.

Reporting communicable disease

Summit Community Care providers must comply with the state's Communicable Disease Reporting requirements in accordance with state code #, the state's Childhood Lead Poisoning Screening and Reporting Legislative Review Act (2002) and any additional state codes. Summit Community Care providers must also comply with state requirements for reporting to registries and programs, include the Cancer Control Registry.

A complete list of reportable communicable diseases is available at **https://www.summitcommunitycare.com/provider**.

Examples of reporting requirements include but are not limited to:

- Individuals with vaccine-preventable diseases.

- Infants, toddlers, and school-age children experiencing developmental delays as evidenced by development assessments or interperiodic exams.
- Members with sexually transmitted and other communicable diseases including HIV.
- Members diagnosed with or suspected of being infected with tuberculosis (report must be made within 24 hours).
- Laboratories and/or providers must report results of all blood lead screening tests to the state and Summit Community Care within 72 hours.

Health promotion programs

Summit Community Care provides health promotion programs to encourage members to use health services appropriately and lead healthier lives. These programs include education about prenatal care, prevalent chronic conditions, and preventive screenings. Your patients are all assigned a Care Coordinator who can assist them in accessing these programs.

Initial health appointments for Summit Community Care members

Summit Community Care members 21 and over must be offered an initial appointment within 45 days of their date of enrollment with the PCP or within 21 days of request, whichever is sooner, unless one of the following exceptions applies:

- Appointments for initial EPSDT screens shall be offered to new enrollees within 60 days of the enrollee's enrollment date with Summit Community Care, or at an earlier time if 1) an earlier (exam is needed to comply with the periodicity schedule or 2) if the child's case indicates a more rapid assessment or 3) a request results from an emergency medical condition. The initial screen shall be completed within three months of the enrollee's enrollment date with Summit Community Care unless we determine the new enrollee is UpToDate with the EPSDT periodicity schedule. To be considered timely, all EPSDT screens, laboratory tests and immunizations shall take place within 30 days of their scheduled due dates for children under the age of two and within 60 days of their due dates for children age two and older. Periodic EPSDT screening examinations shall take place within 30 days of a request.
- For pregnant and postpartum women who have not started to receive care, or individuals requesting family planning services, the initial health visit must be scheduled and occur within 14 calendar days of the date the member requests the appointment.

During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age-appropriate physical exam.

In addition, at the initial health visit, initial prenatal visit, or when physical status, behavior of the member or laboratory findings indicate substance use disorder, refer the member to the Department of Behavioral Health.

Routine and urgent appointments for Summit Community Care members

To ensure members receive care in a timely manner, providers must maintain the following appointment availability standards:

Primary care practitioners

Type of visit	Availability standard

Emergency care (life threatening)	Immediately at the nearest facility
Urgent care visits	Within 24 hours of request
Routine, nonurgent care visits	Within 21 calendar days of request
Preventive care visits	Within 30 calendar days of request
Initial appointments for pregnant women or persons needing family planning	Within 14 calendar days of request

Specialist practitioners

Type of visit	Availability standard
Urgent care visits	Within 24 hours of referral
Routine, non-urgent care	Within 60 calendar days of referral

Behavioral health practitioners

Type of visit	Availability standard
Emergency care (life threatening)	Immediately at nearest facility
Care for non-life-threatening emergencies	Within 6 hours of request
Urgent care — behavioral, substance abuse care	Within 24 hours of request
Routine visit for routine care	Within 10 business days of request
Follow-up routine care, nonurgent care	Within 21 calendar days

Advance directive

Summit Community Care respects the right of the member to control decisions relating to his or her own medical care, including the decision to have the medical or surgical means or procedures calculated to prolong life provided, withheld, or withdrawn. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

Summit Community Care adheres to the Patient Self-Determination Act and maintains written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving directions to healthcare providers about treatment choices in certain circumstances. There are two types of advance directives. A durable power of attorney for healthcare (for example, durable power) allows the member to name a patient advocate to act on his or her behalf. A living will allow the member to state his or her wishes in writing but does not name a patient advocate.

Member Services and Outreach associates encourage members to request an advance directive form and education from their PCP at their first appointment. The PCP must offer an advance directive form to all members over age 18 and document each member's response to an offer to execute the advance directive in the member's medical record.

Members over age 18 can execute an advance directive by requesting it from their PCP. Their response regarding the decision on an advanced directive must be documented in the medical record. Summit Community Care and/or its providers will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual provider may conscientiously object to an advance directive.

Member Services and Outreach associates will assist members with frequent questions about advance directives. However, no associate of Summit Community Care may provide legal advice regarding advance directives. Additionally, no associate may serve as witness to an advance directive or as a member's designated agent or representative.

Summit Community Care notes the presence of advance directives and the member's response to whether he or she wants to establish an advance directive in the medical records when conducting medical chart audits. A living will and durable power of attorney are in **Appendix A Forms**.

Culturally and linguistically appropriate services

Patient panels are increasingly diverse, and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Summit Community Care wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values, and preferred means of having those needs met.
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Summit Community Care ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Summit Community Care encourages providers to access and utilize **MyDiversePatients.com**.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice - Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective health care to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST): Helps providers understand HCST and the implications for diverse patients and the benefits of reducing HCST to both providers' patients and practices, and how to do so.**

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and health care needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Summit Community Care appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Interpreter services

Oral interpretive services are available either in-office or telephonically at no cost to you or the member. If you serve a Summit Community Care member with whom you cannot communicate, call Member Services at **844-405-4295** (**TTY 711**) to access an interpreter. For immediate needs, Summit Community Care has Spanish language interpreters available without delay and can provide access to interpreters of other languages within minutes.

Summit Community Care recommends that requests for in-office interpreter services be made at least one business day in advance of the appointment. If a member with special needs needs an

interpreter to accompany them to a clinic appointment, a case manager/care coordinator can arrange for the interpreter to be present.

Providers are required to offer interpretive services to members who may require assistance. Providers should document the offer and the members' response and reiterate that interpretive services are available at no cost. Family and friends should not be used to provide interpretation services, except at a member's request.

Nondiscrimination statement

Summit Community Care does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates based on race, color, or national origin in providing aid, benefits or services to beneficiaries. Summit Community Care does not utilize or administer criteria affecting discriminatory practices based on gender or identity. Summit Community Care does not select site or facility locations that exclude individuals from, denying the benefits of or subjecting them to discrimination based on gender or identity. In addition, in compliance with the Age Act, Summit Community Care may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Summit Community Care provides health coverage to members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact Summit Community Care with an allegation of discrimination are informed immediately of their right to file. This also occurs when a Summit Community Care representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. Summit Community Care documents, tracks, and trends all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington DC 20201
- By phone at: **800-368-1019** (**TTY/TTD: 800-537-7697**)

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Summit Community Care provides free tools and services to people with disabilities to communicate effectively. Summit Community Care also provides a free language service to people whose primary language is not English (e.g., qualified interpreters and information written in other languages). These services can be obtained by calling the customer service number on their member ID card (**844-462-0022**).

If you or your patient believes that Summit Community Care has failed to provide these services or discriminated in any way based on race, color, national origin, age, disability, gender, or gender identity, you can file a grievance with the grievance coordinator via Provider Services at **844-462-0022**.

Equal program access based on gender

Summit Community Care gives individuals equal access to health programs and activities without discriminating based on gender. Summit Community Care must also treat individuals consistently with their gender identity and is prohibited from discriminating against any individual or entity based on a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, gender, gender identity, age or disability).

Summit Community Care may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual since a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Critical incident reporting and management

We have a critical incident/quality of care reporting and management system for incidents and quality of care concerns that occur where a member is receiving services. As a participating Summit Community Care provider, you must participate in critical incident and quality of care reporting. Immediate action will be taken to ensure the member is protected from further harm. Critical incidents and quality of care concerns will be tracked and presented to our quality improvement committee for review.

A critical incident, also known as a major incident or a quality-of-care concern, means an occurrence that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital.
2. Results in the death of any person.
3. Requires emergency mental health treatment for the member.
4. Requires the intervention of law enforcement.
5. Requires the use of restrictive interventions.
6. Requires a report of child abuse pursuant to *§ 12-18-102, § 12-18-103(7), 12-18-402(b)* or a report of abuse or maltreatment of an at-risk person pursuant to *ACA 12-12-1708*.
7. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in 1, 2 or 3.
8. Involves a member's location being unknown by provider staff who are assigned protective oversight.

Providers must report critical incidents and quality of care concerns to Summit Community Care in accordance with applicable requirements. The maximum time frame for reporting an incident to Summit Community Care is 24 hours. The initial report of an incident within 24 hours may be submitted verbally, in which case the person, agency or entity making the initial report will submit a follow-up written report within 48 hours. The report should be made verbally to Provider Services at **844-462-0022** with follow-up written report to **Arkansas Quality**. The *Incident Report Form* is located in the **Appendix** section.

Suspected abuse, neglect and exploitation of adult members must be immediately reported to the Arkansas Adult Abuse Hotline at 800-482-8049. Suspected brutality, abuse or neglect of members who are children must also be immediately reported. Reports of suspected child abuse and dependent abuse must be made by calling the Department of Human Services' Child Abuse Hotline at **800-482-5964**.

Providers must immediately (i.e., within 24 hours) take steps to prevent further harm to all members and respond to any emergency needs of members.

Providers must conduct an internal critical incident/quality of care investigation and submit a report on the investigation by the end of the next business day. Summit Community Care will review the provider's report and follow up with the provider as necessary to ensure an appropriate investigation was conducted and corrective actions were implemented within applicable times.

Providers must cooperate with any investigation conducted by Summit Community Care or outside agencies (e.g., Adult Protective Services, Child Protective Services, and law enforcement).

For Summit Community Care HCBS providers and CES Waiver providers, see **Appendix C**.

Medical records documentation standards

Member records

Summit Community Care requires medical records to be maintained in a current, detailed and organized manner and permits effective and confidential patient care and quality review.

Providers must maintain medical records that conform to professional medical practice and appropriate health management. A permanent medical record must be maintained at the primary care site for every member and be available to the PCP and other providers. Medical records must be kept in accordance with Summit Community Care and state standards as outlined below.

Member visit data

Documentation of individual encounters must provide adequate evidence of, at a minimum:

1. **History and physical exam**: Appropriate subjective and objective information must be obtained for the presenting of complaints.
2. For members receiving behavioral health treatment, documentation must include at-risk factors (e.g., danger to self-and/or others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social health) and efforts to coordinate care with all behavioral health providers after obtaining the appropriate release(s) of information.
3. Admission or initial assessment must include current support systems or lack of support systems.
4. For members receiving behavioral health treatment, an assessment must be completed for each visit relating to client status and/or symptoms of the treatment process. Documentation may indicate initial symptoms of the behavioral health condition as decreased, increased, or unchanged during the treatment period.
5. Plan of treatment must include the activities, therapies, and goals to be carried out.
6. **Diagnostic tests**
7. **Therapies and other prescribed regimens**: For members who receive behavioral health treatment, documentation must include evidence of family involvement as applicable and include evidence that the family was included in therapy sessions when appropriate.
8. **Follow-up**: Encounter forms or notes must have a notation when indicated concerning follow-up care, calls, or visits. The specific time to return must be noted in weeks, months or as needed. Unresolved problems from previous visits are addressed in subsequent visits.

9. Referrals, results thereof and all other aspects of member care, including ancillary services.

Summit Community Care will systematically review medical records to ensure compliance with standards and will institute actions, as appropriate, for improvement when standards are not met. Access to or copies of medical records must be provided, free of charge, within five days of our request.

Summit Community Care policies are designed to maintain an appropriate record-keeping system for services to members. This system will collect all pertinent information related to the medical management of each member and make that information readily available to appropriate health professionals and state agencies. All records will be retained in accordance with the record retention requirements of 45 CFR 74.164 (i.e., records must be retained for ten years from the date of service). Records will be made accessible upon request to agencies of the state and federal governments.

Medical record standards

The records reflect all aspects of patient care, including ancillary services. Documentation of each visit must include:

1. Date of service.
2. Purpose of visit.
3. Diagnosis or medical impression.
4. Objective finding.
5. Assessment of patient's findings.
6. Plan of treatment, diagnostic tests, therapies, and other prescribed regimens.
7. Medications prescribed.
8. Health education provided.
9. Signature and title or initials of the provider rendering the service:
    a. If more than one person documents the medical record, there must be a record on file as to what signature is represented by which initials.

These standards shall, at a minimum, meet the following medical record requirements:

1. **Patient identification information**: Each page or electronic file in the record must contain the patient's name or ID number.
2. **Personal/biographical data**: The record must include the patient's age, gender, address, employer, home and work telephone numbers and marital status.
3. All entries must be dated, and the author identified with credentials.
4. Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one provider reviewer.
5. **Allergies**: Medication allergies and adverse reactions must be prominently noted on the record. When clinically appropriate, the note of *No Known Allergies* (i.e., the absence of allergies) must be documented in an easily recognizable location.
6. **Past medical history** (for members seen three or more times): Past medical history must be easily identified, including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
7. **Immunizations**: For pediatric records of children age 13 and under, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and dates given when possible.
8. **Diagnostic information**: Information used to arrive at a diagnosis, such as in-office examinations, laboratory and radiology reports, or specialist consultation, must be documented.

9. **Medication information**: Medication information and/or instructions to members are included.
10. **Identification of current problems**: Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record.
11. **Condition specific education**: The members must be provided with basic teaching and instruction regarding physical and/or behavioral health conditions.
12. **Smoking/alcohol/substance abuse**: A notation concerning cigarette and/or alcohol use or substance abuse must be stated if present for members age 12 and older. Abbreviations and symbols may be appropriate.
13. **Consultations, referrals and specialist reports**: Notes from referrals and consultations must be included in the record. Consultation, laboratory, and X-ray reports filed in the chart must have the ordering provider's initials or other documentation signifying review. Consultation and any abnormal laboratory and imaging study results must have an explicit notation in the record of follow-up plans.
14. **Emergency care**: All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the member is enrolled.
15. **Hospital discharge summaries**: Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the member is enrolled with the provider's panel and for prior admissions, as necessary. Prior admissions pertain to admissions which may have occurred prior to the member being enrolled and are pertinent to the member's current medical condition.
16. **Advance directive**: For medical records of adult members, the medical record must document whether the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for healthcare relating to the provision of healthcare when the individual is incapacitated.
17. Documentation of evidence and results of medical, preventive, and behavioral health screenings must be included.
18. The record must include documentation of all treatment provided and the results of such treatment.
19. The record must include documentation of the team of providers involved in the multidisciplinary team of a member needing specialty care.
20. The record must include documentation in the physical and behavioral health records of clinical care integration. Documentation should include:
    a. Screening for behavioral health conditions, including those which may affect physical healthcare and vice versa, and referral to behavioral health providers when problems are indicated
    b. Screening and referral by behavioral health providers to PCPs when appropriate
    c. Receipt of behavioral health referrals from physical medicine providers and the disposition and/or outcome of those referrals
    d. A summary of the status and/or progress from the behavioral health provider to the PCP at least quarterly or more often if clinically indicated
    e. A written release of information permitting specific information sharing between providers
    f. Documentation that behavioral health professionals are included in the primary and specialty care service teams described in this contract when a member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder

Provider notification to Summit Community Care

The provider must notify Summit Community Care in writing within five days, unless otherwise stated below, following the occurrence of any of the following events:

- The provider's license to practice in any state is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions. Notification of any such action must be furnished in writing to Summit Community Care immediately.
- The provider 1) learns that he or she has become a defendant in any malpractice action relating to a member who also names Summit Community Care as a defendant or receives any pleading, notice or demand of claim or service of process relating to such a suit or 2) is required to pay damages in any such action by way of judgment or settlement. Notification must be furnished in writing to Summit Community Care immediately.
- The provider is disciplined by a state board of medicine or a similar agency.
- The provider is sanctioned by or debarred from participation with Medicare or Medicaid.
- The provider is convicted of a felony relating directly or indirectly to the practice of medicine. Notification must be furnished in writing to Summit Community Care immediately.
- There is a change in the provider's business address or telephone number.
- The provider becomes incapacitated in such a way that the incapacity may interfere with patient care for 21 consecutive days or more.
- There is no change in the nature or extent of services rendered by the provider.
- There is any material change or addition to the information and disclosures submitted by the provider as part of the application for participation with Summit Community Care.
- The provider's professional liability insurance coverage is reduced or canceled. Notification must be given in writing to Summit Community Care at least five days before such a change.
- There is any other act, event, occurrence or the like that materially affects the provider's ability to carry out his or her duties under the *Participating Provider Agreement*.
- The provider's member panel is reaching capacity according to the established capacity standards set in the *Standards and Measures for Appropriate Availability to Provider Policy*. At least 30 days' advance notice must be given.
- There is no change to hours of operation or staffing levels.
- There is an inability to meet timely access to care and services according to the established appointment access standards set in the *Appointment Guidelines Policy*.

First line of defense against fraud

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste, and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- *Fraud:* Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person.
- *Waste*: Includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered driven by intentional actions but occurs when resources are misused.

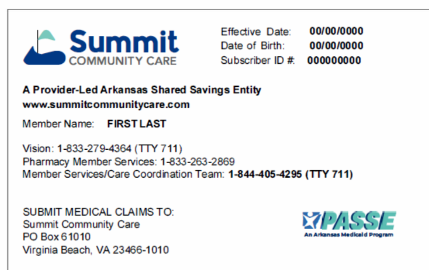
- *Abuse*: When healthcare providers or suppliers do not follow good medical practices, resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

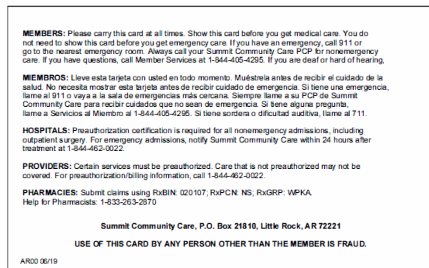
To help prevent fraud, waste or abuse, providers can educate members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the Summit Community Care member identification card. It is the first line of defense against fraud. Summit Community Care may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member, even if that person presents a Summit Community Care member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Every Summit Community Care member ID card lists the following:

- Effective date of Summit Community Care membership
- Member date of birth
- Subscriber number (Summit Community Care identification number)
- Carrier and group number (RXGRP number) for injectables
- PCP name, telephone number and address
- Copays for office visits, emergency room visits, and pharmacy services (if applicable)
- Behavioral health benefit
- Vision service plan telephone number and dental service plan telephone number
- Member Services and 24/7 Nurse HelpLine telephone numbers

Summit Community Care member identification card sample:





Presentation of a member identification (ID) card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries

on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at **844-462-0022**.

Providers should encourage members to protect their ID cards as they would like a credit card, to always carry their Summit Community Care card and report any lost or stolen cards to us as soon as possible. Understanding the numerous opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. If you or a patient suspects ID theft, call our Compliance Hotline at **877-725-2702**. Providers should instruct their patients who suspect ID theft to watch the *Explanation of Benefits* (*EOBs*) for any errors and then contact Member Services if something is incorrect.

Reporting fraud, waste, and abuse

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud. Learn more at **www.fighthealthcarefraud.com**.

You can report your concerns by:

- Visiting **https://provider.summitcommunitycare.com**, scrolling to the bottom footer and click on **Report Waste, Fraud or Abuse**
- Call Provider Services at **844-462-0022**
- Calling our Special Investigations Unit fraud hotline at **866-847-8247**

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. No individual who reports violations or suspects fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators. We appreciate your time in referring suspected fraud but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of provider fraud, waste, and abuse

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was performed

When reporting concerns involving a ***provider*** (a doctor, dentist, counselor, medical supply company, etc.), include:
- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

Examples of member fraud, waste, and abuse

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (Identification) card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service plan area
- Using someone else's ID card

When reporting concerns involving a ***member***, include:
- The member's name.
- The member's date of birth, member ID or case number if you have it.
- The city where the member resides.
- Specific details describing fraud, waste, or abuse.

Investigation process

We investigate all reports of fraud, abuse and waste for all services provided under the contract, including those that are subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include, but is not limited to:
- *Written warning and/or education:* We send certified letters to the provider documenting the issues and the need for improvement. Letters may include training or requests for recoveries or may advise of further action.
- *Medical record review:* We review medical records to substantiate allegations or validate claims submissions.
- *Special claims review:* A certified professional coder or investigator evaluates claims and places payment or system edits on file. This type of review prevents automatic claim payment in specific situations.
- *Recoveries:* We recover overpayments directly from the provider within 30 days. Failure of the provider to return the overpayment after 30 days may result in reduced payment of future claims or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308

Attn: investigator name, #case number

Paper medical records and/or claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at 800-AVAILITY (282-4548) for more information.

Acting on investigative findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.
If a provider has committed fraud, abuse or waste, the provider:

- Will be referred to the Special Investigations Unit.
- May be presented to the credentials committee and/or peer review committee for disciplinary action including provider termination.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member has committed fraud, waste or abuse, the member may be involuntarily dis-enrolled from our healthcare plan, with state approval.

Relevant legislation

Federal False Claims Act (FCA)

We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act* (*FCA*). The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500-$11,000 per false claim.

The *FCA* also contains *Qui Tam,* or *whistleblower*, provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under *Qui Tam* provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The *Health Insurance Portability and Accountability Act* (*HIPAA*) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in healthcare fraud, and simplifies the administration of health insurance.

Our company strives to ensure both Summit Community Care and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers shall have the following procedures implemented to demonstrate compliance with the *HIPAA* privacy regulations:

- Our company recognizes its responsibility under *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the *HIPAA* definition of treatment, payment, or healthcare operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.
- Internet email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information, e.g., Excel spreadsheets with claim information; such information should be mailed or faxed.
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific individual, P.O. Box, or department at our company.
- Our company voice mail system is secure, and password protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.

When contacting us, please be prepared to verify the provider's name, address, and tax identification number (TIN) or member's provider number.

Marketing policies

We want our members to make the best healthcare decisions possible, and when members ask for our assistance, we want to provide assistance without undue influence.

We recognize providers occupy a unique, trusted, and respected part of people's lives. Given the complexity of modern-day healthcare and the inherent difficulties communicating with some of the populations we serve, there are potentially serious pitfalls when providers try to assist in the decision-making- process. For that reason, we are committed to following strict enrollment and marketing guidelines and honoring the rules for all state healthcare programs.

Summit Community Care providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that he or she select membership in a particular plan. The state marketing practice policies prohibit network providers from making any of the following false or misleading claims:

- The provider's office staff are employees or representatives of the state, county, or federal government.
- Summit Community Care is recommended or endorsed by any state or county agency, or any other organization.
- The state or county recommends that a prospective member enroll with a specific health plan.
- A prospective member or medical recipient loses Medicaid or other welfare benefits if the prospective member does not enroll with a specific Medicaid MCO.

These policies also prohibit network providers from taking the following actions:

- Making marketing presentations, advising or recommending to an eligible individual that they select membership in a specific Medicaid MCO.
- Offering or giving away any form of compensation, reward, or loan to a prospective member to induce or procure member enrollment in a specific Medicaid MCO.
- Engaging in direct marketing to members is designed to increase enrollment in a particular health plan. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of members originally obtained for enrollment purposes from confidential state or county data sources, or from the data sources of other contractors.
- Employing marketing practices that discriminate against potential members other than persons specifically excluded from coverage under our contract. Providers may not discriminate based on marital status, age, religion, sex, national origin, language, sexual orientation, ancestry, or pre-existing psychiatric problems or medical conditions, such as pregnancy, disability, or AIDS.
- Reproducing or signing an enrollment application for the member.
- Displaying materials only from the provider's contracted managed health care organizations and excluding others.

Anti-gag provisions

If the provider is acting within the lawful scope of practice, Summit Community Care will not prohibit a provider from advising a member about his or her health status, medical care, or treatment for the member's condition or disease regardless of whether benefits for such care or treatment options are provided by Summit Community Care. Summit Community Care will not retaliate or act against a provider for advising the member under these circumstances.

4 Provider credentialing

Credentialing is the process performed by Summit Community Care to verify and confirm each applicant within the scope of credentialing meets the established criteria and qualifications for consideration to join a Summit Community Care network. Summit Community Care uses the current National Committee for Quality Assurance (NCQA) Health Plan Accreditation Requirements for the credentialing and recredentialing of licensed independent providers with whom it contracts and who fall within its scope of authority and action.

Initial credentialing is performed when an application is received, and recredentialing is conducted at least every three years thereafter or as otherwise required by state regulations and at the discretion of Summit Community Care. HCBS providers must be re-credentialed annually.

During recredentialing, each provider must show evidence of continuance of satisfying the requirements and must have satisfactory results relative to the Summit Community Care measures for quality healthcare and service.

A. Credentialing requirements

Each provider must remain in full compliance with the Summit Community Care credentialing criteria as set forth in its credentialing policies and procedures and all applicable laws and regulations. Each provider will complete the Summit Community Care credentialing application form. Summit Community Care will use the uniform standard credential application from the Credentialing Vendor Organization established by DHS.

Summit Community Care established a credentialing committee for the formal determination of recommendations regarding credentialing decisions. Our Medical Director is responsible for the credentialing committee activities, which include making decisions about initial applicants' participation and their continued participation at the time of recredentialing.

B. Credentialing scope

<u>Practitioner types</u>: Summit Community Care credentials the following types of contracted healthcare practitioners when an independent relationship exists between Summit Community Care and the practitioner, or the individual practitioner is listed individually in the Summit Community Care provider network directory. See exclusions below.

- Medical Doctor (MD)
- Doctor of Osteopathic Medicine (DOM)
- Doctor or Podiatric Medicine (DPM)
- Psychologists
- Optometrists
- Nurse practitioners (NP)

- Physician Assistants (PA)
- Certified Nurse Midwives
- Occupational Therapists
- Speech and Language Pathologists
- Physical Therapists
- Independent behavioral health professionals who contract directly with the PASSE including Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Marriage/Family Therapist (LMFT), Licensed Independent Substance Abuse Counselor (LISAC)
- Home and Community Based Providers who provide services under the CES Waiver or the 1915(i) authority
- Board Certified Behavioral Analysts (BCBAs) and
- Any non-contracted provider that is rendering services and sees 50 or more of the contractor's members per contract year.

Summit Community Care has a contractual relationship with practitioners but **does not** require credentialing if the practitioner:
- Practices exclusively in an inpatient setting and provides care for Summit Community Care members only because members are directed to the hospital or another inpatient setting; OR
- Practices exclusively in free-standing facilities or HCBS program and provides care for Summit Community Care members only because members are directed to the facility or program.

Examples of this type of practitioner include but are not limited to:
- Pathologist.
- Radiologists.
- Anesthesiologists.
- Neonatologists.
- Emergency room physicians.
- Urgent care center physicians.
- Urgent care center mid-level providers (e.g., nurse practitioners, physician assistants).
- Hospitalists.
- Pediatric intensive care specialists.
- Physicians, nurses, and other practitioners working for an HCBS provider.
- Certified behavioral analysts, addiction counselors and substance abuse practitioners that provide behavioral health services through other organizations.
- Other intensive care specialists.

Note: Any practitioner who is contracted and practices in the office setting must be credentialed if he/she is listed individually in the Summit Community Care provider network directory.

Healthcare delivery organizations (HDOs): Summit Community Care credentials the following types of HDOs:
- Hospitals
- Home health agencies
- Behavioral health facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings such as:
    - Adult family care/foster care homes
    - Ambulatory detox

    - Community mental health centers (CMHC)
    - Crisis stabilization units
    - Intensive family intervention services
    - Intensive outpatient — mental health and/or substance abuse
    - Methadone maintenance clinics
    - Outpatient mental health clinics
    - Outpatient substance abuse clinics
    - Partial hospitalization — mental health and/or substance abuse
    - Residential treatment centers (RTC) — psychiatric and/or substance abuse
- Birthing centers
- Home infusion therapy when **not** associated with another currently credentialed HDO

The following HDOs are only subject to a certification requirement process:
- Clinical laboratories (*CLIA Certification of Accreditation* or *CLIA Certificate of Compliance*)
- End-stage renal disease (ESRD) service providers (dialysis facilities)
- Portable X-ray suppliers
- Home infusion therapy when associated with another currently credentialed HDO
- Federally qualified health centers (FQHC)
- Rural health clinics

C. Credentialing application process

Each practitioner and HDO within the scope of credentialing must complete a credentialing application deemed acceptable by Summit Community Care (e.g., CAQH, Summit Community Care or the state) upon request. Each provider must comply with other such credentialing criteria as may be established by Summit Community Care.

Each provider must agree to submit for verification all requested information necessary to be credentialed or recredentialed to provide services in accordance with the standards established by Summit Community Care. Each provider shall cooperate with Summit Community Care as necessary to conduct credentialing and recredentialing pursuant to Summit Community Care policies, procedures, and rules.

The credentialing application contains the practitioner's or the HDO authorized representative's signature that serves as an attestation of the credentials summarized in and included with the application. The practitioner's or the HDO authorized representative's signature also serves as a release of information to verify credentials externally. Summit Community Care is responsible for externally verifying specific items attested to on the application. Any discrepancies between information included with the application and information obtained by Summit Community Care during the external verification process will be investigated and documented and may be grounds for refusal of acceptance into the network or termination of an existing provider relationship. The signed agreement also documents the provider's agreement to comply with the Summit Community Care managed care policies and procedures.

Summit Community Care may utilize the Arkansas State Medical Board's (ASMB) Centralized Credentials Verification Service for primary source verification of the following Credentialing Information:
(A) Information regarding a physician's: (i) Professional training, qualifications, background, practice history, and experience, for example, status of medical license; (ii) Clinical hospital privileges; (iii) Status

of Drug Enforcement Administration certificate; (iv) Education, training, and board certification; (v) Work history; (vi) Current malpractice coverage; (vii) History of professional liability or malpractice claims; (viii) Drug or alcohol abuse to the extent permitted by law; (ix) History of board appearances; (x) Loss, surrender, restriction, or suspension of license; (xi) Felony convictions; (xii) History of loss or limitation of privileges or disciplinary activity; (xiii) Attestation of the correctness and completeness of the application; and (xiv) History of Medicare or Medicaid or other sanctions; and
(B) Other objective information required by accrediting organizations to credential physicians. Summit Community Care is responsible for externally verifying specific items attested to on the application not included in the CCVS. Any discrepancies between information included with the application and information obtained by Summit Community Care during the external verification process will be investigated and documented and may be grounds for refusal of acceptance into the network or termination of an existing provider relationship.

The Summit Community Care credentialing committee will make decisions regarding participation of initial applicants at the time of credentialing and their continued participation at the time of recredentialing. Upon request from Summit Community Care, the provider shall explain information obtained that may vary from what was submitted by the provider, and the provider shall submit proposed corrections to any erroneous information submitted by another party. The provider must submit a written explanation or may appear before the credentialing committee if deemed necessary by the credentialing committee.

Following verifications of all submitted documentation as more specifically described below, the practitioner file will be administratively deemed complete and be submitted to the health plan medical director or credentialing committee for review and approval. To the extent allowed under applicable law or state agency requirements and in accordance with NCQA Standards and Guidelines, the credentialing committee may delegate the authority to review and approve complete files to the medical director.

Each provider has the right to inquire about the status of his/her application. Provider Services can be contacted via the following:

- Phone: **844-462-0022**
- Mail: Credentialing
  Summit Community Care
  P.O. Box 62429
  Virginia Beach, VA 23466-2429

As an applicant for participation with Summit Community Care, each provider has the right to review information obtained from primary verification sources during the credentialing process to the extent permitted by law. The provider will be notified if information obtained in support of the assessment or reassessment process varies from the information submitted by the provider. Upon notification from Summit Community Care, the provider has the right to explain information obtained that varies from what was provided and to make corrections to any erroneous information submitted by another party. The provider must submit a written explanation or appear before the credentialing committee if deemed necessary.

The decision to approve initial or continued participation or to terminate a provider's participation will be communicated in writing within 60 days of the credentialing committee's decision. In the event the

provider's participation or continued participation is denied, the provider will be notified in writing. If continued participation is denied, the provider will be allowed 30 days to appeal the decision.

Provider notification to Summit Community Care

The provider must notify Summit Community Care in writing within five days, unless otherwise stated below, following the occurrence of any of the following events:

- The provider's license to practice in any state is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions. Notification of any such action must be furnished in writing to Summit Community Care immediately.
- The provider 1) learns that he or she has become a defendant in any malpractice action relating to a member who also names Summit Community Care as a defendant or receives any pleading, notice or demand of claim or service of process relating to such a suit or 2) is required to pay damages in any such action by way of judgment or settlement. Notification must be furnished in writing to Summit Community Care immediately.
- The provider is disciplined by a state board of medicine or a similar agency.
- The provider is sanctioned by or debarred from participation with Medicare or Medicaid.
- The provider is convicted of a felony relating directly or indirectly to the practice of medicine. Notification must be furnished in writing to Summit Community Care immediately.
- There is a change in the provider's business address or telephone number.
- The provider becomes incapacitated in such a way that the incapacity may interfere with patient care for 21 consecutive days or more.
- There is any change in the nature or extent of services rendered by the provider.
- There is any material change or addition to the information and disclosures submitted by the provider as part of the application for participation with Summit Community Care.
- The provider's professional liability insurance coverage is reduced or canceled. Notification must be given in writing to Summit Community Care at least five days before such a change.
- There is any other act, event, occurrence, or the like that materially affects the provider's ability to carry out his or her duties under the *Participating Provider Agreement*.
- The provider's member panel is reaching capacity according to the established capacity standards set in the *Standards and Measures for Appropriate Availability to Provider Policy*. At least 30 days' advance notice must be given.
- There is no change to hours of operation or staffing levels.
- There is an inability to meet timely access to care and services according to the established appointment access standards set in the *Appointment Guidelines Policy*.

The occurrence of one or more of the events listed above may result in the termination of the *Participating Provider Agreement* for cause or other remedial action as Summit Community Care in its sole discretion deems appropriate.

Should a provider be terminated from the network or otherwise not approved for participation through the recredentialing process, the provider has the right to appeal the Summit Community Care decision consistent with the Summit Community Care credentialing policies and procedures.

Peer review

The Summit Community Care Quality Management Program includes review of quality-of-care issues identified for all care settings. Member complaints, adverse events and other information are used to evaluate the quality of care and service provided. If a quality issue should result in concern regarding a physician's compliance with standards of care or service, all elements of peer review will be followed. The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. The peer review committee will review cases and recommend disciplinary actions to be taken, including remedial steps up to and freeze of panel and/or provider termination. The medical director will inform the provider of the peer review committee's recommendations and follow up. Provider participation is encouraged. Outcomes are reported to the appropriate internal and external entities, Quality Management, and the medical advisory committee.

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are:

- To participate in the implementation of the established peer review system.
- To review and make recommendations regarding individual provider peer review cases.
- To work in accordance with the medical director.

Should investigation of a member grievance result in concern regarding a provider's compliance with community standards of care or service, the elements of peer review will be followed.

Peer review includes investigation of provider actions by or at the discretion of the medical director. The medical director acts based on the quality issue or the level of severity, invites the cooperation of the provider, and consults with and informs the medical advisory committee and peer review committee as appropriate. The peer review process is a major component of the medical advisory committee's monthly agenda.

The quality of care and peer review policies are available upon request.

A. Credentialing eligibility criteria

Each provider must remain in full compliance with the Summit Community Care credentialing criteria as set forth in its credentialing policies, procedures, and all applicable laws and regulations.

Each **practitioner** within the scope of the Summit Community Care Credentialing Program applying for participation in the Summit Community Care programs or provider network(s) shall meet the following criteria to be considered for participation. Applicants who do not meet the criteria below will be notified of the failure to meet criteria.

I. Initial applications should meet the following criteria to be considered for participation, with exceptions reviewed and approved by the credentialing committee (CC):
    A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties ABMS, American Osteopathic Association AOA, Royal College of Physicians and Surgeons of Canada RCPSC, College of Family Physicians of Canada CFPC, American Board of Foot and Ankle Surgery ABFAS, American Board of Podiatric Medicine ABPM, or American Board of Oral and Maxillofacial Surgery ABOMS) in the clinical discipline for which they are applying.

B. If not certified, MDs and DOs will be granted five years or a period consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
C. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Noncertified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
    1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training, and certification requirement:
        a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC, CFPC, ABPM, ABFAS, ABOMS) in the clinical specialty or subspecialty for which they are applying, which has now expired, AND a minimum of ten consecutive years of clinical practice. OR
        b. Training, which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. OR
        c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in the Summit Community Care network AND the applicant's professional activities are spent at that institution at least 50 percent of the time.
    2. Practitioners meeting one of these three alternative criteria (a, b, c) will be viewed as meeting all Summit Community Care education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Summit Community Care review and approval. Reports submitted by delegate to Summit Community Care must contain sufficient documentation to support the above alternatives as determined by Summit Community Care.
E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), an HFAP accredited hospital, or a network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. These physicians would expect an appropriate referral arrangement with a network practitioner to provide inpatient care.

II. Criteria for selecting practitioners
    A. New applicants (credentialing)
        1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions
        2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote
        3. Primary source verifications within acceptable time frames of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies

4. No evidence of potential material omission(s) on application
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to members
6. No current license actions
7. No history of licensing board action in any state
8. No current federal sanction and no history of federal sanctions (per System for Award Management SAM, OIG and OPM report nor on NPDB report)
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who treat members in more than one state must have a valid DEA/CDS registration for each applicable state.
   Initial applicants who have NO DEA/CDS registration will be viewed as not meeting criteria, and the credentialing process will not proceed. However, if the applicant can provide evidence that he/she has applied for a DEA/CDS registration, the credentialing process may proceed if all the following are met:
   a. It can be verified that this application is pending.
   b. The applicant has arranged for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
   c. The applicant agrees to notify Summit Community Care upon receipt of the required DEA/CDS registration.
   d. Summit Community Care will verify the appropriate DEA/CDS registration via standard sources.
      i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90 calendar day timeframe will result in termination from the network.
      ii. <u>Initial</u> applicants who possess a DEA certificate in a state other than the state in which they will be seeing the company's members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration, the credentialing process may proceed if <u>all</u> the following criteria are met:
         1. It can be verified that the applicant's application is pending.
         2. The applicant has arranged for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained.
         3. The applicant agrees to notify the company upon receipt of the required DEA registration.
         4. The company will verify the appropriate DEA/CDS registration via standard sources.
         5. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day- time frame will result in termination from the network.

      Office-based practitioners who voluntarily choose to have a DEA/CDS registration that does not include all controlled substance schedules (for example, Schedule, II, III or IV), if that practitioner certifies the following:
         1. Controlled substances from these Schedules are not prescribed within his/her scope of practice; and

2. He/she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances from these schedules should it be clinically appropriate; and
3. DEA/CDS registration is or was not suspended, revoked, surrendered, or encumbered for reasons other than those.

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions
11. Meets credentialing standards for education/training for the specialty(ies) in which practitioner wants to be listed in the Summit Community Care network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons
12. No involuntary terminations from an HMO or PPO
13. No "yes" answers to attestation/disclosure questions on the application form, with the exception of the following:

Investment or business interest in ancillary services, equipment, or supplies

a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization
b. Voluntary surrender of state license related to relocation or nonuse of said license
c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria
d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business)
e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year-, post residency training window
f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion
g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction

14. No history of or current use of illegal drugs or history of or current alcoholism
15. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field
16. -No work history gap greater than six months in the past five years except those related to parental leave or immigration, where twelve-month gaps will be acceptable. No history of criminal/felony convictions or a plea of no contest
17. A minimum of the past ten years of malpractice case history is reviewed.

Note: The CC will individually review any practitioner who does not meet one or more of the criteria required for initial applicants.

B. Additional participation criteria and exceptions for behavioral health practitioners (non-physician) credentialing.

1. Licensed Clinical Social Workers ("LCSW") or other master level social work license type:
   a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education ("CSWE") or the Canadian Association on Social Work Education ("CASWE").
   b. Program must have been accredited within three (3) years of the time the practitioner

graduated.

c. Full accreditation is required, candidacy programs will not be considered.
d. If master's level does not meet criteria and practitioner obtained PhD as a clinical psychologist but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association ("APA") or be regionally accredited by the Council for Higher Education Accreditation ("CHEA"). In addition, a Doctor of Social Work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

2. Licensed professional counselor ("LPC") and marriage and family therapist ("MFT") or other master level license type:

   a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
   c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs ("CACREP"), or Commission on Accreditation for Marriage and Family Therapy Education ("COAMFTE") listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.
   d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria, this doctoral program must be accredited by the APA or regionally accredited by the CHEA. A Practitioner with a doctoral degree in one of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and;
   e. Licensure to practice independently.

3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three (3) years of the time of the practitioner's graduation.
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
   c. Certification by the American Nurses Association ("ANA") in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner.

Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

4. Clinical psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology, or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner's graduation.
    c. Education/training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
    d. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist due to further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical neuropsychologist:
    a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology ("ABPN") or American Board of Clinical Neuropsychology ("ABCN").
    b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
    c. Clinical neuropsychologists who are not Board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
        i Transcript of applicable pre-doctoral training, OR
        ii Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate), OR
        iii Letters from supervisors in clinical neuropsychology (including number of hours per week), OR
        iv Minimum of five (5) years' experience practicing neuropsychology at least ten (10) hours per week.

6. Licensed psychoanalysts:
    a. Applies only to Practitioners in states that license psychoanalysts.
    b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license.
        i. Practitioners shall possess a master's or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must be accredited within 3 years of the time the Practitioner graduates.
        ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
            (a) A program located outside the United States and its territories may

be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.

(b) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.

(c) Meet examination requirements for licensure as determined by the licensing state.

C. Additional participation criteria and exceptions for nurse practitioners, certified nurse midwives, physician's assistants (nonphysician) credentialing.

1. Process, requirements and verification – nurse practitioners:
    a. The nurse practitioner applicant will submit the appropriate application and supporting documents as required of any other practitioners except differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this, and the applicant will be administratively denied.
    d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested, and primary source verified via normal company procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this, and the applicant will be administratively denied.
    e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
        i. Certification program of the American Nurse Credentialing Center (**https://www.nursingworld.org/our-certifications**), a subsidiary of the American Nursing Association (**http://www.nursingcertification.org**); or
        ii. American Academy of Nurse Practitioners – Certification Program (**https://www.aanpcert.org**); or
        iii. National Certification Corporation (**http://www.nccwebsite.org**); or

iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) (**https://www.pncb.org/pncb-exams**); OR
v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY (**http://oncc.org**);
iv. American Association of Critical Care Nurses (**https://www.aacn.org/certification/verify-certification**) ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care This certification must be active and primary source verified.

This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Summit Community Care is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding the history of any actions taken against any hospital privileges held by the NP will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
g. The NP applicant will undergo the standard credentialing processes outlined in the Summit Community Care Credentialing Policies. NPs (Nurse Practitioner) are subject to all the requirements outlined in these Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the NP may be listed in the Summit Community Care provider directories. As with all providers, this listing will accurately reflect their specific licensure designation, and these providers will be subject to the audit process.
i. NPs will be clearly identified as such:
    i. On the credentialing file;
    ii. At presentation to the Credentialing Committee; and
    iii. On notification to Network Services and to the provider database.

2. Process, requirements, and verifications – Certified nurse midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other Practitioner except for differing information regarding education, training and board certification.
    b. The required educational/training will be at a minimum that required for licensure as a Registered Nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, if state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the

state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.

c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this, and the applicant will be administratively denied.
d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested, and primary source verified via normal company procedures. If there are in force adverse actions against the DEA, the applicant will be notified, and the applicant will be administratively denied.
e. All CNM applicants will be certified by either:
    i. The National Certification Corporation for Ob/Gyn and Neonatal Nursing; or
    ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

    This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by Summit Community Care is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic Credentialing Committee.
f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding the history of any actions taken against any hospital privileges held by the CNM will be obtained.
g. Any history of any adverse action taken by any hospital will trigger a Level II review. Should the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

The CNM applicant will undergo the standard credentialing process outlined in Summit Community Care's Credentialing Policies. CNMs are subject to all the requirements of these Credentialing Policies including (but not limited to): the requirement for Committee review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the CNM may be listed in the Summit Community Care provider directories. As with all providers, this listing will accurately reflect their specific licensure designation, and these providers will be subject to the audit process.
i. CNMs will be clearly identified as such:
    i. On the credentialing file;
    ii. At presentation to the Credentialing Committee; and
    iii. On notification to Network Services and to the provider database.

3. Process, requirements, and verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other Practitioners except differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions.
    d. Any applicants whose licensure status does not meet these criteria or who have adverse actions regarding Medicare or Medicaid will be notified of this and administratively denied.
    e. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested, and primary source verified via normal company procedures. If there are in force adverse actions against the DEA, the applicant will be notified, and the applicant will be administratively denied.
    f. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Summit Community Care is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to geographic Credentialing Policy #8 and submitted for individual review by the Credentialing Committee.
    g. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding the history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
    h. The PA applicant will undergo the standard credentialing process outlined in the Summit Community Care's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): Committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
    i. Upon completion of the credentialing process, the PA may be listed in the Summit Community Care provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
    j. PA's will be clearly identified such:
        i. On the credentialing file;
        ii. At presentation to the Credentialing Committee; and
        iii. On notification to Network Services and to the provider database.

Summit Community Care reserves the right, in its reasonable discretion, to waive the board certification requirement when Summit Community Care determines: 1) that there are extenuating or unusual circumstances that warrant the waiver of such requirement **and** 2) the CC determines there is no reasonable suspicion of future substandard professional conduct and/or competence.

In addition to the minimum criteria listed, Summit Community Care may consider other information when determining credentialing/network participation status. All providers are subject to the satisfaction and maintenance, in the sole judgment of Summit Community Care of all credentialing standards adopted by Summit Community Care.

Health Delivery Organization (HDO) Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body, or in the absence of such accreditation, Summit Community Care may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If an HDO has satellite facilities that follow the same policy and procedures, Summit Community Care may limit site visits to the main facility. Nonaccredited HDOs are subject to individual review by the CC and will be considered for member access need only when the CC review indicates compliance with Summit Community Care standards, and there are no deficiencies noted on the Medicare or state oversight review that would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three years to assess the HDO's continued compliance with Summit Community Care standards.

Each **health delivery organization (HDO)** within the scope of the Summit Community Care Credentialing Program applying for participation in Summit Community Care programs or provider network(s) shall meet the following criteria to be considered for participation. Applicants who do not meet the criteria will be notified of the failure to meet criteria.

- Possess a current, valid, unencumbered, unrestricted and Non probationary professional license in the state(s) where it provides services to Summit Community Care members if such license is applicable.
- Must not be currently sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid, or the Federal Employees Health Benefits Program (FEHB).
- Must be in good standing with any other applicable state or federal regulatory body as defined in Credentialing Policy.
- Application and supporting documentation must not contain any material omissions or falsifications including any additional information requested by Summit Community Care.
- Complaints received from members and/or other providers may be reviewed for compliance with Summit Community Care standards.
- Performance indicators obtained during the credentialing, recredentialing or ongoing monitoring process, if applicable, must meet Summit Community Care standards.
- No indictments or convictions, or pleadings of guilty or no contest to, a felony or any offense involving fraud, criminal activities, abuse, or neglect nor evidence of such conviction or pleadings by the principals of the facility.
- Any history of disciplinary actions or investigations including termination, warnings, or notices of potential poor performance related to the HDO's license or accreditation must be reviewed and

must not raise reasonable suspicion of future substandard performance or harm to members. Determination will be based on the disciplinary action or sanction and other information obtained during the credentialing, recredentialing or sanction monitoring process.

- Acceptable accreditation from a company recognized entity exists. If not accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Summit Community Care quality and certification criteria standards have been met.

In addition to the minimum criteria listed, Summit Community Care may consider other information when determining credentialing/network participation status. All providers are subject to the satisfaction and maintenance, in the sole judgment of Summit Community Care of all credentialing standards adopted by Summit Community Care.

Additional Participation Criteria for HDOs: HDO Type and Summit Community Care Approved Accrediting Agent(s)

Medical facilities

Facility type (medical care)	Acceptable accrediting agencies
Acute Care Hospital	CIQH, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM, DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Skilled Nursing Facilities/Nursing Homes	BOC INT'L, CARF, TJC

Behavioral health

Facility type (behavioral health care)	Acceptable accrediting agencies
Acute Care Hospital — Psychiatric Disorders	CTEAM, DNV/NIAHO, TJC, HFAP
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient — Mental Health and/or Substance Abuse	ACHC, DNV/NIAHO, TJC, COA, CARF
Outpatient Mental Health Clinic	HFAP, TJC, CARF, CHAP, COA
Partial Hospitalization/Day Treatment — Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, HFAP, TJC
Residential Treatment Centers (RTC) — Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

Facility type (behavioral health care)	Acceptable accrediting agencies
Acute Inpatient Hospital — Detoxification Only Facilities	DNV/NIAHO, HFAP, TJC, CTEAM
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC, COA
Outpatient Substance Abuse Clinics	CARF, TJC

If facilities, ancillaries or hospitals are not accredited, Summit Community Care will accept a copy of the most recent state or CMS review in lieu of performing an onsite review. If accreditation or a copy of the most recent review is unavailable, an onsite review will be performed.

The organization will be notified by phone or in writing if information obtained in support of the assessment or reassessment process varies greatly from the information submitted by the organization. Organizations have the right to review information submitted to support the assessment process and correct errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee if so requested. The organization is allowed 30 days to correct the information and request additional review of the corrected documentation.

A decision to terminate an organization's participation will be communicated in writing.

5 Grievances and appeals

Provider Services: **844-462-0022**
Member Services phone: **844-405-4295**
Member Services Hours of Operation: **Monday to Friday, 8:30 a.m. to 5 p.m.**

Overview

We encourage Summit Community Care providers and members to seek resolution of issues through our grievances and appeals process. The issues may involve dissatisfaction or concern about another provider, the plan, or a member.

We want to assure providers that they have the right to file an appeal with us for denial, deferral or modification of a claims disposition or post-service request. Providers also have the right to appeal on behalf of a member for denial, deferral or modification of a prior authorization or request for concurrent review. These appeals are treated as member appeals and follow the member appeal process.

Grievances are tracked and trended, resolved within established time frames, and referred to a peer review when needed. The Summit Community Care grievances and appeals process meets all requirements of state and federal law and accreditation agencies.

The building blocks of this process are the adverse benefit determination, complaint, grievance, and appeal.

An **adverse benefit determination** is any of the following:
- A denial or limited authorization of a requested service, including determinations based on the type, level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit
- A reduction, suspension, or termination of a previously authorized service
- A denial, in whole or in part, of a payment for a service
- Failure to provide services in a timely manner
- Failure to adhere to the required time frames for standard resolution of grievances and appeals
- For a resident of a rural area with only one PASSE, the denial of the member's request to obtain services outside the network
- The denial of the member's request to dispute financial liability

A **complaint** is an expression of dissatisfaction made about Summit Community Care's decision or services received from Summit Community Care.

A **grievance** is an expression of dissatisfaction about any matter filed at any time, either in writing (formally) or verbally (informal), to Summit Community Care by a provider about any aspect of our operation, the provision of healthcare services, or the activities or behaviors (other than our action) as defined in this chapter.

An **appeal** is a review by Summit Community Care of an adverse benefit determination.

An **expedited appeal** is an appeal when Summit Community Care determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

An **inquiry** is a request for additional information or clarification regarding benefit coverage or how to access medical care/covered benefits. An inquiry is an informational request handled at the point of entry or forwarded to the appropriate operational area for final response. An inquiry is not an expression of any dissatisfaction.

An **action** is a:
- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of a payment for a service.
- Failure to provide services in a timely manner, as defined by the state.
- Failure to act within the time frames specified by the state.

Please note: Providers are prohibited from penalizing a member in any way for filing a grievance or complaint. Summit Community Care will not take any punitive action against a member or provider for filing or participating in a complaint, grievance, or appeal.

Provider grievances and appeals are classified into the following categories:
- Provider grievances relating to the operation of the plan, including:
    - Benefit interpretation
    - Claim processing
    - Reimbursement
- Provider appeals related to actions

Member grievances, complaints and appeals include, but are not limited to, the following:
- Access to healthcare services
- Care and treatment by a provider
- Issues having to do with how we conduct business

Please note: Summit Community Care offers members an expedited appeal process for decisions involving urgently needed care.

Summit Community Care will ensure that all grievance or complaint decisions and appeal resolutions are made by qualified personnel. The decision maker will be a qualified healthcare professional with the appropriate clinical expertise is treating the member's condition or disease if:
- The decision involves an appeal of a denial based on lack of medical necessity.
- The decision involves a grievance regarding denial of an expedited resolution of an appeal, or
- The decision involves a grievance or appeal involving clinical issues.

Summit Community Care will ensure that the decision makers on complaints, grievances and appeals are not:
- Involved in any previous level of review or decision-making, and

- The subordinate of anyone involved in a previous level of review or decision-making.

Summit Community Care will also ensure that the decision maker considers all comments, documents, records, and other information submitted by the appellant, without regard as to whether such information was submitted or considered in the initial adverse decision.

Complaints

Summit Community Care will accept and resolve complaints made by members or providers.

- All complaints must be followed up by close of business on the business day following receipt of the complaint.
- If the complaint is not resolved within 10 business days, Summit Community Care must enter the complaint as a grievance and complete the grievance process to resolve the matter.

Complaints may be filed by:

- The member or the member's parent or legal guardian or
- A provider, whether it is a participating provider.

Providers: grievances relating to the operation of the plan

A provider may be dissatisfied or concerned about another provider, a member, or an operational issue.

A grievance may be filed any time a provider becomes aware of the problem. Summit Community Care will send a written acknowledgement to the provider within five business days of receiving a grievance. Summit Community Care may request medical records, or an explanation of the issues raised in the grievance by:

- Phone 844-462-0022
- Fax, with a signed and dated letter.

Mail, with a signed and dated letter to:

Summit Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429

Written grievances must include:

- Provider's name
- Date of the incident
- Description of the incident

The timeline for responding to the request for more information is as follows: For standard grievances or appeals, providers must comply with the request for additional information within 10 calendar days of the date that appears on the request.

Providers: grievance response timeline

Summit Community Care notifies providers in writing of the resolution, including their right of appeal, if any. Findings or decisions of peer review or quality of care issues are not disclosed. Summit Community Care sends a written resolution letter to the provider upon receipt of the grievance.

- Provider grievances: Summit Community Care sends a written resolution letter to the provider within 30 business days of the receipt of the grievance.
- Provider medical necessity appeals: Summit Community Care sends a written resolution letter to the provider within 30 calendar days of the receipt of the appeal.

Members: grievances and appeals

To help ensure that members' rights are protected, all Summit Community Care members are entitled to a complaint, grievance, and appeals process. The building blocks of this process are the complaint, grievance, and the appeal:

Members have the following time periods to file:

- **Grievance/Complaint**: verbally or in writing at any time the member becomes aware of the problem
- **Appeal:** verbally or in writing within 60 calendar days of the date on the adverse benefit determination letter

Members: complaints & grievances

If a member wants to file a complaint or grievance, the member may call Member Services. Written grievances must be sent to the Grievance and Appeals department telling us about the problem. All complaints must be followed up by the close of business on the business day after receipt. If the complaint is not resolved within 10 business days, the complaint must be entered as a grievance and complete the grievance process to resolve the matter. The member will need to tell us the following:

- Who is part of the grievance
- What happened
- When the incident happened
- Where the incident happened
- Why they were not happy with the healthcare services received

Attach documents that will help us investigate the problem. Mail the grievance to:

Summit Community Care
Attn: Grievance and Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

The member does not have to be the person filing a grievance or complaint. Complaints may be filed by:

- The member's parent or legal guardian
- A direct service provider, whether it is a participating provider

Grievances can be filed by the member or:

- The member's parent or legal guardian
- A direct service provider, whether it is a participating provider

- An authorized representative on behalf of the above individuals

Grievances or complaints filed by the authorized representative or provider on behalf of the member require written consent from the member. If the member is a minor or is incompetent or incapacitated, the member's representative may submit the grievance or complaint on the member's behalf.

If the member cannot mail the form or letter, he or she may call Provider Services, and we will provide assistance by documenting the request. We send the member an acknowledgment letter within five business days after receiving the grievance by mail or phone. The acknowledgement letter includes the receipt date and contact information for Member Services. Summit Community Care sends a grievance resolution letter to the member within 30 calendar days after receiving the grievance.

Members: grievance extensions

The 30-day time limit may be extended up to 14 days if the grievant asks for an extension or Summit Community Care documents that additional information is necessary to resolve the grievance, the information cannot be obtained within the 30-day time limit and it is in the member's best interest to extend the time limit.
If the time limit is extended, Summit Community Care must:

- Provide verbal notice of the reason for extension to the grievant by close of business on the day of the determination to extend the grievance time limit, and
- Provide written notice of the extension to the grievant within two calendar days of the determination.

Please note: A member's grievance related to an action already taken is considered an appeal.

Members: filing appeals

Members have the right to appeal Summit Community Care's denial of services or payment for services, in whole or in part. A denial of this type is called an action. Except expedited appeals, all verbal appeals must be followed with a written, signed (by the appellant) appeal within 10 calendar days of the verbal filing.

The following individuals may file an appeal as the "appellant":

- The member
- The member's parent or legal guardian
- An attorney authorized to represent the member
- Another authorized representative of the member, including the representative of the member's estate if the member is deceased
- A provider that is the subject of the adverse action/adverse decision, or the provider's legal representative or attorney.

Appeals filed by the authorized representative or provider on behalf of the member require written consent from a member.

Action: the denial or limited authorization of a requested service, including the type or level of service

Actions may include the following:

- Denial or limited authorization of a requested service, including the type or level of service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for service
- Failure to provide services in a timely manner, as defined by the state of Arkansas
- Failure of Summit Community Care to act within required time frames
- For a resident of a rural area with only one PASSE, the denial of a member's request to exercise his/her right, under *42 CFR 438.52(b)(2)(ii*), to obtain services outside of the network, if applicable

Please note: Summit Community Care will resolve any grievance or appeal, internal or external, at no cost to the member.
Member appeals are divided into the following categories:

Standard appeal: The appropriate process when a member or his/her representative requests that Summit Community Care reconsider the denial of a service or payment for services, in whole or in part.

Expedited appeal: An appeal when Summit Community Care determines, or the provider indicates when making the request on the member's behalf or supporting the member's request, that taking the time for a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

Members: response to standard appeals

After a written appeal request is received, the case is taken into consideration and investigated by Summit Community Care's Grievances and Appeals department. The member or his or her representative and the provider are given the opportunity to submit written comments and documentation relevant to the appeal. Summit Community Care may request medical records, or a provider explanation of the issues raised in the appeal by:

- Phone.
- Fax, with a signed and dated letter.
- Mail, with a signed and dated letter.

Providers are expected to comply with the request for additional information within 10 calendar days. When the appeal is the result of a medical necessity determination, a healthcare professional who was not involved in the initial decision reviews the case. The healthcare professional contacts the provider, if needed, to discuss alternatives.

Upon request of an appeal, members or their authorized representatives are provided with a copy of their case file free of charge and sufficiently before the appeal's resolution. The appellant will also be provided with an opportunity to present evidence and testimony and make allegations of fact or law, either in person or in writing, as requested by the appellant.

Members: resolution of standard appeals

Standard appeals are acknowledged in writing within five business days of receipt and resolved within 30 calendar days of receipt of the initial written or verbal request. Members are notified in writing of the appeal resolution which will include details regarding their right to request a State Fair Hearing.

Members: extensions

If Summit Community Care is unable to resolve the appeal within the standard 30 days for a standard appeal or 72 hours for an expedited appeal, the resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to 14 calendar days if:

- The appellant requests an extension
- Summit Community Care demonstrates there is a need for additional information, and the delay is in the member's best interest.
- If the time frame is extended other than at the appellant's request, Summit Community Care must provide verbal notice of the reason for the delay to the appellant by close of business on the day of the determination and written notice of the reason for the delay to the appellant. The appellant will also be informed of the right to file a grievance if he or she disagrees with the decision.
- The appeal will be resolved as expeditiously as the member's health condition requires and no later than the date the extension expires.

Members: expedited appeals

If the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health, or ability to attain, maintain or regain maximum function, the appellant may request an expedited appeal. Summit Community Care will resolve each expedited appeal and provide notice to the appellant as quickly as the member's health condition requires not to exceed 72 hours after receipt of the appeal. Summit Community Care will inform the appellant of the limited time available to present evidence and allegations of fact or law. Members may request an expedited appeal by calling our Member Services at **844-405-4295**.

If Summit Community Care denies the request for an expedited appeal, it will immediately transfer the appeal to the time frame for standard resolution and notify the appellant of the transfer.

Summit Community Care may also extend the time frame for expedited appeals resolution by 14 calendar days if:

- The appellant requests the extension.
- Summit Community Care demonstrates that there is a need for additional information and that the delay is in the member's best interest.

If the time frame is extended other than at the appellant's request, Summit Community Care must provide verbal notice of the reason for the delay to the appellant by close of business on the day of the determination and written notice of the reason for the delay to the appellant within two calendar days of the determination. The appellant will also be informed of the right to file a grievance if he or she disagrees with the decision.

The appeal will be resolved as expeditiously as the member's health condition requires and no later than the date the extension expires.

Members: timeline for expedited appeals

Members have the right to request an expedited appeal within 60 calendar days from the date on the initial notice of action letter. Expedited appeals are acknowledged by telephone, if possible. Summit Community Care must inform the appellant of the limited time available to present evidence and allegations of fact and law and ensure that the appellant understands any time limits that may apply.

If Summit Community Care denies a request for an expedited appeal, we must:

- Transfer the appeal to the time frame for standard resolution.
- Provide verbal notice of the resolution to the appellant by close of business on the day of resolution and follow up within two calendar days with written notice.

Members: response to expedited appeals

Summit Community Care may request medical records, or a provider explanation of the issues raised in an expedited appeal by:

- Phone.
- Fax, with a signed and dated letter.
- Mail, with a signed and dated letter.

Providers are expected to comply with the request for additional information within 24 hours.

Members: resolution of expedited appeals

Summit Community Care resolves expedited appeals as quickly as the member's health condition requires, not to exceed 72 hours after receipt of the appeal. The member is notified by telephone of the resolution, if possible. Summit Community Care follows up with a written resolution letter within 72 hours of the expedited appeal decision.

Members: continuation of benefits during appeal

Upon request by the member or his or her parent or legal guardian, Summit Community Care must continue the member's benefits while their appeal is pending, in accordance with federal regulations, when all of the following requirements are met:

- The request for appeal is timely in accordance with 42CFR Part 438.420.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The member or his or her parent/legal guardian timely files for continuation of benefits
- If, at the member's request, Summit Community Care continues or reinstates the benefits while the

appeal is pending, the benefits must continue until one of the following occurs:

- The appellant withdraws the appeal
- The member or the member's parent/legal guardian withdraws the request for continuation of benefits. The appellant fails to request a fair hearing and continuation of benefits within 10 calendar days after Summit Community Care sends the appeal resolution notice that is not in the member's favor.

If the final resolution of the appeal or fair hearing is averse to the appellant, Summit Community Care may recover the cost of services furnished to the member while the appeal or fair hearing was pending to the extent that they were furnished solely because of the requirements for continuation of benefits.

Members: requesting a state fair hearing

If a member is dissatisfied with the appeal decision after exhausting Summit Community Care's internal grievance and appeal process, the member has the right to file an appeal with the Arkansas Department of Human Services (DHS) and request a State Fair Hearing within 90 calendar days from the date of the resolution letter.

The appellant may also request a fair hearing if Summit Community Care fails to adhere to the notice and timing requirements applicable to the appeal process. If the appeal is considered adverse, the appellant may request a fair hearing. The written request must be sent to:

DHS Office of Appeals and Hearing
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437
Phone: **501-682-8622**
Fax: **501-404-4628**

The process is as follows:

- DHS sends a notice of the hearing request to Summit Community Care.
- Within two business days, Summit Community Care must provide the Adverse Benefit Determination Notice and Appeal Resolution Notice that is the subject of the Fair Hearing.
- Within 10 business days of receipt of the request, Summit Community Care must provide an evidence packet to the Fair Hearing officer and the appellant.
- DHS notifies all parties of the date, time, and place of the hearing. Representatives from Summit Community Care's administrative, medical, and legal departments may attend the hearing to present testimony and arguments. Summit Community Care's representatives may cross-examine the witnesses and offer rebutting evidence.
- A fair hearing officer renders a decision at the hearing.
- If the fair hearing officer overturns Summit Community Care's decision and finds in favor of the appellant and Summit Community Care did not furnish services while the appeal and fair hearing was pending, Summit Community Care must authorize or provide the disputed services promptly and expeditiously as the member's health condition requires, but no later than 72 hours from the date Summit Community Care receives the fair hearing decision.
- If the member files for continuation of benefits within 10 calendar days of receipt of the appeal resolution notice, Summit Community Care must continue the member's benefits while the fair hearing is pending and until one of the following occurs:

- The appellant withdraws the fair hearing request
- The member withdraws the request for continuation of benefits or
- The fair hearing officer issues a hearing decision averse to the member

Members: confidentiality

All grievances and appeals are handled in a confidential manner. Summit Community Care does not discriminate against a member for filing a grievance or requesting a State fair hearing. Members receive information about our grievance and appeal process with their adverse benefit determination notice. Members may request a translated version in a language other than English.

Members: discrimination

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Summit Community Care representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident or is assisted if they request assistance. We document, track, and trend all alleged acts of discrimination.

6 Covered health services

Overview

Summit Community Care must provide a complete and comprehensive benefit package equivalent to the benefits available to Medicaid participants through the Medicaid fee-for-service delivery system.

Carve-out services, which are not subject to capitation and are not a Summit Community Care responsibility, are still available for members. Medicaid will reimburse these services directly on a fee -for -service basis. Excluded services include:

a. Nonemergency medical transportation (NET) provided through the PAHP;
b. Transportation to and from an Early Intervention Day Treatment (EIDT) and Adult Development Day Treatment (ADDT) when provided by a contracted transportation broker;
c. Dental benefits in a capitated program;
d. School-based services provided by school employees or their contracted vendor when the service is listed on the Individualized Education Plan (IEP), in accordance with the Individuals with Disabilities Education Act (IDEA). When this occurs, the biller must utilize the school district provider number as well as the Local Education Agency (LEA) number;
e. Skilled nursing facility services; Limited Rehabilitation Stay is not considered an excluded skilled nursing facility service.
f. Assisted living facility services;
g. Human Development Center (HDC) services; i. This means full admission to a HDC. ii. Respite stays and conditional admission at HDCs are not excluded services.
h. Waiver services provided to the elderly and adults with physical disabilities through the AR Choices in Homecare program or the Arkansas Independent Choices program, or a successor waiver for the elderly and adults with physical disabilities;
i. Transplant services as of May 27, 2020, forward and post-transplant services for one (1) year following the date of transplant; and j. Abortions, except as allowed by State or Federal law.

A Summit Community Care PCP serves as the entry point for access to covered healthcare services. The PCP is responsible for providing members with medically necessary covered services or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member.

A member has the right to access certain services without prior referral or authorization by a PCP. This applies to specified self-referred services and emergency services. Summit Community Care is responsible for reimbursing out-of-plan providers who have furnished these services to members (see **Self-Referral Services**).

Covered benefits and services

The following covered benefits and services are listed alphabetically.

Audiology services

Audiology services are a covered state benefit.

Blood and blood products

Blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin are covered.

Behavioral health and IDD HCBS

PASSE Program includes an array of home and community-based services (1915i CES Waiver) for members with developmental disabilities and/or behavioral health needs. Detailed information on these services will follow in the Behavioral health and IDD HCBS section of this manual.

Case management services

Case management services are covered for members who need such services, including members with special healthcare needs.

Case management focuses on the timely, proactive, collaborative, and member-centric coordination of services for individuals. These individuals can be identified with complex medical conditions, repeated admissions for the same condition, or high-risk obstetrics (OB). Summit Community Care assists members who are found to have potentially preventable emergency department utilization and those who qualify for the Lock In Program.

The defining features of Summit Community Care case management programs are:

- A collaborative process that includes contact with the member, family member, caregiver and physician or other healthcare providers.
- A process carried out using communication and available resources to promote quality and effective outcomes.
- A process that assists in optimizing the members' healthcare outcomes through plans designed to empower members to use the benefits, services, and options available to meet individual health needs.

Case Management Programs

Complex Case Management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Stabilization, also known as Post Discharge Management (PDM), helps case managers focus interventions on behaviors that can help prevent readmissions. This program focuses member education, which leads to self-management of post discharge- needs, including completion of a personal health record, medication reconciliation and follow-up- appointments, necessary home care and community resources.

High-risk OB Case Management is focused on pregnant members identified by early OB assessment as being at risk for an early delivery or poor birth outcome influenced by a known maternal or fetal condition or risk factor.

Case Management process

Summit Community Care case managers perform the activities of assessment, planning, facilitation, and support throughout the continuum of care and provide evidenced-based, member-centric care planning that is consistent with recognized standards of case management practice and accreditation requirements.

Case managers consider Summit Community Care members' needs for:

- Social services.
- Educational services.
- Therapeutic services.
- Other nonmedical support services (personal care, WIC, transportation).

The Summit Community Care Case Management team will also provide education and counseling on member compliance with prescribed treatment programs.

A case manager may perform home visits as necessary as part of the Summit Community Care Case Management program and can respond to a member's urgent care needs during this home visit. Call Provider Services to refer a member to case management.

Summit Community Care welcomes provider referrals of patients who can benefit from the case management support, as well as member self-referral or caregiver referrals. Please call the Provider Services toll-free number at **844-462-0022** and request the Case Management team. All case managers are licensed RNs and social workers. Case managers are available from 8 a.m. to 5 p.m. local time. Confidential voicemail is available 24 hours a day.

Clinical trials

Clinical trials and experimental treatment are not covered.

Diabetes care services

Summit Community Care covers all medically necessary diabetes care services. For members who have been discharged from a hospital inpatient stay for a diabetes-related diagnosis, these diabetes care services include the following:

- Diabetes nutrition counseling
- Diabetes outpatient education
- Diabetes-related DME and disposable medical supplies including:
- Blood glucose meters for home use
- Finger-sticking devices for blood sampling
- Blood glucose monitoring supplies
- Diagnostic reagent strips and tablets used in testing for ketone, glucose in urine, and glucose in blood
- Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear
- Routine foot care

Diabetic supplies

Diabetic supplies covered under the pharmacy benefit include:
- Blood Glucose Meters
- Blood Glucose Test Strips
- Lancets
- Lancet Devices
- Control Solutions
- Syringes
- Pen Needles

Disposable medical supplies/durable medical equipment

Authorization

Authorizations for durable medical equipment (DME) and/or disposable medical supplies (DMS) will be provided promptly so as not to adversely affect the member's health. Urgent determinations are made within one business day of receipt of necessary clinical information but no later than 72 hours from the date of the initial request. Non-urgent determinations are made within two business days of receipt of the necessary clinical information but no later than fourteen calendar days from the date of the initial request.

For code-specific prior authorization requirements for DME, prosthetics and orthotics ordered by network providers or facilities, use our Prior Authorization Lookup tool at **https://www.summitcommunitycare.com/provider.**

A properly completed and physician signed certificate of medical necessity *CMN* must accompany each prior authorization request for the following services: hospital beds, support surfaces, motorized wheelchairs, manual wheelchairs, continuous positive airway pressure devices, lymphedema pumps, osteogenesis stimulators, transcutaneous electrical nerve stimulator units, seat-lift mechanisms, power operated- vehicles, external infusion pumps, parenteral nutrition equipment, enteral nutrition equipment and oxygen. Summit Community Care and the provider must agree on HCPCS and/or other codes for billing covered services. All custom wheelchair prior authorizations require the medical director's review.

DMS are covered, including disposable incontinence supplies for medical conditions associated with prolonged urinary or bowel incontinence if necessary to prevent institutionalization or infection, and all supplies used in the administration or monitoring of prescriptions by the member.

DME is covered when medically necessary, including equipment used in the administration or monitoring of prescriptions by the member.

Early and Periodic Screening, Diagnostic and Treatment services

For members under age 21, all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services rendered by an EPSDT-certified provider are covered and recorded in accordance with the EPSDT

periodicity schedule. Additional EPSDT information is available at **Early and Periodic Screening, Diagnostic and Treatment (summitcommunitycare.com)**. The EPSDT provider toolkit is located at **https://www.summitcommunitycare.com/provider**. On The Training Academy page under Education and Training. Providers rendering EPSDT services receive training on these services through the state's program. Services include:

- Annual comprehensive physical examination, health, and developmental history, including an evaluation of both physical and behavioral health development; the implementation of an approved developmental screening tool (e.g., Ages and Stations Questionnaire ASQ or Parents Evaluation of Developmental Status PEDS) should begin at the 9-month, 18 month and 24- to 30-month visit. The results of the developmental surveillance and screening and the screening tool used should be documented in the patient's chart. Children identified as being at risk for developmental delays should have documented counseling and referral for additional evaluation services.
- Immunizations and review of required documentation.
- Laboratory tests for at-risk screening include Tb risk assessment, hematocrit and blood lead level test and assessments.
- Health education/anticipatory guidance, including a dental referral at 12 months old.

Partial or interperiodic well-child services and healthcare services necessary to prevent, treat or ameliorate physical, behavioral, or developmental problems or conditions with services in sufficient amount, duration, and scope to treat the identified condition, and are subject to limitation only based on medical necessity, including:

- Chiropractic services.
- Nutrition counseling.
- Audiological screening when performed by a PCP.
- Private-duty nursing.
- Durable medical equipment including assistive devices.
- Any other benefits listed in this section.

Providers and Summit Community Care are responsible for making appropriate referrals for community resources not covered by Medicaid like the Women, Infants and Children (WIC) nutritional program.

Family planning services

Comprehensive family planning services are covered including:

- Office visits for family planning services
- Laboratory tests, including Pap smears
- Contraceptive devices such as Mirena, Paraguard and Implanon (Prior Authorization is not required.)
- Voluntary sterilization (including Essure Micro-Insert if done in an obstetrician's office)

Members may see any Arkansas Medicaid provider they choose, without referral, for family planning services, including out of network providers.

Home health services

Home health services are covered when the member's PCP or attending provider certifies the services are medically necessary on a part-time, intermittent basis by a member who requires home visits. Prior authorization is required for coverage of procedures and services. Summit Community Care may choose

to provide coverage of home health services to a non-homebound member, but this is not a mandatory benefit. Covered home health services are delivered in the member's home and include:

- Skilled nursing services including supervisory visits.
- Home health aide services.
- Physical therapy services.
- Occupational therapy services.
- Speech pathology services.
- Medical supplies used in a home health visit.

Hospice care services

Hospice care services are covered for members who are terminally ill with a life expectancy of six months or less. Hospice services can be provided in a hospice facility, a long-term care facility or at home. Notification is required for coverage of outpatient hospice services. Prior authorization is required for home healthcare and most DME.

Inpatient hospital services

Inpatient hospital services are covered. Elective admissions require prior authorization for coverage. Emergency admissions require notification within 24 hours or by the next business day. To be covered, preadmission testing must be performed by a Summit Community Care-preferred laboratory vendor or network facility outpatient department. See the *Provider Referral Directory* at **https://www.summitcommunitycare.com/provider** for a complete listing of participating vendors.

For special rules for length of stay for childbirth, see the **Childbirth-Related Provisions** section.

Laboratory services

Diagnostic and laboratory services performed by providers who are *Clinical Laboratory Improvement Act of 1998* (*CLIA*)-certified or have a waiver of certificate registration and a *CLIA* identification number are covered. However, viral-load testing, genotypic, phenotypic or drug resistance testing used in treatment of HIV/AIDS are reimbursed directly by DHS and must be rendered by a DHS-approved provider and be medically necessary. Prior authorization is required for genetic testing. All laboratory services furnished by nonparticipating providers require prior authorization by Summit Community Care, except for hospital laboratory services for an emergency medical condition. If a convenient alternative is not available, prior authorization is required for members to access network hospital outpatient departments for blood drawings and/or specimen collection.

To ensure outpatient diagnostic laboratory services are directed to the most appropriate setting, laboratory services should be sent to a Summit Community Care-preferred laboratory vendor (e.g., Lab Corp or Quest Diagnostics). Laboratory services provided in a state hospital will be reimbursed under certain circumstances including:

- Services identified by Summit Community Care as stat laboratory procedures
- Services rendered in an emergency room setting with an emergency diagnosis.
- Services rendered in conjunction with ambulatory surgery services (RV0360-RV0369, RV0481, RV0490-RV0499, RV0720-RV0729, RV0750-RV0759, and RV0790-RV0799).
- Services rendered in conjunction with observation services (RV0760-RV0769).
- Services billed with certain chemotherapy, obstetric and sickle cell diagnosis codes (C00-C14.8, C15.3-C26.9, C30.0-C39.9, C40.0-C41.9, C43.0-C44.9, C45.0-C49.9, C50.01-C50.92,

C51.0-C58, C60.0-C63.9, C6.1-C68.9, C69.0-C72.9, C73-C75.9, C76.0-C80.2, C81.00-C96.9, D00.00-D09.9, D37.01-D48.9, D49.0-D49.9, D57.00-D57.819, O01.0-O01.9, O02.0-O02.81, O02.1, O00.0-O00.9, O03.0-O03.9, O08.0-O08.9, O09.00-O09.93, O10.011-O10.02, O10.111-O10.12, O10.211-O10.22, O10.311-O10.32, O10.411-O10.42, O10.911-O10.92,O11.1-O15.1, O15.9-O16.9, O20.0-O24.02, O24.111-O24.12, O24.311-O24.32, O24.410-O24.429, O24.811-O24.82, O24.911-024.92, O25.10-O25.2, O26.00-O26.62, O26.711-O26.72, O26.811-O29.93, O30.00-O48, O60.00-O77.9, O80-O82, Z331, Z3400-Z3493, Z390-Z392, Z51.11-Z51.12).

Physicians may continue to perform laboratory testing in their office but must otherwise direct outpatient diagnostic laboratory tests to a Summit Community Care-preferred laboratory vendor (e.g., LabCorp or Quest Diagnostics).

Long-term care facility services/nursing facility services

Long-term care facilities include chronic hospitals, rehabilitation hospitals and nursing facilities. Summit Community Care is responsible for the first 30 days in a long-term care facility. Prior authorization is required for coverage from Summit Community Care.

When a member is transferred to skilled nursing or long-term care facility and the length of the member's stay is expected to exceed 30 days, medical eligibility approval of the Department of Health for long-term institutionalization must be secured as soon as possible.

Summit Community Care covers the first 30 days or until medical eligibility approval is obtained, whichever is longer. If required disenrollment procedures are **not** followed, financial responsibility continues until the state's requirements for the member's disenrollment are satisfied. For a member to be disenrolled from Summit Community Care based on a long-term care facility admission, all the following must first occur:

- A DHS application for a departmental determination of medical necessity must be filed. If a length of stay of more than 30 days is anticipated at the time of admission, the application should be filed at the time of admission.
- DHS must determine the member's long-term care facility admission was medically necessary, in accordance with the state's criteria.
- The member's length of stay must exceed 30 consecutive days.
- Summit Community Care must file an application for disenrollment with DHS, including documentation of the member's medical and utilization history if requested.

Inpatient acute care services provided within the first 30 days following admission to a long-term care facility are **not** considered an interruption of the Summit Community Care-covered 30 continuous days in a long-term care facility, if the member is discharged from the hospital back to the long-term care facility.

A member with serious behavioral illness, intellectual disability or a related condition may **not** be admitted to a nursing facility (NF) unless the state determines NF services are appropriate for coverage. For each member seeking NF admission, a preadmission screening and resident review (PASRR) ID screen must be completed.

The first section of the PASRR ID screen exempts a member if both:

1. NF admission is directly from a hospital for the condition treated in the hospital.
2. The attending provider certifies, before admission to the NF, that the member will likely need less than 30 days of NF services.

Outpatient hospital services

Medically necessary outpatient hospital services are covered.

Oxygen and related respiratory equipment

Oxygen and related respiratory equipment are covered.

Personal care services

Personal care services are covered for those members who meet functional eligibility requirements.

Pharmacy services

Summit Community Care will maintain drug formularies in compliance with state benefits. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high-risk and special-needs populations, and vaccines prescribed to protect individuals against vaccine preventable diseases. If a generic equivalent drug is not available, a new brand-name drug rated as P (priority) by the FDA (Food and Drug Administration) will be added to the formulary. Coverage may be subject to prior authorization to ensure medical necessity for specific therapies. For formulary drugs requiring prior authorization, a decision will be provided in a timely manner so as not to adversely affect the member's health. Decisions are made within 24 hours of receipt of necessary clinical information. If the service is denied, Summit Community Care will notify the prescriber and the member in writing of the denial.

When a prescriber believes a nonformulary drug is medically indicated, Summit Community Care has procedures in place for nonformulary requests. The state expects a nonformulary drug to be approved if documentation is provided indicating the formulary alternative is not medically appropriate.
The Summit Community Care pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness or limiting the need for hospitalization. Members have access to national pharmacy chains and many independent retail pharmacies. Summit Community Care contracts with CarelonRx as the pharmacy benefits manager. All members must utilize a contracted CarelonRx network pharmacy when filling prescriptions for benefits to be covered. Several large chains and most independent pharmacies are contracted with CarelonRx.

Monthly limits

Each prescription may be filled for up to a maximum 31-day supply. Maintenance medications for chronic illnesses must be prescribed and dispensed in sufficient quantities — not to exceed the maximum 31-day supply per prescription — to effect optimum economy in dispensing. For drugs that are specially packaged for therapy exceeding 31 days, the days' supply limit (other than 31), as approved by the state, will be allowed for claims processing.

Mail order

Prescription home delivery (mail order) services are offered through Walmart Home Delivery. All prescriptions are included, and any Summit Community Care member can qualify for this service. Prescriptions under the mail order benefit are limited to a 31-day supply. To start this process members may complete the home delivery form found on the Summit Community Care website at https://www.summitcommunitycare.com/arkansas-passe/arar_caid_ingenioorderform_eng.pdf.

Covered drugs

The Summit Community Care Pharmacy program utilizes a *Preferred Drug List* (*PDL*), which has been reviewed and approved by Arkansas DHS. The *PDL* is a list of the preferred drugs within the most prescribed therapeutic categories. Many over-the-counter (OTC) medications are also included in the *PDL* and should be considered for first-line therapy when appropriate. To access the *PDL*, go to **https://arkansas.magellanrx.com/provider/docs/rxinfo/PDL.pdf** or visit the Summit Community Care Pharmacy Information and Tools page (**https://provider.summitcommunitycare.com/arkansas-provider/pharmacy**) and click on the link to the *Preferred Drug List (PDL)*.

Vaccines

Summit Community Care covers certain pharmacy vaccines for members as part of the pharmacy benefit. These vaccines include:

- COVID-19
- Hepatitis A
- Hepatitis B
- Haemophilus influenzae type b (Hib)
- Human papillomavirus (HPV)
- Influenza (seasonal flu)
- Meningococcal
- Measles, mumps, rubella (MMR)
- Pneumococcal (PCV13)
- Inactivated polio virus (IPV)
- Shingles
- Tetanus, diphtheria, pertussis (Tdap)
- Varicella (chickenpox)

For members 19 years of age or older: Vaccines can be obtained either from a prescriber's office or from an in-network pharmacy that offers vaccinations.

For members under 19 years old: Vaccines are provided free of charge by the Vaccines for Children (VFC) program. Members can receive vaccines from providers enrolled in the VFC program (mostly medical providers). Vaccines can be obtained from an in-network pharmacy that is enrolled in the VFC program.

Diabetic supplies

Effective June 1, 2020, members can fill prescriptions for preferred diabetic supplies, including diabetic meters, testing strips, control solutions, lancets, and lancet devices, at any in-network pharmacy with a prescription. Insulin pen needles and syringes will continue to be covered under the pharmacy benefit at any in-network pharmacy with a prescription. Some of the preferred diabetic supplies and products are listed below. This list is not all-inclusive, and products that are nonpreferred may require prior authorization.

- **Meters:** Limit of one meter per member every 12 months

Product name	Product NDCs
TRUE METRIX meter	• 08528-1474-01 • 56151-1470-02 • 56151-1470-04 • 21292-0006-05 • 11917-0166-89
TRUE METRIX AIR meter	• 56151-1490-02 • 56151-1494-01 • 21292-0007-16 • 11917-0173-89
TRUE METRIX AIR W/BLUETOOTH meter	• 56151-1494-03
TRUE METRIX GO meter	• 56151-1950-02

GNP TRUE METRIX AIR meter	• 87701-0427-39 • 87701-0426-25
RELION TRUE METRIX meter	• 56151-1491-02 • 81131-0403-27

Members can call 866-788-9618 to have a meter delivered to their home.

- **Test strips:** Limit of 200 test strips per month

Product name	Product NDCs
TRUE METRIX test strips	• 56151-1460-01 • 56151-1460-04
GNP TRUE METRIX test strips	• 87701-0426-26 • 87701-0426-27 • 87701-0426-53 • 87701-0427-60
RELION TRUE METRIX test strips	• 56151-1461-01 • 56151-1461-04

- **Lancets:** Limit of 200 lancets per month
- **Pen needles and syringes**

Pharmacist-administered injectable medications

Summit Community Care covers select injectable medications from in-network, participating pharmacies, * which include:

Long-acting injectable antipsychotics	Contraceptives
• Abilify Maintena • Aristada • Fluphenazine Decanoate • Haliperidol Decanoate • Invega Sustenna • Invega Trinza • Perseris • Risperdal Consta	• Depo-Provera • Depo-SubQ Provera 104 • Medroxyprogesterone Acetate

*All pharmacies in our network have received billing instructions to ensure there is no cost to the member. Please contact the pharmacy to find out whether it is a participating pharmacy.

Exclusions

Neither the state nor Summit Community Care cover the following:

- Drugs not approved by the FDA
- Drugs not on the *OTC Drug Formulary*
- Drugs to help members get pregnant
- Drugs used for cosmetic reasons
- Drugs for hair growth
- Drugs used to treat erectile problems
- Drugs used for weight loss
- Experimental or investigational drugs

Pharmacy restriction (lock-in)

The Summit Community Care pharmacy restriction process limits members to a single pharmacy to obtain their medications. The need for restriction is decided following the member's medication claims review. Members identified with uncoordinated care, excessive utilization or suspected patterns of fraud and abuse may also be referred to the pharmacy department.

Using predefined queries, the members are identified and reviewed by the Health Plan if they meet criteria for lock-in. Members selected for lock-in by the Health Plan will be notified in advance of the lock-in and may appeal a lock-in decision within sixty (60) days of the date of notice of lock-in either in writing or orally by calling Pharmacy Member Services at 1-833-263-2869. The network pharmacy provider will also be notified in writing of the decision to lock in the member to a pharmacy within ten (10) business days and prior to the actual lock-in date.

Pharmacy prior authorization

Providers are strongly encouraged to write prescriptions for preferred products as listed on the *PDL*. If for medical reasons a member cannot use a preferred product, providers are required to contact Summit Community Care Pharmacy Services to obtain prior authorization in one of the following ways:

- Call **844-462-0022** Monday to Friday from 8 a.m. to 8 p.m. CST or 10 a.m. to 2 p.m. CST on Saturdays.
- Fax all information required and a prior authorization form to **844-429-7761** for general pharmacy requests and **844-429-7762** for medical injectable requests. Prior Authorization forms are located at
  - **https://provider.summitcommunitycare.com/arkansas-provider/forms** or
  - **https://provider.summitcommunitycare.com/arkansas-provider/pharmacy**
- Submit an electronic prior authorization request via one of the following links:
  - **https://www.covermymeds.com/main/partners/anthem/** or
  - **https://www.covermymeds.com/main/solutions/provider/**

Providers may use the online Prior Authorization Lookup Tool to:

- Submit requests for general pharmacy — medications dispensed directly to a member from retail pharmacy or shipped from a specialty pharmacy.
- Request medical injectables for those medications obtained by your office/facility for onsite infusion or administration.
- Check prior authorization status.
- Appeal denied requests.
- Upload supporting documents and review appeal status.

To access the Precertification Lookup Tool, log in at **https://provider.summitcommunitycare.com/arkansas-provider/prior-authorization-lookup**; you must be a registered user to access the tool. The site also offers tutorials to guide you through the medication prior authorization process and other helpful functions.

The information will be reviewed by a clinical pharmacist and/or medical director for medical necessity, and the provider will be notified within 24 hours of receipt of the necessary clinical information.

If the service is denied, the prescriber and the member are notified in writing of the denial. All decisions are based on medical necessity and are determined according to certain established medical criteria. Summit Community Care may not cover brand name medications where there is an FDA-approved

therapeutically equivalent generic. Requests for brand name- medications when there is a generic available will follow the prior authorization process to determine medical necessity. Some drugs have daily quantity and/or dosage limits and are identified as such on the *PDL*. Request for drugs exceeding the limits will require prior authorization to determine medical necessity.

Examples of medications that may require prior authorization are listed below (this list is not all-inclusive and is subject to change):

- Drugs not listed on the *PDL*
- Brand-name products for which there are therapeutically equivalent generic products available
- Self-administered injectable products
- Drugs that exceed certain limits (for information on these limits please contact the Pharmacy department)

Drug coverage under medical benefit

Drugs that are only administered to members by healthcare professionals are available under the medical benefit and can be obtained in several ways:

- **Buy and bill:** Physicians may purchase drugs directly through pharmaceutical wholesalers and distributors and submit a claim to Summit Community Care. To review the list of services and drugs that are billable on the medical benefit for Summit Community Care, please refer to the **state fee schedule**.
- **Delivery:** Physicians may request delivery of a member specific specialty medication that will be administered in their office by calling Summit Community Care's contracted medical specialty pharmacy (MSP), CVS Specialty®.
- **Referral:** Physicians may refer their members to infusion suites and outpatient hospital services

Note: CVS Specialty® is an independent company providing pharmacy services on behalf of Summit Community Care.

Medical specialty pharmacy (MSP)

Summit Community Care is pleased to announce a drug delivery option that enhances medication accessibility to both members and providers. Summit Community Care is contracted with CVS Specialty® as the MSP. CVS Specialty® can deliver member specific medication that is covered under the Summit Community Care medical benefit to your office for administration to the member.

To set up delivery or check a prescription order status, please call **877-254-0015**, and you will be transferred to a pharmacist for a verbal prescription order. Please plan to provide your member's Summit Community Care ID located on their ID card. Staff will obtain additional information necessary to support the delivery of the medication, including the need by date. Please allow up to 10 days for processing and shipping. The staff will then make an outbound call to your member to obtain consent as needed to support the delivery of the medication to your office. Once all necessary information is obtained for shipping, the staff will call your office to confirm delivery.

You may also fax prescription orders to **866-336-8479** and a staff member will call your office to obtain additional information necessary to support the delivery of the medication as described above.

Note: If it is an urgent medication request and the need by date is less than seven days from the order date, please indicate this so the order can be expedited.

Physician and advanced practice nurse specialty care services

Specialty care services provided by a physician, or an advanced practice nurse (APN) are covered when such services are medically necessary and are outside of the PCP's customary scope of practice.

Specialty care services covered under this section also include:

- Services performed by nonphysicians or non-APN practitioners within their scope of practice, employed by a physician to assist in the provision of specialty care services and working under the physician's direct supervision.
- Services provided in a clinic by or under the direction of a physician or dentist.
- Services performed by a dentist or dental surgeon when the services are customarily performed by physicians.

Summit Community Care shall clearly define and specify referral requirements to all providers.

A member's PCP is responsible for making the determination based on Summit Community Care referral requirements (i.e., whether a specialty care referral is medically necessary).

PCPs must follow Summit Community Care specialty referral protocol for children with special healthcare needs who suffer from a moderate to severe chronic health condition that:

- Has significant potential or actual impact on health and ability to function.
- Requires special healthcare services.
- Is expected to last longer than six months.

A child who is functioning one third or more below chronological age in any developmental area must be referred for specialty care services intended to improve or preserve the child's continuing health and quality of life, regardless of the services ability to affect a permanent cure.

Podiatry services

Summit Community Care provides its members medically necessary podiatry services when furnished by a licensed podiatrist within the scope of practice under state law.

No prior authorization is required for network providers for in-office evaluation & management services, testing and procedures.

Primary care services

Primary care is received through a member's PCP who acts as a coordinator of care and has the responsibility to provide accessible, comprehensive, and coordinated healthcare services covering the full range of benefits for which a member is eligible. In some cases, members will opt to access certain primary care services by self-referral to providers other than their PCPs (e.g., school-based health centers). Primary care services include:

- Addressing the members' general health needs.
- Coordination of the member's healthcare.
- Disease prevention and health promotion and maintenance.
- Treatment of illness.
- Maintenance of the members' health records.

- Referral for specialty care.

For female members: If the member's PCP is not a woman's health specialist, she may see a participating woman's health specialist, without a referral, for covered services necessary to provide women's routine and preventive healthcare services.

Primary behavioral health services (mental health and substance use disorders)

Primary behavioral health services required by members, including clinical evaluation and assessment, provision of primary behavioral health services, and/or referral for additional services as appropriate are covered. Reference the behavioral health services chapter for specific services.

The PCP of a member requiring behavioral health services may elect to treat the member if the treatment, including visits for buprenorphine treatment, falls within the scope of the PCP's practice, training and expertise. Neither the PCP nor Summit Community Care may bill the behavioral health system for the provision of such services because these services are included in the capitation rates. When, in the PCP's judgment, a member's need for behavioral health treatment cannot be adequately addressed by primary behavioral health services provided by the PCP, the PCP should, after determining the member's eligibility based on probable diagnosis, refer the member to behavioral health services at **844-462-0022**.

Rehabilitative services

Rehabilitative services, including medically necessary physical therapy, speech therapy and occupational therapy, are covered.

Prior authorization must be obtained from Summit Community Care for physical therapy, speech therapy, and occupational therapy services beyond the initial evaluation. Summit Community Care conducts medical necessity reviews for therapy services and medical necessity criteria must be met. Providers can request authorization from Summit Community Care by calling **844-462-0022** or by faxing clinical information to **501-224-1355**.

Second opinions

Upon member request, Summit Community Care will provide for a second opinion from a qualified healthcare professional within the network and, if necessary, will arrange for the member to obtain a second opinion outside of the Summit Community Care network.

Transplants

Pre- and post-transplant surgery services are covered. The division of Medicaid Services Fee-for -Service (FFS) will cover transplant surgery and post-transplant services for one year after surgery.

Transportation

Transportation services for Medicaid members is covered related to the provision of triage and stabilization services for emergency medical conditions only and as described in 42 C.F.R. § 440.170(a) for medical examinations and treatment.

Vision care services

The following routine vision services are available to eligible Medicaid beneficiaries and are administered by EyeMed:

- **Age 21 and over**: One comprehensive eye exam including refraction and one pair of prescription eyeglasses every 12 months. Adults with diabetes are eligible to receive a second pair of eyeglasses within the twelve-month period if their prescription changes to more than one diopter. Post Cataract patients are also eligible for a second pair of glasses. Contact lenses are covered only if medically necessary.
- **Under age 21**: One comprehensive eye exam including refraction and one pair of prescription eyeglasses every 12 months. Kids with diabetes are eligible to receive a second pair of eyeglasses within the twelve-month period if their prescription changes to more than one diopter. If eyeglasses are lost or broken beyond repair, an additional pair is covered through the state optical laboratory. Contact lenses are covered only if medically necessary.
- All beneficiaries must choose a frame from the state-mandated frame collection. If a member wishes to pay out of pocket for a frame outside the collection, the member receives no benefits for the entire pair of eyeglasses. All pairs of eyeglasses must be ordered via the EyeMed claim portal, which in turn leverages the state's contracted optical laboratory, Select Optical.
- For additional information related to routine vision services, including frames and lens restrictions, please review the EyeMed Provider Manual at **https://www.eyemedinfocus.com/summit/**.

In addition to routine vision services, EyeMed administers medical-surgical eye care services for all eligible beneficiaries. For additional information related to medical-surgical services, including prior authorization for certain surgeries, therapeutic procedures, and injectable drugs, please review the EyeMed Provider Manual at **https://www.eyemedinfocus.com/summit/.**

Benefit limitations

Excluded Medicaid Services

The following items and services are excluded from coverage:

- The service is not included as a covered service in the state plan.
- The service is of an amount, duration, and scope over a limit in the MCO contract between Arkansas and Summit Community Care.
- The service is not medically necessary as defined in the MCO contract between Arkansas and Summit Community Care.
- The service is a prescription drug for which Summit Community Care has received prior approval in writing from DHS to exclude from the *Summit Community Care Formulary*.

The service is an inpatient transplantation surgery (Summit Community Care shall cover pre- and postoperative costs of the transplant surgery). The division of Medicaid Services Fee-for -Service (FFS) will cover transplant surgery and post-transplant services for one year after surgery.

- The service is cosmetic, except that the following services shall not be considered cosmetic:
  - Surgery required correcting a condition resulting from surgery or disease
  - Surgery required to correct a condition created by an accidental injury
  - Surgery required to correct a congenital deformity
  - Surgery required correcting a condition that impairs the normal function of a part of the body
  - Surgery to address gender dysphoria as identified in DHS policy
- The service is sterilization for an enrollee under age 21.

- The service is an abortion except as allowed by State or Federal law.
    - None of the funds appropriated under this act, and none of the funds in any trust fund to which funds are appropriated under this act, shall be expended for health benefits coverage that includes coverage of abortion.
    - The limitations established in the preceding sections shall not apply to an abortion:
        - If the pregnancy is the result of an act of rape or incest
        - In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed
    - Nothing in this section shall be construed as prohibiting the expenditure by a state; locality; entity; or private person of state, local or private funds (other than a states or locality's contribution of Medicaid matching funds).
    - Nothing in this section shall be construed as restricting the ability of Summit Community Care from offering abortion coverage or the ability of a state or locality to contract separately with such a provider for such coverage with state funds (other than a states or locality's contribution of Medicaid matching funds).
- The service is described as a non-MCO covered service, which is covered by the Medicaid State Plan but not described as a Summit Community Care covered service and, therefore, not the responsibility of Summit Community Care under the contract.
- The service is an investigational or experimental treatment if it is a diagnostic or treatment service that, in accordance with relevant evidence, is not considered to fall within the range of professionally accepted clinical practice with respect to illness, disability, or condition that is the focus of a coverage determination.
- The services are part of a clinical trial protocol; Summit Community Care shall cover all inpatient and outpatient services furnished over a clinical trial but shall not cover the services included in it.

Over-the-counter drugs

Summit Community Care covers over-the-counter drugs in compliance with state benefits. For more information, refer to the *PDL* at **https://arkansas.magellanrx.com/provider/docs/rxinfo/PDL.pdf**. Family and friends should not be used to provide interpretation services, except at a member's request.

Guidelines for working with an interpreter

Use the following guidelines for better communication when speaking through an interpreter:

- Keep your sentences short and concise — the longer and more complex your sentences, the less accurate the interpretation.
- When possible, avoid using medical terminology, which is unlikely to translate well.
- Ask key questions in several different ways to ensure the questions are fully understood, and you get the information you need.
- Be sensitive to potential member embarrassment, reticence, or confusion. It is possible your questions or statements were not understood.
- Ask the member to repeat the instructions you have given as an effective review of how well the member has understood.

Services for the deaf and hard of hearing

Members have the right to receive assistance through a TTY/TDD line. Summit Community Care can help you telephonically communicate with members with impaired hearing via a translation device. Call the Member Services using the TTY relay service at 711. In-office sign language assistance is also available. Call Member Services at **844-405-4295** (**TTY 711**) to arrange for the service.

Additional communication options for members and providers

Summit Community Care policies are designed to ensure meaningful opportunities for members with limited English proficiency (LEP) to obtain access to healthcare services and to help members with LEP overcome language barriers and fully use services or benefits.

The Summit Community Care provider directory includes a list of languages spoken by participating primary and specialty care providers. Translation assistance options are available at no cost to the member or provider. Upon request, written materials are available in large print, on tape and in languages other than English (dependent upon the plan's population). Member materials are written at a fifth-grade reading level per state requirement.

Summit Community Care will not prohibit a provider, acting within the scope of his or her practice, from advising a member about his or her medical care or treatment for the condition or disease regardless of whether benefits are provided by Summit Community Care. Summit Community Care will not retaliate against a provider for advising the member.

Member rights and responsibilities

Summit Community Care is committed to ensuring members are treated in a manner that acknowledges their rights and responsibilities.

Summit Community Care members have the right to:

- Be treated with respect and dignity.
- Know that when they speak with providers, it's private.
- Have an illness or treatment explained to them in a language they can understand.
- Participate in decisions about their care.
- Receive a full, clear and understandable explanation of treatment options and risks of each option so they can make an informed decision, regardless of cost or whether it is part of covered benefits.
- Refuse treatment or care.
- Be free of physical and chemical restraints except for emergency situations.
- Be free of restraint or seclusion used as coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraint and seclusion.
- See their medical records and request a change if incorrect.
- Choose an eligible primary care provider/primary dental provider (PCP/PDP) from within the Summit Community Care network and change their PCP/PDP.
- Make a grievance (complaint) about the health plan or care provided to them and receive an answer.
- Request an appeal or a fair hearing if they believe Summit Community Care was wrong in denying, reducing or stopping a service or item.
- Receive family planning services and supplies from the provider of their choice.

- Obtain medical care without unnecessary delay.
- Receive information on advance directives and choose not to have or continue any life sustaining treatment.
- Receive a copy of the Summit Community Care member handbook and/or provider directory.
- Receive information about our practitioners and other providers.
- Continue treatment they are currently receiving until they have a new treatment plan.
- Receive interpretation and translation services free of charge.
- Refuse oral interpretation services.
- Receive transportation services free of charge.
- Get an explanation of prior authorization procedures.
- Receive information about the Summit Community Care organization, its services, its practitioners and providers, financial condition, and any special ways we pay providers.
- Receive information on their rights and responsibilities.
- Obtain summaries of customer satisfaction surveys.
- Make suggestions to Summit Community Care about the rights and responsibilities.
- Furnished healthcare services that are available and accessible in a timely manner; coordinated; sufficient in amount, duration, or scope; and provided in a culturally competent manner, in order to meet the member's specific needs.
- Be free to exercise his or her rights and that the exercise of those rights does not adversely affect the way Summit Community Care or its network provider, subcontractors, or the state treat the member.

Summit Community Care members have the responsibility to:

- Treat those providing care with respect and dignity.
- Follow the rules of the Medicaid Managed Care Program and Summit Community Care.
- Follow plans and instructions they receive from providers.
- Tell providers about their health conditions.
- Work as a team with providers in deciding what healthcare is best for them and developing mutually agreed-upon treatment goals and following the treatment plans to the best of their ability.
- Go to scheduled appointments.
- Tell providers at least 24 hours before the appointment if they must cancel appointments.
- Ask for more explanation if they do not understand a provider's instructions.
- Go to the emergency room only if they have a medical emergency.
- Tell their health plan, practitioners, and providers about medical and personal problems that may affect their health.
- Report to Economic Security Administration (ESA) and Summit Community Care if they or a family enrollee have other health insurance or if they have a change in address or phone number.
- Report to ESA and Summit Community Care if there is a change in family (i.e., deaths, births, etc.).
- Help providers in getting medical records from providers who have treated them in the past.
- Tell Summit Community Care if they were injured as the result of an accident or at work.

Summit Community Care will provide members with notice of any change that the state defines as significant at least 30 days before the intended effective date of the change.

Restrictive interventions in an HCBS setting

Members have a right to have safeguards in place to prevent restrictive interventions. As such, Summit Community Care promotes these guidelines concerning the use of restraints, seclusion, and restrictive intervention:

- Physical restraints (i.e., use of a staff member's body to prevent injury to the member or another person) are allowed in cases of emergency; an emergency exists for any of the following conditions:

The members have not responded to de-escalation techniques and continue to escalate behavior.
The member is a danger to self or others.
The safety of the members and those nearby cannot be assured through positive reinforcement.

- The member must be continuously under direct observation of staff members during any use of restraints.
- If the use of personal restraints occurs more than three times per month, use should be discussed by the interdisciplinary team, which is made up of the physician and both clinical and direct care staff and addressed in the person-centered support plan (PCSP).
  - When emergency procedures are implemented, PCSP revisions including but not limited to: 1) psychological counseling, 2) review of medications with medication change or 3) a change in environmental stressors that are noted to precede escalation of behavior may be implemented.
- For members in an HCBS setting, use of mechanical or chemical restraint or seclusion is not allowed.
- Providers must not allow maltreatment or corporal punishment (i.e., the application of painful stimuli to the body to terminate behavior or as a penalty for behavior) of members. Providers' policies and procedures must state that corporal punishment is prohibited.
- Restrictive interventions cannot include:
  - Aversion techniques.
  - Restrictions on member's rights, including the right to physically leave.
  - Mechanical or chemical restraints.
  - Seclusion.

All use of restraint must be documented in the member's case record, including the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event. Use of restrictive interventions also requires submission of an incident report no later than the end of the second business day following the incident.

These interventions might be implemented to deal with aggressive or disruptive behaviors related to the activity or possession. Please note, before implementing absence from a specific social activity or temporary loss of personal possession, the member must first be counseled about the consequences of the behavior and the choices they can make.

Providers must train staff, families, and the members to recognize and report unauthorized use of restrictive interventions. All personnel involved in restrictive interventions must receive training in behavior management techniques and abuse and neglect laws, rules, regulations and policies. The personnel must be qualified to perform, develop, implement, and monitor or provide direction intervention as applicable.

Before the use of restraints or restrictive interventions, a written behavior management plan must be developed to ensure the rights of members. The plan must:

- Include a provision for alternative methods to avoid the use of restraints and seclusions.
- Be written or supervised by a qualified professional.
- Be designed so that the rights of the members are protected.
- Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation or put the member at medical risk.
- Specify the length of time the restraint or restrictive intervention is to be used, who will authorize the use of restraint or seclusion, and the methods for monitoring the member.

Emergency services and self-referrals

Emergency room medical record review

All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted in the emergency room medical records.

Summit Community Care is only responsible for the hospital admission days incurred while the member is enrolled in Summit Community Care regardless of the date of admission.

In addition, providers must verify that members are assigned to Summit Community Care. To validate member eligibility, call the Summit Community Care Interactive Voice Response (IVR) system at **844-462-0022** or on Availity at: **www.availity.com**.

Self-referred and emergency services

Summit Community Care will reimburse out-of-plan providers for the following services:

- Emergency services provided in a hospital emergency facility
- Family planning services (except for sterilizations)
- Services related to pregnancy when a member has begun receiving services from an out-of-plan provider prior to enrolling in Summit Community Care
- Initial medical examination for children in state custody
- Annual diagnostic and evaluation services for members with HIV/AIDS
- Renal dialysis provided at a Medicare-certified facility
- The initial examination of a newborn by an on-call hospital physician when Summit Community Care does not arrange for the service prior to the baby's discharge
- Services performed at a birthing center including an out-of-state center located in a contiguous state

Behavioral health and IDD crisis stabilization and post-stabilization

The emergency department's treating provider determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's provider must contact Summit Community Care for authorization of further services. If we do not respond within one hour, we consider the necessary services authorized.

The emergency department should send a copy of the emergency room record to the care management team within 24 hours. The PCP should:

- Review and file the chart in the member's permanent medical record.
- Contact the member.

- Schedule a follow-up office visit or a specialist referral, if appropriate.

Readmission

Summit Community Care follows the state of Arkansas 30-day readmission policy. We may review hospital admissions on a specific member if two or more admissions are related based on same or similar conditions. The claim review, which includes a review of medical records if requested from the provider, may result in necessary adjustments. If so, we will make all necessary adjustments to the claim (including recovery of payments) not supported by the medical record. Providers who do not submit the requested medical records or who do not remit the overpayment amount identified by us may be subject to a recoupment.

Post-discharge outreach, diversion plans and crisis assessments

Post-discharge outreach
Summit Community Care inpatient providers are required to conduct outreach to all members being discharged from inpatient care to encourage the member's attendance at follow-up appointments with a behavioral health specialty provider within seven calendar days of discharge.

Summit Community Care will require providers to maintain records of the results of such outreach efforts and will require reporting of this information to Summit Community Care on a regular basis. We conduct on-site audits of member records quarterly.

-Providers are also encouraged to use these outreach opportunities to ensure discharged members/caregivers could fill necessary prescriptions and scheduled any needed follow-up appointments. If members/caregivers need assistance with filling prescriptions or appointment scheduling, encourage them to contact Summit Community Care Member Services at **844-462-0022** (**TTY 711**) for assistance.

Diversion plans
When clinically indicated, providers should consider developing diversion plans when conducting crisis assessments for members at risk for admission to higher levels of care. Diversion plans should include appropriate member and family/caregiver involvement to assist the member in safely achieving stabilization at a lower level of care.

The provider should contact the member/family/caregiver as appropriate and as soon as possible following the diversion to offer needed outpatient services.

Crisis assessments
To determine the need for any further services or referral to any services, providers must initiate follow-up- contact within one business day when delivering crisis assessments/screenings to any member seen for or provided with any emergency service and not detained for inpatient care and treatment.

Self-referred services for children with special healthcare needs

Children with special healthcare needs are those children who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required for children.

Children with special healthcare needs may self-refer to providers outside the Summit Community Care network under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care and appropriate plans of care. Self-referral for children with special healthcare needs will depend on whether the condition that the basis for the child's special healthcare needs is diagnosed before or after the child's initial enrollment in Summit Community Care.

Medical services related to a special-needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

- For a new member: A child who at the time of initial enrollment was already receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing out-of-network provider submits the plan of care to Summit Community Care for review and approval within 30 days of the child's effective date of enrollment into Summit Community Care, and Summit Community Care approves the services as medically necessary.
- For an established member: A child who is already enrolled in Summit Community Care when diagnosed as having a special healthcare need that requires a plan of care, including specific types of services, may request a specific out-of-network provider. Summit Community Care is obligated to grant the member's request unless a local, in-network specialty provider with the same professional training and expertise is available to provide the same services and service modalities.

If Summit Community Care denies, reduces, or terminates services, members have an appeal right regardless of whether they are a new or established member. Pending the outcome of an appeal, Summit Community Care may reimburse for services provided.

Specialty referrals

Summit Community Care will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits covered by Arkansas Medicaid. If a specialty provider cannot be identified, please contact Summit Community Care for assistance by calling **844-462-0022**

Services for children

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program ensures members under the age of 21 receive comprehensive screening, diagnostic and treatment services as early as possible to identify physical or behavioral health conditions. These services are based on the Periodicity Schedule, which is located at **https://www.summitcommunitycare.com/provider**.

A web based EPSDT provider training was developed by Georgetown University's National Center for Education in Maternal and Child Health in collaboration with the DHS and maintained by Georgetown University. The training module is based on the Bright Futures guidelines and has been tailored to the needs of the provider community. This training module satisfies the EPSDT and IDEA provider training requirements. Successful completion of the training module is expected of all providers providing EPSDT services within 30 days of joining the Summit Community Care network and every two years thereafter. This training will provide five hours of category one credits toward the AMA Physician's Recognition Award and is paid for by Summit Community Care.

For children under age 21, Summit Community Care shall assign the member to a PCP certified by the state's EPSDT program unless the member or member's parent, guardian or caretaker specifically requests assignment to a PCP who is not EPSDT-certified. In this case, the non-EPSDT-certified provider is responsible for ensuring the child receives well-childcare according to the EPSDT schedule. If a member refuses services, the PCP must document the refusal in the member's health record. During the initial examination and assessment, the provider must perform applicable EPSDT screenings and services, based on the periodicity schedule and any additional assessments needed, with the appropriate tools. If a child is identified to have special healthcare needs or at risk of a developmental delay by the developmental screen required by EPSDT, the provider shall refer the child to specialty care and must make a referral to the Summit Community Care Case Management department.

The EPSDT assessment must include the following:

- Comprehensive health and developmental history assessment including physical, oral, and mental health
- Unclothed comprehensive physical exam
- Immunizations* (based off the Periodicity Schedule and in accordance with ACIP recommendations)
- Laboratory tests including lead toxicity screenings (if lead level is greater than or equal to 5 ug/dL, provider must make a referral to the Summit Community Care Case Management department)
- Health education and explanation of EPSDT services
- Vision services (based off the Periodicity Schedule and as needed)
- Hearing services (based off the Periodicity Schedule and as needed)
- Dental services (based off the Periodicity Schedule and as needed)
- Mental health and substance use screening (including a maternal depression screening at the 1-month, 2-month, 4-month and 6-month well-child visits; if a mental health issue or substance use

is determined, the provider must make a referral to the Summit Community Care Case Management department)
- Any needed diagnostic services for further evaluation and treatment or referrals, as needed to support improving health conditions

* All applicable providers must be enrolled in the Vaccines for Children (VFC) program. Summit Community Care will not reimburse providers for vaccines provided through the VFC program unless the vaccine was unavailable through the VFC program and can be proven through written documentation to Summit Community Care.

For the EPSDT population, members must be offered an initial appointment within 45 days of their date of enrollment with the PCP or within 30 days of request, whichever is sooner, unless the following exception applies:

Appointments for initial EPSDT screens shall be offered to new enrollees within 60 days of the enrollee's enrollment date with Summit Community Care, or at an earlier time if an earlier exam is needed 1) to comply with the periodicity schedule or 2) if the child's case indicates a more rapid assessment or 3) if a request results from an emergency medical condition. The initial screen shall be completed within three months of the enrollee's enrollment date with Summit Community Care unless Summit Community Care determines the new enrollee is up to date with the EPSDT Periodicity Schedule. To be considered timely, all EPSDT screens, laboratory tests and immunizations shall take place within 30 days of their scheduled due dates for children under the age of 2 and within 60 days of their due dates for children age 2 and older. Periodic EPSDT screening examinations shall take place within 30 days of request.

Members with special healthcare needs

In general, to provide care to members with special healthcare needs, it is important for providers to:
- Demonstrate their credentials and experience to Summit Community Care for treatment of special populations.
- Collaborate with Case Management staff on issues pertaining to a special needs member's care.
- Document the plan of care and care modalities and update the plan annually.

Summit Community Care members may receive services in the following manner from Summit Community Care and/or Summit Community Care providers:
- Be assigned a case manager trained as a nurse or social worker. The case manager will work with the member's PCP, and other providers to plan the treatment and services needed. The case manager will not only help plan for the care but will also help keep track of the healthcare services the member receives during the year and serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and case manager, when required, will coordinate referrals for needed specialty care, including specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. PCPs should follow the referral protocols established by Summit Community Care for sending members to specialty care networks.
- All providers are required to treat individuals with disabilities consistent with the requirements of the *Americans with Disabilities Act of 1990 (P.L.101-336 42 U.S.C. §12101 et. seq.)* and regulations disseminated under it.

Services for pregnant and postpartum women

Taking Care of Baby and Me®

Taking Care of Baby and Me® is a proactive case-management program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files, claims data, hospital census reports, Availity, and notification of pregnancy forms, as well as provider and self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, breastfeeding support, and counseling. When it comes to our pregnant members, we are committed to keeping both mom and baby healthy.

We encourage all our moms-to-be to take part in our Taking Care of Baby and Me® program, a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum checkups.

As part of the Taking Care of Baby and Me® program, eligible members are offered the My Advocate® program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR). Eligible members receive regular phone calls with tailored content from a voice personality (Mary Beth). This program does not replace the high touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers and improve member and baby outcomes. For more information on My Advocate visit **www.myadvocatehelps.com**.

Summit Community Care requires notification of pregnancy after the first prenatal visit and notification of delivery following birth. You may complete the notification of pregnancy and delivery in the online Interactive Care Reviewer accessed through the Availity Portal or fax the forms to Summit Community Care at **800-964-3627**.

You should also complete the maternity form in Availity:

- Perform an Eligibility and Benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the member is pregnant. Choose **Yes**, if applicable. If you indicate **Yes** you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will now be available. You may access the form by navigating to the **Applications** tab and selecting the **Maternity** link.

Childbirth-related provisions

There are special rules to determine the length of hospital stay following childbirth:

- A member's length of hospital stay after childbirth is determined in accordance with the ACOG and American Academy of Pediatrics (AAP) guidelines for prenatal care, unless the 48-hour (for uncomplicated vaginal delivery) or 96-hour (for uncomplicated cesarean section) length of stay guaranteed by state law is longer than that required under the guidelines.
- If a member must remain in the hospital after childbirth for medical reasons, and she requests her newborn remain in the hospital while she is hospitalized, additional hospitalization of up to four days must be provided for the newborn and is covered.
- If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by state law, a home visit must be provided.
- When a member opts for early discharge from the hospital following childbirth (before 48 hours for vaginal delivery or before 96 hours for cesarean section), one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.
- The hospital is responsible for notifying Summit Community Care of the birth of a child within 24 hours or by the next business day.

If a member remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, is covered.

Children with special healthcare needs

Summit Community Care will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special healthcare needs, as appropriate. For complex cases involving multiple medical interventions, social services or both, a multidisciplinary team must be used to review and develop the plan of care for children with special healthcare needs.
- Refer special needs children to specialists as needed, including specialty referrals for children found to be functioning at one-third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT Periodicity Schedule.
- Allow children with special healthcare needs to access out-of-network specialty providers as specified in the special provisions and guidelines in **Self-Referred Services for Children with Special Healthcare Needs**.
- Log any complaints made to the state or to Summit Community Care about a child who is denied services. All denial letters sent to children, or their representatives, must state that members can appeal by calling the state at **800-482-8988**.
- Work closely with the schools that provide education and family services programs to children with special needs.
- Ensure coordination of care for children in state-supervised care. If a child in state supervised care moves out of the area and must transfer to another MCO, the state and Summit Community Care will work together to find another MCO as quickly as possible.

Individuals with HIV/AIDS

Individuals with HIV/AIDS are enrolled in one of the state's MCOs.

The following service requirements apply for persons with HIV/AIDS:

- An HIV/AIDS specialist for treatment and coordination of primary and specialty care must be involved in the patient's care.
- A Diagnostic Evaluation Service (DES) assessment can be performed once every year at the member's request. The DES includes a physical, behavioral, and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES provider for the evaluation.
- Substance abuse treatment within 24 hours of request.
- The right to ask Summit Community Care to send him or herself to a site that performs HIV/AIDS-related clinical trials. Summit Community Care may refer members with HIV/AIDS to facilities or organizations that can provide members access to clinical trials.
- The local health department will designate a single staff member to serve as a contact. In all instances, providers will maintain the confidentiality of member records and eligibility information in accordance with all federal, state, and local laws and regulations and use this information only to assist the member to receive needed healthcare services.
- Summit Community Care case management services are covered for any member diagnosed with HIV. These services must be provided with the member's consent to facilitate timely and coordinated access to appropriate levels of care and to support continuity of care across the continuum of qualified service providers. Case management will link HIV-infected members with the full range of benefits (e.g., primary behavioral healthcare and somatic healthcare services) and referral for any additional needed services including specialty behavioral health services, social services, financial services, educational services, housing services, counseling, and other required support services. HIV case management services include:
    - Initial and ongoing assessment of the member's needs and personal support systems, including using a multidisciplinary approach to develop a comprehensive, individualized service plan. This includes periodic re-evaluation and adaptation of the plan.
    - Coordination of services needed to implement the plan.
    - Outreach for the member and the member's family by which the case manager and the PCP track services received, clinical outcomes and the need for additional follow-up care.

The member's case manager will serve as the member's advocate to resolve differences between the member and providers of care pertaining to the course or content of therapeutic interventions.

If a member initially refuses HIV case management services, the services are to be available at any later time if requested by the member.

Individuals who are homeless

If an individual is identified as homeless, Summit Community Care may provide a case manager to coordinate healthcare services.

Adult members with impaired cognitive ability/psychosocial problems

Support and outreach services are available for adult members needing follow-up care who have impaired cognitive ability or psychosocial problems and who can be expected to have difficulty understanding the importance of care instructions or difficulty navigating the healthcare system.

MCO support services (outreach)

Summit Community Care enacts a variety of outreach campaigns to support our members in getting the care they need. These campaigns are focused on topics including completion of EPSDT services, preventive care, condition self-management, and medication adherence. Outreach methods include phone, texts, mailings, community events and in person.

PASSE BH & IDD HCBS services

In addition to traditional Medicaid State Plan services, the PASSE Program includes an array of home and community-based waiver services for members with developmental disabilities and/or behavioral health needs.

1915(c) Home and Community Based Waiver (formerly CES waiver services)	
Supportive living	Supportive living is an array of individually tailored services and activities provided to enable eligible beneficiaries to reside successfully in their own homes, with their family, or in an alternative living residence or setting. Alternative living residences include apartments, leased or owned homes, or provider group homes. Supportive living services must be provided in an integrated community setting. The services are designed to assist beneficiaries in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the home- and community-based setting. It excludes room and board expenses, including general maintenance, upkeep, or improvement to the home. The habilitation objective to be served by each activity should be documented in the member's PCSP. Services are flexible to allow for unforeseen changes needed in schedules and times of service delivery. Services are approved as maximum days that can be adjusted within the annual plan year.
Respite	Respite services are provided periodically on a short-term basis to beneficiaries unable to care for themselves due to the absence of or need for relief of non-paid primary caregivers. Respite services may include the cost of room and board charges when allowable for circumstances under 42 CFR 442.182 (d). Respite should not be furnished to compensate relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.
Supported employment	Supported employment is a tailored array of services that offers ongoing support to beneficiaries with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred or

	been interrupted or intermittent due to a significant disability and who need ongoing support to maintain their employment.
Adaptive equipment	Adaptive equipment is a piece of equipment, or product system used to increase, maintain, or improve functional capabilities of members, whether commercially purchased, modified, or customized. The adaptive equipment services include adaptive, therapeutic, or augmentative equipment that enables a member to increase, maintain, or improve their functional capacity to perform daily life tasks that would not be possible otherwise. Consultation by a medical professional must be conducted to ensure the adaptive equipment will meet the needs of the members. Adaptive equipment includes enabling technology, such as safe home modifications, that empower members to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance while still providing monitoring and response for those members, as needed. Enabling technology allows members to be proactive about their daily schedule and integrates member choice. Adaptive equipment also includes Personal Emergency Response Systems (PERS), which is a stationary or portable electronic device used in the member's place of residence and that enables the member to secure help in an emergency. The system is connected to a response center staffed by trained professionals who respond to activation of the device. PERS services may include the assessment, purchase, installation, and monthly rental fee. Computer equipment, including software, can be included as adaptive equipment. Specifically, computer equipment includes equipment that allows the members increased control of their environment, to gain independence, or to protect their health and safety. Vehicle modifications are also included as adaptive equipment. Vehicle modifications are adaptations to an automobile or van to accommodate the special needs of the member. The purpose of vehicle modifications is to enable the member to integrate more fully into the community and to ensure the health, safety, and welfare of the member. Vehicle modifications exclude adaptations or modifications to the vehicle that are of general utility and not of direct medical or habilitative benefit to the member; purchase, down payment, monthly car payment or lease payment; or regularly scheduled maintenance of the vehicle.
Environmental modifications	Modifications made to the member's place of residence that are necessary to ensure the health, welfare, and safety of the member or that enable the member to function with greater independence and without which, the member would require institutionalization. Examples of environmental modifications include the installation of wheelchair ramps, widening doorways, modification of bathroom facilities, installation of specialized electrical and plumbing systems to accommodate medical equipment, installation of sidewalks or pads, and fencing to ensure non-elopement, wandering, or straying of members with decreased mental capacity or aberrant behaviors.

	Exclusions include modifications or repairs to the home which are of general utility and not for a specific medical or habilitative benefit; modifications or improvements which are of an aesthetic value only; and modifications that add to the total square footage of the home. Environmental modifications that are permanent fixtures to rental property require written authorization and release of current or future liability from the property owner.
Specialized medical supplies	Specialized medical equipment and supplies include: 1) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; 2) Such other durable and non-durable medical equipment not available under the State plan that is necessary to address the member's functional limitations and has been deemed medically necessary by the prescribing physician. 3) Necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items not of direct medical or remedial benefit to the member. All items shall meet applicable standards of manufacture, design, and installation. The most cost-effective item should be considered first. Additional supply items are covered as a Waiver service when they are considered essential and medically necessary for home and community care: 1) Nutritional supplements. 2) non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage. 3)Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under state plan are exhausted
Supplemental support service	The supplemental support service helps improve or enable the continuance of community living. Supplemental support service will be based on demonstrated needs as identified in a beneficiary's person-centered service plan as unforeseen problems arise that, unless remedied, could cause disruptions in the beneficiary's services, placement, or place him or her at risk of institutionalization.
Consultation services	Consultation services are clinical and therapeutic services which assist the individual, parents, legally responsible persons, responsible individuals, and service providers in carrying out the member's PCSP and any associated plans that are included in the PCSP. These services are direct in nature. The PASSE will be responsible for maintaining the necessary information to document staff qualifications. Staff who meet the certification criteria necessary for other consultation functions may also provide these activities. These activities include, but are not limited to: 1) Provision of updated psychological and adaptive behavior assessments; allowable providers: psychologist, psychological examiner, speech therapist, physical therapist, occupational therapist with the scope of their practice area. 2) screening assessing and developing CES Waiver services treatment plans; allowable providers: Qualified Developmental Disabled Professional, psychologist, psychological examiner, speech therapist, physical therapist, occupational therapist,

	dietitian, positive behavior support specialist, licensed clinical social worker, professional counselor, registered nurse, certified communication and environmental control specialist, board certified behavior analyst within the scope of their practice area. 3) Training of direct services staff or family members in carrying out special community living services strategies identified in the member's PCSP as applicable to the consultation specialty; 4) Providing information and assistance to the persons responsible for developing the member's PCSP as applicable to the consultation specialty; 5) Participating on the interdisciplinary team, when appropriate to the consultant's specialty; 6) Consulting with and providing information and technical assistance with other service providers or with direct service staff or family members in carrying out the member's PCSP specific to the consultant's specialty; 7)Assisting direct services staff or family members to make necessary program adjustments in accordance with the member's PCSP and applicable to the consultant's specialty; 8) Determining the appropriateness and selection of adaptive equipment to include communication devices, computers, and software consistent with the consultant's specialty; 9) Training or assisting members, direct services staff, or family members in the set up and use of communication devices, computers, and software consistent with the consultant's specialty; 10) Training of direct services staff or family members by a professional consultant in: a) activities to maintain specific behavioral management programs applicable to the member b) activities to maintain speech pathology, occupational therapy, or physical therapy program treatment modalities specific to the member. c) The provision of medical procedures not previously prescribed but now necessary to sustain the members in the community. 11) Training or assisting by advocacy consultants to members and family members on how to self-advocate. 12) Rehabilitation counseling 13) Screening, assessing, and developing positive behavior support plans, assisting staff in implementation, monitoring, reassessment, and plan modifications; A positive behavior support plan is required when high level of behavioral related risk is identified in the PASSE Risk Mitigation Plan. Allowable providers include Psychologist, Psychological Examiners, PBS, BCBA within the scope of their practice area. 14) Training and assisting members, direct services staff or family members in proper nutrition and special dietary needs.

Crisis intervention services	Crisis intervention services are delivered in a geographic area conducive to rapid intervention and can be done in the member's place of residence or other local community site depending on where the behaviors are occurring by a mobile intervention team or professional; available 24 hours a day, 365 days a year. Services targeted to provide technical assistance and training in areas of behavior already identified.
Community transition services	Community transition services are non-recurring set-up expenses for beneficiaries who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the beneficiary or his or her guardian is directly responsible for his or her own living expenses.

All Community and Employment Supports (CES) wavier service must be delivered in accordance with the waiver requirements and consistent with the Division of Disability Services CES Wavier Provider Manual, which is included in the Appendix and incorporated herein.

1915(i) Home and Community Based Waiver (HCBS) services	
Behavior assistance	Behavioral Assistance is an outcome-oriented intervention provided individually or in a group setting with the child/youth and/or his/her caregiver(s) that will provide the necessary support to attain the treatment plan's goals. Services involve applying positive behavioral interventions and support within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance quality of life and strengthen skills in many life domains.
Adult rehabilitative day services	A continuum of care is provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing support and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of

	medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan.
Peer supports	Peer support is a consumer-centered service provided by individuals (ages 18 and older) who self-identify as someone who has or is receiving behavioral health services and thus can provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.), which impact beneficiaries' functional ability. Services are provided on an individual or group basis, and in either the beneficiary's home or community environment.
Family support partners	Family Support Partners is a service provided by peer counselors, or Family Support Partners (FSP), who model recovery and resiliency for caregivers of children or youth with behavioral healthcare needs. Family Support Partners come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency. A FSP may assist, teach, and model appropriate child-rearing strategies, techniques, and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and childcare activities. It may also assist the family in securing community resources and developing natural supports.
Supportive life skills development	**Life skills development** services are designed to assist beneficiaries in acquiring the skills needed to support an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrate accountability, and making goal-directed decisions related to independent living (i.e., educational/vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness, and nutrition).
Child and youth support services	Child and Youth Support Services are clinical, time-limited services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; working with teachers/schools to modify classroom environment to increase positive behaviors in the classroom; and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of their illness and training the parents in effective interventions and techniques for working with the schools. Services might include an In-Home Case Aide. An In-Home Case Aide is an intensive, time-limited therapy for youth in the beneficiary's home or, in rare instances, a community-based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out of-home placement.

	Services may deal with family issues related to the promotion of healthy family interactions, behavior training, and feedback to the family.
Supportive employment	**Supportive employment** is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society. Service settings may vary depending on individual need and level of community integration and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.
Partial hospitalization	Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment equal to an inpatient program but less than 24-hour. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than four days in that week.
Mobile crisis intervention	Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)
Therapeutic communities	Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the people served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual

	within his or her community, and progress is measured within the context of that community's expectation.
Residential community reintegration	The Residential Community Reintegration Program is designed to serve as an intermediate level of care between Inpatient Psychiatric Facilities and Outpatient Behavioral Health Services. The program provides twenty-four hour per day intensive therapeutic care provided in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. The program is also offered as a step-down or transitional level of care to prepare a youth for less intensive treatment. Services include all allowable Outpatient Behavioral Health Services (OBHS) based on the beneficiary's age and any additional interventions to address the beneficiary's behavioral health needs.
Planned and emergency respite services	Respite provides temporary direct care and supervision for a beneficiary in the beneficiary's community that is not facility-based. The primary purpose is relief to the principal caregiver of an individual with a behavioral health need. Respite services de-escalate stressful situations and provide a therapeutic outlet.
Supportive housing	Designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural support in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey**.**

All 1915(i) HCBS services must be delivered in accordance with the waiver requirements and consistent with the Division of Behavioral Health Outpatient Behavioral Health Provider Manual, which is included in the Appendix and incorporated herein.

BH and IDD overview

Behavioral health (BH) and Intellectual and Development Disabilities (IDD) services are covered for the treatment of mental, emotional or substance use disorders and intellectual and developmental disabilities (IDD). In this chapter, we will refer to behavioral health providers and providers specializing in IDD as specialty providers.

We provide coverage of medically necessary services if they are:

- In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health and/or IDD care.
- Furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- The most appropriate level or supply of service that can safely be provided.
- Unable to be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
- Not experimental or investigative.
- Not primarily for the convenience of the member or provider.

For more information about these services, providers should call **844-462-0022** and members should call **844-405-4295**.

Individuals with physical or intellectual and developmental disabilities

Before placement of an individual with a physical disability into an intermediate or long-term care facility, Summit Community Care will assess the needs of the individual and the community as supplemented by other Medicaid services. The Summit Community Care medical director will conduct a second opinion review of the case before placement. If the medical director determines the transfer to an intermediate or long-term care facility is medically necessary and the expected stay will be greater than 30 days, Summit Community Care will obtain approval from DHS before making the transfer.

Providers who treat individuals with physical, intellectual, or developmental disabilities must be trained in special communication requirements of individuals with disabilities. Summit Community Care is responsible for accommodating hearing-impaired members who require and request a qualified interpreter. Summit Community Care can delegate the financial risk and responsibility to providers and is responsible for ensuring members have access to these services.

- Summit Community Care providers must be clinically qualified to provide DME and assistive technology services for both adults and children.
- Summit Community Care informational materials are approved by persons with experience in the needs of members with disabilities, thereby ensuring the information is presented in a way members understand the material, whether on paper or by voice translation.
- Summit Community Care provides training to its triage, Member Services and Case Management staff on the special communications requirements of members with physical disabilities. Summit Community Care will clearly indicate to its providers how this provision is to be implemented

Behavioral health covered services

In addition to services identified above under 1915(i) Home and Community Based Waiver (HCBS) services, the following are covered behavioral health services:

- Psychoeducation
- Multi-family Behavioral Health Counseling
- Mental Health Diagnosis
- Interpretation of Diagnosis
- Substance Abuse Assessment
- Psychological Evaluation
- Pharmacologic Management
- Psychiatric Assessment
- Crisis Intervention
- Acute Crisis Units
- Substance Abuse Detoxification
- Counseling Level Services
- Individual Behavioral Health Counseling
- Group Behavioral Health Counseling
- Marital/Family Behavioral Health Counseling with Beneficiary Present
- Marital/Family Behavioral Health Counseling without Beneficiary Present

- Rehabilitative Level Services
- Pharmacological Counseling by RN
- Assertive Community Treatment
- Therapeutic Host Home
- Recovery Support Partners for Substance Abuse
- Intensive Level Services

Behavioral health access standards

Service type	Maximum time for admission/appointment
Psychiatric inpatient hospital services	24 hours (involuntary)/24 hours (voluntary); travel distance does not exceed 30 minutes by public transportation for at least 98 percent of members.
24-hour psychiatric residential treatment	Within 14 calendar days of receipt of the request for service; if urgent, no later than 72 hours of receipt of the request for service
Outpatient	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service
Intensive outpatient (may include day treatment adult, intensive day treatment children and adolescent or partial hospitalization)	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service
Inpatient facility services (substance use)	24 hours (involuntary)/24 hours (voluntary)
24-hour residential treatment services (substance use)	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service
Outpatient treatment services (substance use)	Within 14 calendar days
Crisis stabilization	Within four hours of referral

Behavioral health prior authorization

We require prior authorization for behavioral health inpatient admissions and certain outpatient services. Behavioral health uses MCG Guidelines criteria, and the following is a list of services that must be prior authorized:

- Inpatient admissions
- Residential admissions
- Non-routine outpatient BH services (i.e., intensive outpatient)
- Routine outpatient BH services for out-of-network providers only
- Partial hospital programs
- Electroconvulsive therapy
- Psychological and neuropsychological testing

Recovery and resiliency

Summit Community Care believes physical and behavioral health services should be rendered in a manner that supports the recovery of persons experiencing mental illness and enhances the development of resiliency of those who are impacted by mental illness, serious emotional disturbance and/or substance use disorder issues. Recovery is a consumer-driven process in which consumers find their paths to work, learn, and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite a disability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement reflect our desire that all behavioral health services be delivered to promote individual recovery and build resiliency. The 10 fundamental components of recovery as elucidated by SAMHSA include:

1. **Self-direction:** Consumers lead, control, exercise choice over and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. The recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
2. **Individualized and person-centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences, experiences (including past trauma) and cultural background in all its diverse representations. Individuals also identify recovery as being an ongoing journey and a result, as well as an overall paradigm for achieving wellness and optimal mental health.
3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives and are educated and supported in so doing. They can join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. **Nonlinear:** Recovery is not a step-by-step process, but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to fully engage in recovery.
6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. **Peer support:** Mutual support including the sharing of experiential knowledge and skills and social learning plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

8. **Respect:** Community, systems and societal acceptance and appreciation of consumers including protecting their rights and eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in oneself are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. **Hope:** Recovery provides the essential and motivating message of a better future- that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process for children and youth that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Services provided to children and youth with serious emotional disturbances and their families should be delivered based on the System of Care Values and Principles endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child centered and family focused with the needs of the child and family dictating the types and mix of services provided.
- Community based with the focus of services as well as management and decision-making responsibility resting at the community level.
- Culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- The guiding principles of a system of care include:
    - Children should have access to a comprehensive array of services that address the child's physical, emotional, social, educational, and cultural needs.
    - Children should receive individualized services in accordance with their unique needs and potential, which is guided by an individualized service plan.
    - Children should receive services within the least restrictive, most normative environment that is clinically appropriate.
    - Children should receive services that are integrated, with linkages between child serving agencies and programs and mechanisms for planning, developing, and coordinating services.
    - Children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family.
    - Children should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics.

Telehealth

Virtual services are telemedicine, telehealth, e-consulting, and provider home visits that are part of a patient care treatment plan and are provided at the individual's home or in a community setting. These services are provided using mobile secure telecommunication devices, electronic monitoring equipment, and include clinical provider care, behavioral health therapies, speech, occupational and physical therapy services, and treatment provided to an individual at their residence.

Source: PASSE Program, Sec. II, p. 8-9, (3/1/19).

Telemedicine is defined as the use of electronic information and communication technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. Telemedicine includes store-and-forward technology and remote patient monitoring.

For a telemedicine encounter to be covered by Medicaid, the practitioner and the patient must be able to see and hear each other in real time.

*Source: **AR Medicaid Provider Manual. Section I General Policy. Rule 105.190. Updated Aug. 1, 2018***

Arkansas Medicaid provides payment to a licensed or certified healthcare professional or a licensed or certified entity for services provided through telemedicine if the service provided through telemedicine is comparable to the same service provided in-person.

Coverage and reimbursement for services provided through telemedicine will be on the same basis as for services provided in-person. While a distant site facility fee is not authorized under the Telemedicine Act, if reimbursement includes payment to an originating site (as outlined in the above paragraph), the combined amount of reimbursement to the originating and distant sites may not be less than the total amount allowed for healthcare services provided in-person.

Source: ***AR Medicaid Provider Manual. Section I General Policy. Rule 105.190. Updated Aug. 1, 2018. (Accessed Dec. 2020).***

Telehealth can connect a provider's office to a **specialty center** by:

- **Live video consult**: The PCP and specialist meet at the same time using HIPAA compliant video conferencing technology.
- Telehealth offers multiple benefits to providers and members:
    - The members can continue to be cared for by their local provider.
    - The member does not need to travel long distances to receive specialist care.
    - The PCP receives all records and test results from the encounter.
    - The PCP consults with the specialist participating in the telehealth encounter to design any necessary course of treatment.

Telehealth can also be used for nonclinical consults such as community services, continuing medical education and other provider training sessions.

To find out more about telehealth, or for contracting questions, please call Provider Services at **844-462-0022**.

Service standards

- **Access** — Summit Community Care pays for telehealth care services delivered by care providers contracted with the health plan. The telehealth providers must confirm member eligibility every time members access virtual visits, like in-person visits.

- **Staffing Credentials** — All professional staff are certified or licensed in their specialty or have a level of certification, licensure, education and/or experience in accordance with state and federal laws.
- **Staff Orientation and Ongoing Training** — The telehealth providers must comply with all applicable state, federal and regulatory requirements relating to their obligations under contract with Summit Community Care. Telehealth providers must participate in initial and ongoing training programs including policies and procedures.
- **Service Response Time** — The telehealth provider will comply with the response time requirements outlined in their contract.
- **Compliance and Security** — The telehealth platform should be HIPAA compliant and meet state, federal and 508 compliance requirements. The telehealth providers will conduct all member Virtual Visits via interactive audio video telecommunications systems using a secure technology platform and will maintain member records in a secure medium, which meets state and federal law requirements for security and confidentiality of electronic patient information.
- **Certification** — Summit Community Care strongly encourages providers to obtain CHIQ, URAC or ATA accreditation.
- **Continuous Quality Improvement (CQI)** — The telehealth providers must have a documented CQI program for identifying through data opportunities for real, time measured improvement in areas of core competencies. There must be demonstrated ties between CQI findings and staff orientation, training, policies, and procedures.
- **Member Complaints** — The telehealth providers are not delegated for complaint resolution but will log, by category and type, member complaints and should refer member complaints to the National Call Center.
- **Regulatory Assessment Results** — Summit Community Care reserves the right to request access to any applicable regulatory audit results.
- **Utilization** — The telehealth provider will comply with the reporting requirements outlined in their contract.
- **Electronic Billing/Encounter Coding** — The telehealth provider will submit Virtual Visit encounters or claims with proper coding as part of its existing encounter submission process.
- **Eligibility Verification** — The telehealth provider will use existing eligibility validation methods to confirm Virtual Visit benefits.
- **Case Communication** — The telehealth provider will support patient records management for Virtual Visits using existing EMR systems and standard forms. Its EMR records should contain required medical information including referrals and authorizations.
- **Joint Operating Committee** — The telehealth provider will participate in Joint Operations Meetings (JOM) or similar committees with the health plan to review data reports, quality issues, and address any administration issues at least quarterly if applicable.
- **Professional Environment** — The telehealth provider will help ensure that, when conducting Virtual Visits with members, the rendering care provider is in a professional and private location. The telehealth provider (rendering care providers) will not conduct member Virtual Visits in vehicles or public areas.
- **Medical Director —** The telehealth provider will employ or engage a licensed care provider as medical director. The medical director is responsible for clinical direction.

Eligible Providers:

A healthcare provider treating patients in Arkansas through telemedicine shall be fully licensed or certified to practice in Arkansas and is subject to the rules of the appropriate state licensing or

certification board. The professional or entity at the distant site must be an enrolled Arkansas Medicaid Provider.

Source:
AR Medicaid Provider Manual. Section I General Policy. Rule 105.190. Updated Aug. 1, 2018. (Accessed Dec. 2020).

Virtual care can include an interdisciplinary care team or be provided by individual clinical service providers.

Source:
PASSE Program (3/1/19), Sec. II-9 (Accessed Dec. 2020).

Provider rendering telehealth services must comply with all credentialing requirements stipulated in their Provider Agreements.

Live Video Eligible Sites

Patient-Led Arkansas Shared Savings Entity (PASSE) Program
Virtual and telehealth services can be provided at the individual's home or in a community setting. The following activities will not be considered a reportable encounter when delivered to a member of the PASSE:

- Audio-only communication including without-limitation, interactive audio;
- A fax machine;
- Text messaging; or
- Electronic mail systems

Virtual and telehealth services are provided in lieu of providing the same services at a practice site or provided at the individual's place of residence. Therefore, these services must have patient consent, documented in the patient integrated medical records, and submitted as a claims or encounter from a contracted provider as medically necessary service.
***Source:* *PASSE Program, p. II-9, (3/1/19). (Accessed Dec. 2020)*.**

All laws regarding the privacy, security and confidentiality of healthcare information and a patient's rights to his or her medical information and personal information shall apply to Telehealth interactions. This section shall not be construed to alter the scope of practice of any healthcare provider or authorize the delivery of healthcare services in a setting, or in a manner, not otherwise authorized by law. Telehealth services are used to support healthcare when the provider and patient are physically separated. Typically, the patient communicates with the provider via interactive means i.e. live audio/video feed. Participating Providers and Facilities shall be solely responsible for ensuring the security and privacy of their interactive audio/video platform. Such platform must at a minimum include technical, administrative and physical safeguards to ensure that all information pertaining to covered members is protected in accordance with applicable law utilizing controls equivalent to those necessary for compliance with the *Health Insurance Portability and Accountability Act ("HIPAA")*. Provider rendering telehealth services must comply with all credentialing requirements stipulated in their Provider Agreements.

Member records and treatment planning for behavioral health

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

- Information related to the provision of appropriate services to a member must be included in his or her record to include documentation in a prominent place whether there is an executed declaration for mental health treatment.
- For members in the priority population, a comprehensive assessment describes the consumer's physical and mental health status at the time of admission to services. This comprehensive assessment covers:
  - A psychiatric assessment that includes:
    - Description of the presenting problem.
    - Psychiatric history and history of the member's response to crisis situations.
    - Psychiatric symptoms.
    - Diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM).
    - Mental status exam.
    - History of alcohol and drug abuse.
  - A medical assessment that includes:
    - Screening for medical problems.
    - Medical history.
    - Present medications.
    - Medication history.
  - A substance use assessment that includes:
    - Frequently used over-the-counter medications.
    - Alcohol and other drugs and history of prior alcohol and drug treatment episodes.
    - History reflects the impact of substance use in the domains of community functioning assessment.
  - A community functioning assessment or an assessment of the member's functioning in the following domains:
    - Living arrangements, daily activities (vocational/educational)
    - Social support
    - Financial
    - Leisure/recreational
    - Physical health
    - Emotional/behavioral health
    - An assessment of the member's strengths, current life status, personal goals and needs
    - Use of social determinants of health language in treatment plan assessment of members needs
  - A patient-centered, wellness-oriented care plan, which is based on the psychiatric, medical, substance use, and community functioning assessments listed above, must be completed for any member who receives behavioral health services.
- The patient-centered care plan must be completed within the first 14 days of admission to behavioral health services and updated every 90 days, or more frequently as necessary based on the member's progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.

- There must be documentation in every case that the member and, as appropriate, his or her family members, caregivers, or legal guardian, participated in the development and subsequent reviews of the treatment plan.
- For providers of multiple services, one comprehensive treatment/care/support plan is acceptable if at least one goal is written and updated as appropriate for each of the different services being provided to the member.
- The treatment/support/care plan must contain the following elements:
  - Identified problem(s) for which the member is seeking treatment
  - Member goals related to problem(s) identified, written in member-friendly language
  - Measurable objectives to address the goals identified
  - Target dates for completion of objectives
  - Responsible parties for each objective
  - Specific measurable action steps to accomplish each objective
  - Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts that can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
  - Signatures of the member as well as family members, caregivers, or legal guardian as appropriate
  - Clinical progress notes written to document status related to goals and objectives indicated on the treatment plans
  - Correspondence concerning the member's treatment and signed and dated notations of telephone calls concerning the member's treatment
- A brief discharge summary must be completed within 15 calendar days following discharge from services or death.
- Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services should also be included.
- Summit Community Care will monitor provider compliance with treatment plan requirements through medical record reviews or other measures. Providers who do not meet the goal of 100% compliance with treatment plan requirements may be subject to corrective action and may be asked to submit a plan for meeting the 100% requirement.

Behavioral health emergency services

Behavioral health emergency services are those services that are required to meet the needs of an individual who is experiencing an acute crisis resulting from a mental illness, which is at a level of severity that would meet the requirements for involuntary examination and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Examples of behavioral health and alcohol and drug abuse emergency medical conditions are when:

- The member is suicidal.
- The member is homicidal.
- The member is violent with objects.
- The member has suffered a precipitous decline in functional impairment and cannot take care of his or her daily activities.
- The member is alcohol- or drug-dependent and there are signs of severe withdrawal.

In the event of a behavioral health and/or alcohol and drug abuse emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or behavioral health and alcohol and drug abuse crisis service facility. An emergency dispatch service or 911 should be contacted if the member is a danger to themselves or others and cannot go to an emergency setting.

Behavioral health medically necessary services

Summit Community Care defines medically necessary behavioral health services as those that are:

- Reasonably expected to prevent the onset of an illness, condition or disability; reduce or ameliorate the physical, behavioral or developmental effects of an illness, condition, injury or disability; and assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities appropriate for members of the same age.
- Reasonably expected to provide an accessible and effective course of treatment or site of service that is equally effective in comparison to other available, appropriate, and substantial alternatives and is no more intrusive or restrictive than necessary.
- Sufficient in amount, duration, and scope to achieve their purpose as defined in federal law.
- Of a quality that meets standards of medical practice and/or healthcare accepted at the time services are rendered.

Restrictive interventions in an HCBS setting

Members have a right to have safeguards in place to prevent restrictive interventions. As such, Summit Community Care promotes these guidelines concerning the use of restraints, seclusion, and restrictive intervention:

- Physical restraints (i.e., use of a staff member's body to prevent injury to the member or another person) are allowed in cases of emergency; an emergency exists for any of the following conditions:

The members have not responded to de-escalation techniques and continue to escalate behavior.
The member is a danger to self or others.
The safety of the members and those nearby cannot be assured through positive reinforcement.

- The member must be continuously under direct observation of staff members during any use of restraints.
- If the use of personal restraints occurs more than three times per month, use should be discussed by the interdisciplinary team, which is made up of the physician and both clinical and direct care staff and addressed in the person-centered support plan (PCSP).
    - When emergency procedures are implemented, PCSP revisions including but not limited to: 1) psychological counseling, 2) review of medications with medication change or 3) a change in environmental stressors that are noted to precede escalation of behavior may be implemented.
- For members in an HCBS setting, use of mechanical or chemical restraint or seclusion is not allowed.
- Providers must not allow maltreatment or corporal punishment (i.e., the application of painful stimuli to the body to terminate behavior or as a penalty for behavior) of members. Providers' policies and procedures must state that corporal punishment is prohibited.
- Restrictive interventions cannot include:

- Aversion techniques.
- Restrictions to a member's rights, including the right to physically leave.
- Mechanical or chemical restraints.
- Seclusion.

All use of restraint must be documented in the member's case record, including the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event. Use of restrictive interventions also requires submission of an incident report no later than the end of the second business day following the incident.

These interventions might be implemented to deal with aggressive or disruptive behaviors related to the activity or possession. Please note, before implementing absence from a specific social activity or temporary loss of personal possession, the member must first be counseled about the consequences of the behavior and the choices they can make.

Providers must train staff, families, and the members to recognize and report unauthorized use of restrictive interventions. All personnel involved in restrictive interventions must receive training in behavior management techniques and abuse and neglect laws, rules, regulations and policies. The personnel must be qualified to perform, develop, implement, and monitor or provide direction intervention as applicable.

Before the use of restraints or restrictive interventions, a written behavior management plan must be developed to ensure the rights of members. The plan must:

- Include a provision for alternative methods to avoid the use of restraints and seclusions.
- Be written or supervised by a qualified professional.
- Be designed so that the rights of the members are protected.
- Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation or put the member at medical risk.
- Specify the length of time the restraint or restrictive intervention is to be used, who will authorize the use of restraint or seclusion, and the methods for monitoring the member.

Claims submissions & adjudication

Provider reimbursement

Reimbursement policies serve as a guide to assist you with accurate claim submissions and to outline the basis for reimbursement if the services are covered by the member's Summit Community Care plan. Services must meet authorization and medical necessity guidelines appropriate to the procedures and diagnoses, and Arkansas regulations. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claims submissions. Services should be billed with Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, Summit Community Care policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Summit Community Care may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Summit Community Care reimbursement policies are based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent loading some policies in the same manner described; however, Summit Community Care strives to minimize these variations.

Reimbursement hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodology are conditions of payments.

Review schedule and updates

Reimbursement policies undergo review for updates to state contracts, federal, CMS requirements and/or a Summit Community Care business decision. Summit Community Care reviews and revises policies when necessary. The most current policies are available on the provider website at **https://www.summitcommunitycare.com/provider**.

Reimbursement by code definition

Summit Community Care allows reimbursement for covered services based on their procedure code definition, or descriptor, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state, federal or CMS contracts and/or requirements.

1. Evaluations and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services, or procedures

Claim submission

Claims must be submitted according to timely filing guidelines and include all necessary information outlined in the following sections. In addition, all codes used in billing must be supported by appropriate medical record documentation.

Paper claim submission

Summit Community Care encourages electronic claim submission; however, providers have the option to submit paper claims. Summit Community Care utilizes optical character recognition (OCR) technology as part of its front-end claims processing procedures. The benefits of this technology include:

- Faster turnaround times and adjudication.
- Claim status availability within five days of receipt.
- Immediate image retrieval by Summit Community Care staff for claims information, enabling more timely and accurate responses to provider inquiries.

To use OCR technology, claims must be submitted on original, red claim forms (not black and white or photocopied forms) that are laser-printed or typed (not handwritten) in large, dark font. Providers must submit a properly completed *UB-04* or *CMS-1500 (08-05)* claim form within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date Summit Community Care receives notification from DHS of the member's eligibility/enrollment.

In accordance with the implementation timelines set by CMS, the National Uniform Claim Committee (NUCC) and the National Uniform Billing Committee (NUBC), Summit Community Care requires the use of the new *CMS-1500 (08-05)* form for the purpose of accommodating the NPI.

CMS-1500 (08-05) and *UB-04 CMS-1450* claim forms must include the following information prior to the state becoming compliant with the NPI federal rule. Summit Community Care has aligned its NPI and taxonomy code requirements with the state's (HIPAA-compliant where applicable):

- Member's name
- Member's ID number
- Member's date of birth
- Provider name according to contract
- Provider tax ID number and state Medicaid ID number
- Summit Community Care provider number
- NPI of billing provider when applicable
- Date of service
- Place of service
- ICD-10 diagnosis code/revenue codes
- Procedures, services, or supplies rendered, CPT-4 codes/HCPCS codes/diagnosis related groups (DRGs) with appropriate modifiers, if necessary
- Itemized charges
- Days or units
- Modifiers as applicable
- Coordination of benefits (COB) and/or other insurance information
- The prior authorization number or copy of the prior authorization
- Name of referring provider
- NPI of referring provider when applicable
- Any other state-required data

Summit Community Care cannot accept claims with alterations to billing information. Summit Community Care does not accept computer-generated or typewritten claims with information marked through, handwritten, or covered by correction fluid or tape. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Paper claims must be submitted to:
Summit Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010

Please note: AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code.

Electronic claim submission – Electronic Data Interchange (EDI)

Summit Community Care prefers the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services.

Summit Community Care uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers and employers to do business.

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Ways you can use the Availity EDI Gateway

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – **www.availity.com** > Provider Solutions > EDI Clearinghouse.
- Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway).

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's

important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity at **800-AVAILITY (800-282-4548)**.

Availity's Payer IDs

Payer IDs ensures your EDI submissions are routed correctly when received by Availity.
Payer ID: PASSE

Note: *If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.*

Electronic Remittance Advice (835)

Use Availity to register and manage ERA account changes with these three easy steps:

1. Log in to Availity at www.availity.com
2. Select **My Providers**
3. Click on **Enrollment Center** and select **Transaction Enrollment**

Note: *If you use a clearinghouse, billing service or vendor, please work with them on ERA registration.*

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.
Use Enroll Safe (https://enrollsafe.payeehub.org/) to register and manage EFT account changes.
Contact Availity
Please contact Availity Client Services with any questions at **800-Availity (800-282-4548)**

EDI Submission for Corrected Claims

For corrected electronic claims the following frequency code:

- Replacement of prior claim

EDI segments required:
- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

Useful EDI Documentation

Availity EDI Connection Service Startup Guide - This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.

Availity EDI Companion Guide - This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.

Availity Registration Page - Availity register page for users new to Availity.

Washington Publishing Company - X12 code descriptions used on EDI transactions.

CMS-1500 (08-05) claim form

Healthcare practitioners and other persons entitled to reimbursement must use the *CMS-1500 (08-05)* form and instructions provided by CMS for use of the *CMS-1500 (08-05)* as the sole instrument for filing claims with Summit Community Care for professional services. This does not apply to dental services billed by dentists using the *J 512 Form* or its equivalent or pharmacists or pharmacies filing claims for prescription drugs.

Except for parties to a global contract, Summit Community Care may not require a healthcare practitioner or other person entitled to reimbursement to use any code or modifier to file claims for healthcare services different from, or in addition to, what is required under the applicable standard code set for the professional services provided.

Except as noted, Summit Community Care may not use and may not require a healthcare practitioner or other person entitled to reimbursement to use another descriptor with a code or to furnish additional information with the initial submission of a *CMS-1500 (08-05)* that is different from, or in addition to, the applicable standard code set for the professional services provided.

A healthcare practitioner or other person entitled to reimbursement whose billing is based on the amount of time involved will indicate the start and stop time or number of minutes in Field 24G, currently titled Day or Units, of the *CMS-1500 (08-05)* if it is not used to specify the number of days of treatment.

This form is available at **www.cms.hhs.gov**.

UB-04 claim form

Hospitals or persons entitled to reimbursement must use the *UB-04*, and instructions provided by CMS for use of the *UB-04*, as the sole instrument for filing claims with Summit Community Care for hospital and other healthcare services.

Except for parties to a global contract, Summit Community Care may not use and may not require a hospital or other person entitled to reimbursement to use any code or modifier for the filing of claims for hospital and other healthcare services that is different from, or in addition to, what is required under the applicable standard code set for hospital or other healthcare services provided.

Except as noted, Summit Community Care may not use and may not require a hospital or other person entitled to reimbursement to furnish additional information with the initial submission of a

UB-04 that is different from, or in addition to, the applicable standard code set for the hospital or other healthcare services provided.

This form is available at **www.cms.hhs.gov**.

Claim form attachments

Summit Community Care requires the following attachments for a claim to qualify as a clean claim:

- Explanation of benefits statement from the primary payer to the secondary payer unless an electronic remittance notice has been sent by the primary payer to the secondary payer. For eligible members with dual **Commercial insurance** and Medicaid coverage, Summit Community Care maintains a *Commercial Insurance Bypass List* that identifies service codes for which no third-party liability (TPL) information will be required.
- Medicare remittance notice if the claim involves Medicare as a primary payer, and Summit Community Care provides evidence it does not have a crossover agreement to accept an electronic remittance notice. For eligible members with dual Medicare and Medicaid coverage, Summit Community Care maintains a *Medicare Third Party Bypass List** that identifies service codes for which no TPL information will be required.
- Description of the procedure or service which may include the medical record, if a procedure or service rendered has no corresponding CPT or HCPCS code
- Operative notes if the claim is for multiple surgeries or includes modifier 22, 58, 62, 66, 78, 80, 81 or 82
- Anesthesia records documenting time spent on the service if the claim for anesthesia services rendered includes modifiers P4 or P5
- Documents referenced as contractual requirements in a global contract (if applicable)
- Ambulance trip report if the claim is for ambulance services submitted by an ambulance company licensed by the state Emergency Medical Services Systems
- Office visit notes if the claim includes modifiers 21 or 22
- Information related to an audit as specified in writing by Summit Community Care if the Summit Community Care audit demonstrated a pattern of fraud, improper billing, or improper coding
- Admitting notes, if the claim is for inpatient services provided outside of the time or scope of the authorization
- Physician notes, if the claim for services provided is outside of the time or scope of the authorization or if the authorization is in dispute
- Itemized bills, if the claim is for services rendered in a hospital, and the hospital claim has no prior authorization for admission or the claim is for services inconsistent with the Summit Community Care concurrent review determination rendered before the delivery of services regarding the medical necessity of the service

Adjunct claims documentation

The following are permissible categories of disputed claims for which Summit Community Care may request additional information:

- If there is no authorization or a prior authorization and Summit Community Care disputes that the claim is consistent with the basis for denial or because the claim is for services provided outside the time or scope of the authorization and the applicable attachment was not submitted with the claim
- Eligibility for benefits or coverage
- Necessity of a service, procedure or DME rendered or provided by a specialist and not requested by a network PCP on a referral form or consultant treatment plan
- Information necessary to adjudicate the claim consistent with the global contract
- Reasonable belief of incorrect billing
- Additional information not obtained by Summit Community Care from the member within 30 days of receipt of the claim
- Legibility of the claim in a material manner
- Reasonable belief of fraudulent or improper coding, consistent with the Summit Community Care retroactive denial
- Reasonable belief that a claim for emergency service may not meet the standards for an emergency service
- Category approved by the commissioner by regulation

Summit Community Care may not request additional information if an attachment containing the same type of information was submitted with the claim.

Summit Community Care may not request additional information for the following categories of disputed claims:

- Except for global contracts, a description of the procedure or service that is inconsistent with the applicable standard code set
- Reimbursement for hospital services in accordance with the rates approved by the Health Services Cost Review Commission
- Services that were prior authorized by Summit Community Care

A **clean claim** is defined as a claim for reimbursement submitted to Summit Community Care by a healthcare practitioner, pharmacy or pharmacist, hospital or person entitled to reimbursement that contains the required data elements and any attachments requested by Summit Community Care.

An **applicable code set** is defined as the most recent version, as of the date of service, of the following:

- For services rendered by healthcare practitioners, the Current Procedural Terminology (CPT) maintained and distributed by the American Medical Association, including its codes and modifiers and codes for anesthesia services
- For dental services, the Code on Dental Procedures and Nomenclature (CDT), maintained and distributed by the American Dental Association
- For all professional and hospital services, the International Classification of Diseases, Clinical Modification (ICD-10 CM)
- For all other health-related services, the CMS' HCPCS levels I and II and modifiers, maintained and distributed by the U.S. Department of Health and Human Services

- For prescribed drugs, the National Drug Codes (NDC), maintained and distributed by the U.S. Department of Health and Human Services
- For anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists
- For psychiatric services, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-V*) codes, distributed by the American Psychiatric Association
- For hospital and other applicable healthcare services including home health services, the state *UB-04 Uniform Billing Data Elements Specification Manual*
- For hospital services pursuant to a Maryland contract or insurance policy, a revenue code approved by the Health Services Cost Review Commission for a hospital located in the state or by the National or State Uniform Billing Data Elements Specifications for a hospital not located in the state

An **auto code** is defined as an ICD-10 code designed by Summit Community Care as a diagnosis that is an emergency service.

A **modifier** is defined as a code appended to a CPT or HCPCS code to provide more specific information about a medical procedure.

For a paper claim, Summit Community Care will date-stamp the claim with the date received or assign a batch number to the electronic claim that includes the date received. Summit Community Care will maintain a written or electronic record of the date of receipt of a claim. If a provider requests verification, Summit Community Care will provide verification of the date of claim receipt within five working days. The claim is presumed to have been received by Summit Community Care within three working days from the date the provider placed the claim in the U.S. mail if the provider maintains the stamped certificate of mailing for the claim or on the date recorded by the courier if the claim was delivered by courier.

Summit Community Care utilizes auto codes to determine emergency services and provides them to all network practitioners or hospitals rendering emergency services and to all healthcare practitioners or hospitals rendering emergency services that request the auto codes. If the auto codes are updated, the codes will be distributed 30 days prior to implementation.

International Classification of Diseases, 10th Revision (ICD-10) description

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although the term ICD-10 is often used alone, there are two parts to ICD10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

Encounter data

Providers must submit encounter data within the timely filing periods outlined in the **Claims Adjudication** section of this manual through EDI submission methods or *CMS-1500 (08-05)* or *1450/UB-04* claim forms. Include the following information in submissions:

- Member name (first and last name)
- Member ID
- Member date of birth
- Provider name according to contract
- Summit Community Care provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)
- Provider tax ID number
- NPI/API number

Summit Community Care will not reimburse providers for items received free of charge or items given to members free of charge.

Providers must use *HIPAA*-compliant billing codes when billing or submitting encounter data. This applies to both electronic and paper claims. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims or covered services.

Providing after-hours care in an office setting helps reduce inappropriate emergency room use and encourages members to receive appropriate follow-up care. To promote greater access for members, Summit Community Care encourages PCPs to provide efficient quality care in an office setting and will reimburse wellness visits and sick visits billed on the same day.

HEDIS® outcomes are also collected through claim and encounter data submissions. This includes but is not limited to:

- Preventive services (for example, childhood immunization, mammography, and Pap smears).
- Prenatal care (for example, the number and frequency of prenatal visits).
- Acute and chronic illness (for example, ambulatory follow-up and hospitalization for major disorders).

Compliance is monitored by Summit Community Care Utilization and Quality Improvement staff, coordinated with the medical director, and reported to the quality management committee annually. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and may result in termination.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Encounter data for capitated providers

Summit Community Care maintains a system to collect member encounter data. All capitated providers and/or sites must report all member encounters. This is a key component of the Summit Community Care information system, and electronic reporting is encouraged. Failure to submit accurate and timely

reports may result in corrective action up to and including termination of the *Participating Provider Agreement*.

If a provider is capitated, they will receive a monthly check based on factors (e.g., member's age, gender, number of members in provider's panel) including payment for all capitated services rendered.

Due to reporting needs and requirements, Summit Community Care network providers reimbursed by capitation must send encounter data to Summit Community Care for each member encounter. This is done through the CMS-1500 (08-05) claim form. Data must be submitted in a timely manner. Failure to provide information can result in delayed capitation payment.

Additional documentation required for DD and behavioral health services

Additional documentation may be required for services delivered through the CES waiver, intermediate care facilities and various behavioral health services. Providers must comply with all data collection and reporting requirements promulgated by the Office of Long-Term Care, the Division of Developmental Disabilities and the Division of Behavioral Health.

Summit Community Care appreciates that the need for multiple agencies to receive and maintain information for federal program compliance and will collaborate closely with providers and these agencies to simplify documentation requirements and information sharing where feasible.

Claims adjudication/timely filing

Summit Community Care provides timely adjudication of claims. Summit Community Care processes all claims according to accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals. Providers must use *HIPAA*-compliant billing codes when billing on paper or electronically. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims. Summit Community Care will reject claims submitted with noncompliant billing codes. Summit Community Care uses code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

Paper and electronic claims must be filed within 365 calendar days. Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/physician services. Secondary and tertiary claims submitted for payment must be submitted within 180 days from the payment date from Medicare or the third-party payer. Timely filing requirements are defined in the provider agreement. Summit Community Care will deny claims submitted after the filing deadline.

Documentation of timely claim receipt

Claims will be considered timely if submitted:

- By United States mail first class, return receipt requested or by overnight delivery service; you must provide a copy of the claim log that identifies each claim included in the submission
- Electronically; you must provide the clearinghouse-assigned receipt date from the reconciliation reports
- By hand delivery; you must provide a claim log identifying each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery

The claims log maintained by providers must include the following information:

- Name of claimant
- Address of claimant
- Telephone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Name of carrier
- Designated address
- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Patient name
- Date(s) of service/occurrence
- Total charge
- Delivery method

Good cause

If a claim or claim dispute was filed untimely, you have the right to include an explanation and/or evidence explaining the reason for delayed submission. Summit Community Care will contact you for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claim filing is delayed due to:

- Administrative error due to incorrect or incomplete information furnished by official sources (e.g., carrier, intermediary, CMS) to the physician or supplier.
- Incorrect information furnished by the member to the physician or supplier resulting in erroneous filing with another care management organization plan or with the state.
- Delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence.
- Unusual, unavoidable, or other circumstances beyond the service provider's control that demonstrate the physician or supplier could not be expected to file timely.
- Destruction or other damage of the physician's or supplier's records unless such destruction or other damage was caused by the physician's or supplier's willful act of negligence.

Coordination of benefits

Summit Community Care follows state-specific guidelines and all federal regulations when coordination of benefits is necessary with other health insurance (OHI), third-party liability (TPL), medical subrogation or estate recovery. Summit Community Care uses covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members.

OHI and TPL refer to any individual, entity or program that may be liable for all or part of a member's health coverage. The state is required to take all reasonable measures to identify legally liable third parties and treat verified OHI and TPL as a resource of each plan member.

Summit Community Care takes responsibility for identifying and pursuing OHI and TPL for members and puts forth best efforts to identify and coordinate with all third parties against whom members may have

claims for payments or reimbursements for services. These third parties may include Medicare or any other group insurance, trustee, union, welfare, employer organization or employee benefit organization, including preferred provider organizations or similar type organizations, any coverage under governmental programs, and any coverage required to be provided for by state law.
When OHI or TPL resources are available to cover the costs of trauma-related claims and medical services provided to Medicaid members, Summit Community Care will reject the claim and redirect providers to bill the appropriate insurance carrier (unless certain pay-and-chase circumstances apply — see below). Or, if Summit Community Care does not become aware of the resource until after payment for the service was rendered, Summit Community Care will pursue post payment recovery of the expenditure. Providers must not seek recovery more than the Medicaid payable amount.

Pay-and-chase circumstances include:

- Prenatal care for pregnant women, including services which are part of a global OB package.
- Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program.
- Services covered by third-party liability derived from an absent parent whose obligation to pay support is enforced by Child Support Enforcement.

The Summit Community Care subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.

For questions regarding paid, denied, or pended claims, call Provider Services at **844-462-0022**.

Provider claims/payment dispute process

To learn how to submit a claim payment dispute using Availity, sign up for a scheduled webinar or listen to a recorded session:

1. Log in to the Availity Portal > Help & Training > Get Trained.
2. Search the catalog for the term *appeal* to find a listing of the scheduled webinars. Select the date that you wish to register for and then select **Enroll** in the top right-hand corner.
    - To access a recorded session, when you search for the term *appeal*, you'll see the *On-Demand* and *Training Demo* courses at the bottom of the search results. Select the course and then select **Enroll**.

By leveraging Availity for claim payment disputes, providers can:

- Submit disputes through the Availity Essentials any time of the day.
- Send supporting documentation.
- Check the status of a claim payment dispute.
- View claim payment dispute history.
- Download a copy of the dispute outcome letter.
- Indicate there are multiple claims tied to the same issue on one submission, reducing the number of disputes to submit.

Please note: Claim payment disputes that are submitted with multiple claims tied to one issue will be reviewed and processed. If there are multiple claims tied to multiple issues on one dispute submission, the claim payment disputes will be rejected.

Providers claim payment dispute process

If you disagree with the outcome of a claim, you may begin the provider payment dispute process. The simplest way to define a claim payment dispute is the claim is finalized, but you disagree with the outcome.

Please be aware there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we have defined them briefly here:

1. **Claim inquiry**: a question about a claim but not a request to change a claim payment
2. **Claims correspondence**: occurs when Summit Community Care requests further information to finalize a claim — typically includes medical records, itemized bills, or information about other insurance a member may have
3. **Medical necessity appeals**: a pre-service appeal for a denied service in which a claim has not yet been submitted

The provider payment dispute process consists of two internal steps and a third external step. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim payment appeal:** This is the second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. **State fair hearing:** Arkansas Medicaid supports an external review process if you have exhausted both steps in the payment dispute process but still disagree with the outcome. **Note**: Providers should complete both the dispute and/or appeal defined herein **prior to** filing for a state fair hearing with Arkansas Medicaid.

Providers may submit a claim payment dispute for multiple reason(s), including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues. *

* We will consider reimbursement of a claim denied for failure to meet timely filing upon receipt of either 1) documentation the claim was submitted within the timely filing requirements or 2) documentation that claim submission resulted from provider's reasonable efforts to determine the extent of liability.

Claim payment reconsideration
The first step in the claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. **Note:** We cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through the Availity Portal within 90 business days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 90 business days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, the appropriate clinical professionals will review.
We will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to decide, the determination date may be extended by 30 additional calendar days. We will mail a written extension letter before the expiration of the initial 30 calendar days.

We will send our decision in a determination letter, which will include:
- A statement of the provider's reconsideration request.
- A statement of what action Summit Community Care intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.
- An explanation of the provider's right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter.
- The address of where to submit the claim payment appeal.
- A statement that the completion of the claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Claim payment appeal
If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. **Note**: We cannot process a claim payment appeal without a reconsideration on file.

We accept claim payment appeals in writing within 30 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 30 calendar days after the claims reconsideration determination letter will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Summit Community Care professionals.

Summit Community Care will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to decide, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:
- A statement of the provider's claim payment appeal request.
- A statement of what action Summit Community Care intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.
- A statement about how to submit a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to submit a claim payment dispute
To file a claim payment dispute:
- **Verbally (for reconsiderations only):** Call Provider Services at **844-462-0022**.
- **Online (for reconsiderations and claim payment appeals):** Use the secure provider Availity Appeal application at **https://www.availity.com**.* Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission.

  Locate the claim you want to dispute on Availity using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request**" to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.

  For Appeals, your Availity Essentials user account will need the Claim Status role. To Send Attachments from Claim Status, you will need the Medical Attachments role.

- **In writing (for reconsiderations and claim payment appeals):** Mail all required documentation (see below for more details), including the *Claim Payment Appeal Form* or the *Reconsideration Form,* to:

  Payment Dispute Unit
  Summit Community Care
  P.O. Box 62429
  Virginia Beach, VA 23466-2429

  Submit reconsiderations on the *Reconsideration Form* or written claim payment appeals on the *Claim Payment Appeal Form*. To access these forms, visit **https://provider.summitcommunitycare.com/arkansas-provider/forms**.

Required documentation for claims payment disputes
Summit Community Care requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):
- Your name, address, phone number, email address, TIN and NPI (or Arkansas Medicaid ID number, **whichever number is registered with Arkansas Medicaid**)

- The member's name and their Summit Community Care or Medicaid ID number
- A listing of disputed claims, which should include the Summit Community Care claim ID number(s) and the date(s) of service(s)
- All supporting statements and documentation

Claim inquiries
A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps with claim inquiries. Just call **844-462-0022** and choose the *Claims* prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim correspondence
Claim correspondence is different than a payment dispute. Correspondence occurs when Summit Community Care requires more information to finalize a claim. Typically, Summit Community Care makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Summit Community Care will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them. **Type of issue**	**What do I need to do?**
Electronic Data Interchange (EDI) Rejected claim(s)	Please contact Availity Client Services with any questions at **800-Availity (1-800-282-4548)**
EOP requests for supporting documentation (sterilization/ hysterectomy/abortion consent forms, itemized bills and invoices)	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429**
EOP requests for medical records	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429**

	Virginia Beach, VA 23466-2429
Need to submit a corrected claim due to errors or changes on the original submission	**Option 1:** Submit the correct claim via the Availity Portal by selecting *7 – Replacement Claim* in the *Billing Frequency* field under *Claims Information*. **Option 2:** Submit a *Claim Correspondence Form* and your corrected claim to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429** Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received in a timely manner, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Summit Community Care to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOP*.

Type of issue	**What do I need to do?**
Submission of coordination of benefits (COB)/third-party liability (TPL) information	**Option 1:** Dispute the claim via the Availity Portal and include the *EOP* and/or COB/TPL information as an attachment. **Option 2**: Submit a *Claim Correspondence Form*, a copy of your *EOP* and the COB/TPL information to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429**

Medical necessity appeals

Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process as defined here in Provider Manual.

Claims payment inquiries

The Summit Community Care Provider Experience program helps providers with claims payment and issue resolution. Call **844-462-0022** and select the *Claims* prompt to be connected to the Provider Service Unit (PSU) and ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist providers in determining the appropriate process to follow for resolving a claim issue.

Administrative appeals

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of prior authorization or failure by the provider to submit clinical information when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why prior authorization was not obtained or why clinical information was not submitted).

If Summit Community Care overturns its administrative decision, the case is reviewed for medical necessity and, if approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

7 Medical/utilization management

Overview

Summit Community Care, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- Summit Community Care ensures utilization management decisions are fair, independent, and according to approved criteria and available benefits.
- Utilization management decisions are based only on appropriate care and service and coverage.
- Summit Community Care does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

Access to UM staff is available. Summit Community Care associates are available at least eight hours a day, from 8 a.m. to 5 p.m. Central Time, Monday to Friday, for inbound communications regarding UM

inquiries. Clinical professionals are available 24 hours a day, 7 days a week for urgent/emergent inpatient authorizations. Staff will identify themselves by name, title and organizational name when initiating or returning calls regarding UM issues.

Summit Community Care offers TDD/TTY services for members who are deaf, hard of hearing or have speech impairments members. For all members who request language services, Summit Community Care provides services free of charge through bilingual staff or an interpreter to help members with UM issues.

Criteria and clinical information for medical necessity

Summit Community Care *Medical Policies* and *Clinical UM Guidelines*, which are publicly accessible online at **https://www.summitcommunitycare.com/provider**, are the primary guidelines used to determine whether services are a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive.

MCG criteria will continue to be used to determine medical necessity for inpatient care. A list of the specific *Medical Policies* and *Clinical UM Guidelines* used will be posted and maintained on the website and can be obtained in hard copy by written request. To request a copy of the criteria on which a medical decision was based, call Provider Services at **844-462-0022**.

The policies described above will support prior authorization requirements, inpatient care and retrospective review.

Behavioral health will use MCG criteria for all levels of care (see BH section).

Federal and state law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over clinical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts will supersede MCGand our *Medical Policies* and *Clinical UM Guidelines*. Medical technology is constantly evolving, and Summit Community Care reserves the right to review and periodically update medical policy and utilization management criteria. The Summit Community Care UM department reviews the medical necessity of medical services using:

- State guidelines
- Our *Medical Policies* and *Clinical UM Guidelines*
- MCG criteria
- *Carelon Medical Benefits Management Clinical Appropriateness Guidelines*

Summit Community Care follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. To learn more about these procedures, visit the provider website at **https://www.summitcommunitycare.com/provider** or call Provider Services. These procedures apply to:

- Prior authorization.
- Concurrent reviews.
- Retrospective reviews.

Requests for services/care should include current applicable and appropriate ICD and HCPCS/CPT codes and relevant clinical information. Appropriate clinical information includes the following:

- Office and/or hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic testing results
- Treatment plans and progress notes
- Psychosocial history
- Consultation notes
- Operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Estimated/anticipated length and/or frequency of treatment

Our chief medical officer will review any denial of care, including those for EPSDT services and services for enrollees with special healthcare needs. Our chief psychiatric medical officer will review all denials of care for mental health treatment services.

Referral/prior authorization process

Referrals to in-network specialists are not required for payment; however, Summit Community Care highly recommends PCPs supply the member with instructions for follow-up care.

Prior authorization and notification — general

Some covered services require prior authorization prior to being rendered, while others require notification.

Notification is a communication received from a provider informing Summit Community Care of the intent to render covered medical services to a member. For emergent or urgent services, notification must be provided within 24 hours after admission. Notifications may be submitted by phone or fax or web portal (please note, voicemails are not acceptable). If the admission or emergency healthcare service occurs on a holiday or weekend, a utilization review entity shall not require notification until the next business day after the admission or provision of the emergency healthcare service.

Prospective means the coverage request occurred prior to the service being provided. **Prior Authorization** is the prospective process whereby licensed clinical associates apply specific criteria set against the intensity of services and severity of illness to determine the medical necessity and appropriateness of the request.

Services requiring prior authorization include but are not limited to:

- Elective inpatient admissions.
- Select outpatient and specialty care provided outside of the PCP’s scope of practice.
- High-tech radiology.
- Durable medical equipment.
- Home health services.
- Out-of-network services.

- CES Waiver services
- Extension of benefits
- BH residential services.
- BH Partial Hospitalization services
- BH Intensive Outpatient services

The following information should be provided to the Medical Management department for prior authorization at **844-462-0022**. Please have the following information ready when you call.

- Member's name
- Member's address
- Member's Summit Community Care ID number
- Member's date of birth
- Member's PCP
- Scheduled date of admission and/or surgery
- Name of hospital
- Ordering and Servicing Provider NPI
- Ordering and Servicing Provider Address
- Ordering and Servicing Provider Tax ID
- Member's diagnosis
- Attending provider
- Clinical information (if applicable)

All Summit Community Care members scheduled for inpatient surgery must be admitted to the hospital on the day of the surgery except in preapproved medically necessary cases. Summit Community Care will **not** pay for any costs associated with admissions on the day before surgery unless specific medical justification is provided and approved. Each member's case will be examined individually in this respect.

The following are **not** acceptable reasons for an admission before surgery:

- Member, provider, or hospital convenience
- Routine laboratory or X-ray
- NPO (i.e., nothing by mouth)
- Distance or transportation to the hospital
- Most preps

Upon notification, Summit Community Care reviews the clinical basis for admission and authorizes benefits for the admission. The medical director reviews any potential denial of coverage after evaluating the member's medical condition and medical criteria.

To verify whether or not a particular outpatient service requires prior authorization, use the Prior Authorization Look Up Tool at **https://www.summitcommunitycare.com/provider**.

Prior Authorization is **not** required for the following services:

- Routine laboratory tests (excluding genetic testing) performed in the PCP's office or contracted laboratory
- Routine X-rays, EKGs, EEGs or mammograms at a network specialist office at a freestanding radiology facility or at some network hospitals

- Routine outpatient behavioral health therapy services (excluding psychological testing) at a network specialist office.

The medical director will periodically review and revise this list expecting more services to be added as practice patterns of the network warrants.

Interactive Care Reviewer (ICR)

The Summit Community Care Interactive Care Reviewer (ICR) is the preferred method for the submission of preauthorization requests, offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for Summit Community Care members. Additionally, providers can use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, ICR or another online tool).

- **Initiate preauthorization requests online**, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- **Review** requests previously submitted via phone, fax, ICR or another online tool.
- **Instant accessibility** from anywhere, including after business hours.
- **Utilize the dashboard** to provide a complete view of all your organization's UM requests with real-time status updates.
- **Real-time results** for some common procedures.
- **Access ICR** under Patient Registration > *Authorizations and Referrals* via the Availity lEssentials.

Interactive Care Reviewer is accessed through Availity Essentialsat **https://www.availity.com**. You will need to be registered on Availity with your own unique user ID and password and have the appropriate role assignment. To create, submit and update a prior authorization requires the Authorization & Referral Request role. To inquire on a prior authorization, you will need the Authorization Inquiry role assignment. Your organization's Availity Administrator can assign these roles.

For an optimal experience with Summit Community Care ICR, use a browser that supports 128-bit encryption. This includes , Chrome, Microsoft Edge, Firefox, or Safari.

Summit Community Care ICR is not currently available for the following:

- Transplant services
- Services administered by vendors (For these requests, follow the same preauthorization process that you use today.)
- CES Waiver services

Prior authorization determination time frames

For services that require prior authorization, Summit Community Care will determine timely so as not to adversely affect the member's health. For standard non-urgent authorization requests, the determination will be made within two business days (or sooner) of Summit Community Care's receipt of all necessary information needed. For urgent authorization requests, the determination will be made within one (1) business day (or sooner) of Summit Community Care's receipt of all necessary information needed to make the determination, not to exceed 72 hours from the date of the initial request.

If the request lacks clinical information, the organization may extend the decision time frame up to an additional 14 calendar days for routine requests and for 48 hours for urgent preservice requests.

Failure of Summit Community Care to adhere to the above timeline for responding to a provider's request for prior authorization results in the requested services being "deemed" as approved. Summit Community Care will issue an administrative approval for requests where Summit Community Care did not respond within the turn-around times defined herein.

Utilization management — Inpatient services

Standard inpatient admission notification time frames
All elective admissions must receive prior approval through Provider Services at least 72 hours prior to the admission or scheduled procedure. Failure to comply with notification rules will result in an administrative denial.

The hospital is responsible for notifying Summit Community Care of the birth of a child within one business day of the date of birth. For transfer of a newborn from the nursery to the NICU or to another level of care, or to detain a newborn beyond the OB global period, the hospital must notify Summit Community Care within one business day. These circumstances are considered separate, new admissions and are not part of the mother's admission.

Emergent admissions require notification to Summit Community Care within one business day following the admission. Failure to comply with notification rules will result in an administrative denial.

Administrative denial
Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of prior authorization or member ineligibility. Appeals for administrative denials must address the reason for the denial (i.e., why prior authorization was not obtained).

If Summit Community Care overturns its administrative decision, then the case will be reviewed for medical necessity, and if approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

Inpatient specialist referrals
Referrals to in-network specialists are not required for payment; however, Summit Community Care highly recommends PCPs supply the member with instructions for follow-up care. Go to **https://www.summitcommunitycare.com/provider** to download the *Personalized Treatment Plan* form.

Acute inpatient admission
- All medical inpatient hospital admissions will be reviewed for medical necessity within one business day of the facility notification to Summit Community Care.
- Clinical information for the initial (admission) review will be requested by Summit Community Care at the time of the admission notification.
- For medical admissions, the facilities must provide the requested clinical information within 24 hours or the next business day of the request.

Inpatient concurrent review
Each network hospital will have an assigned concurrent review clinician. The concurrent review clinician will conduct a review of the medical records electronically or by telephone to determine the authorization of coverage for an admission.

- When the clinical information is received, a medical necessity review will be conducted using applicable nationally recognized clinical criteria, and a determination will be communicated to the facility.
- The Summit Community Care concurrent review clinician will conduct discharge planning review and help coordinate discharge planning needs with the designated facility staff and the attending provider. The attending provider is expected to coordinate with the member's PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.

If the medical director/physician reviewer denies authorization for an inpatient stay based upon applicable guidelines or criteria, a notice of intent to deny will be provided to the facility and to the attending provider.

Upon notification of the intention to deny, the member's treating physician can request a physician to -physician review to provide additional information not previously submitted to Summit Community Care. The request for this review must be made within two business days of the notification of intent to deny. To initiate this request, the physician or a physician representative may contact Summit Community Care at **844-429-9630, option 1** from 8:00a.m. to 5:00 p.m.

All notifications of intent to deny will be followed with a written adverse determination.

Inpatient retrospective review
Inpatient admissions may be retrospectively reviewed after the member is discharged. If Summit Community Care is notified of the admission while the member is still in the hospital, the review will be considered concurrent and subject to concurrent time frames and guidelines. For additional questions and a quick reference guide, visit the provider website.

Discharge planning
Discharge planning is designed to assist the provider with coordination of the member's discharge when acute care (i.e., hospitalization) is no longer necessary.

When a lower level of care is necessary, Summit Community Care works with the provider to help plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital setting such as:

- Hospice facility
- Skilled nursing facility
- Long-term acute care hospital (LTACH)
- Residential treatment facilities (RTF)
- Partial hospitalization programs (PHP)
- Intensive outpatient programs (IOP)
- Home healthcare

When the provider identifies medically necessary services for the member, Summit Community Care will assist the provider and the discharge planner in providing timely and effective transfer to the next appropriate level of care.

Discharge plan authorizations follow the applicable prior authorization process and determinations are made using nationally recognized clinical criteria or guidelines. Authorizations include home health, durable medical equipment (DME), follow-up visits to providers or outpatient procedures.

Utilization management — Outpatient services

Administrative denial
Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of prior authorization or member ineligibility.
Appeals for administrative denials must address the reason for the denial (i.e., why prior authorization was not obtained).

If Summit Community Care overturns its administrative decision, then the case will be reviewed for medical necessity, and if approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

For code-specific prior authorization requirements performed by a participating provider, visit **https://www.summitcommunitycare.com/provider**.

For prior authorization requirements for behavioral health services, please refer to the Behavioral Health Services chapter in this manual.

In addition, prior authorization is required for all out-of-network care (certain exclusions apply) and for specialty visits (i.e., services beyond the initial evaluation and management) if performed by a nonparticipating provider. Prior authorization requirement review and updates

Summit Community Care will review and revise policies when necessary. The most current policies are available on the secure provider website.

Specialist as PCP referral

Under certain circumstances, a specialist may be approved by Summit Community Care to serve as a member's PCP when a member requires the regular care of the specialist. The criteria for a specialist to serve as a member's PCP include the existence of a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care must be provided by a specialist.
- The administrative requirements of arranging for care exceed the PCP's capacity. This would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must meet the requirements for PCP participation (including contractual obligations and credentialing), provide access to care 24 hours a day, 7 days a week and coordinate the member's healthcare including preventive care.

Reporting changes in address and/or practice status

Please report any status changes either by fax to fax or mail to:

Provider Services
Summit Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429

Second opinions

A member or the member's PCP may request a second opinion for serious medical conditions or elective surgical procedures at no cost to the member. Also, a member of the healthcare team and/or the member's parents or guardians may also request a second opinion. These conditions and/or procedures include but are not limited to the following:

- Treatment of serious medical conditions such as cancer
- Elective surgical procedures such as hernia repair (simple) for adults (age 18 or older), hysterectomy (elective procedure), spinal fusion (except for children under age 18 with a diagnosis of scoliosis) and laminectomy (except for children under age 18 with a diagnosis of scoliosis)
- Other medically necessary conditions as circumstances dictate

The second opinion must be obtained from a network provider (see the *Provider Referral Directory* at **https://www.summitcommunitycare.com/provider**). A second opinion can be obtained from a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and will forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Summit Community Care may also request a second opinion at its own discretion. This includes but is not limited to the following scenarios:

- There is concern about care expressed by the member or the provider.
- Potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business.
- Before initiating denial of coverage of service.
- Denied coverage is appealed.
- An experimental or investigational service is requested.

When Summit Community Care requests a second opinion, Summit Community Care will make the necessary arrangements for the appointment, payment, and reporting. Once the second opinion is completed, Summit Community Care will inform the member and the PCP of the results and the consulting provider's conclusion and recommendation(s) regarding further action.

8 Quality assurance performance improvement

Summit Community Care embraces quality assurance and improvement. The Summit Community Care Quality Assurance Performance Improvement Program is embedded across all aspects of operation. The program develops goals to improve our members' health outcomes, access to care and services, health equity, quality of life and satisfaction with care services. The Summit Community Care standards and goals are based on state and federal rules and regulations, other regulatory requirements, and NCQA standards. Overall performance is measured using HEDIS, CAHPS® and other industry standard- methods of measurement. As providers, you play a vital role in achieving quality improvement.

As part of its Quality Assurance activities, Summit Community Care may conduct a random sampling of provider medical records to assess documentation in accordance with established standards. Summit Community Care may also review quality metrics by provider and communicate specific opportunities for improvement.

For more information about the Summit Community Care Quality Management program, call Provider Services at **844-462-0022**.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

Patient safety

Summit Community Care provides information and resources for providers regarding healthcare safety and standards. An example of a resource is **www.hospitalcompare.hhs.gov**, a CMS website providing specific information on hospitals. This user-friendly site compiles quality indicators for all Medicare certified- hospitals and provides a comparison of quality indicators for services rendered by the selected hospital.

Summit Community Care Member Hotline

The Member Hotline can be reached at **844-405-4295** (**TTY 711**), Monday to Friday from 8 a.m. to 6 p.m. This unit handles, resolves and/or properly refers members' inquiries and complaints to other departments. Additionally, Summit Community Care provides members with information about how to access the Member Services department and Consumer Services Hotline to obtain information and assistance.

Quality management committee

The quality management committee's purpose is to maintain quality as a cornerstone of our culture and to be an instrument of change through demonstrable improvement in care and service.
The quality management committee's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the Quality Management program.
- Establish processes and structure that ensure NCQA compliance.
- Review planning, implementation, measurement, and outcomes of clinical/service quality improvement studies.

- Coordinate communication of quality management activities throughout the health plans.
- Review HEDIS® data and action plans for improvement.
- Review and approve the annual quality management program description.
- Review and approve the annual work plans for each service delivery area.
- Provide oversight and review of delegated services.
- Provide oversight and review of subordinate committees.
- Receive and review reports of Utilization Review decisions and take action when appropriate.
- Analyze member and provider satisfaction survey responses.
- Monitor the plan's operational indicators through the plan's senior staff.

Medical advisory committee

The medical advisory committee (MAC) has multiple purposes:

- Assesses levels and quality of care provided to members and recommends, evaluates, and monitors standards of care
- Identifies opportunities to improve services and clinical performance by establishing, reviewing, and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk, and problem-prone conditions
- Oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care
- Conducts a systematic process for network maintenance through the credentialing/recredentialing process
- Advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members
- Approves and provides oversight of the peer review process, the Quality Management program, and the Utilization Review program.
- Oversees and makes recommendations regarding health promotion activities.

The MAC's responsibilities are to:

- Use an ongoing peer review system to monitor practice patterns to identify appropriateness of care and to improve risk prevention activities.
- Approve clinical protocols/guidelines that help ensure the delivery of quality care and appropriate resource utilization.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Consider and act in response to provider sanctions.
- Provide oversight from credentialing committee decisions to credential/recredential providers for participation in the plan.
- Approve credentialing/recredentialing policies and procedures.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

9 Contact information

Arkansas Medicaid

Go to **https://medicaid.mmis.arkansas.gov/General/DMSCon.aspx** or **https://medicaid.mmis.arkansas.gov/Beneficiary/Contacts.aspx** for Arkansas Medicaid contact information.

Summit Community Care

Provider Services (telephone):	**844-462-0022**
TTY Relay Line:	**711**
Interpretive Services:	**844-405-4295** (TTY **711**)
Provider Inquiry Line:	**844-462-0022**
24-hour Nurse Helpline:	**844-405-4295** (TTY **711**)
Member Services:	**844-405-4295** (TTY **711**)

Call **Summit Community Care Provider Services** for:

- Prior Authorization
- Health plan network information
- Member eligibility
- Claims information
- Inquiries or member issues
- Suggestions you may have to improve Summit Community Care processes.

Other services

Vision

EyeMed Member and Provider Services: **833-279-4364**

- Summit Community Care contracts with EyeMed to administer routine and medical-surgical vision services to eligible beneficiaries. For additional information related to vision care, including prior authorization of certain vision services, please review the EyeMed Provider Manual at https://www.eyemedinfocus.com/summit/

The Summit Community Care website (**https://www.summitcommunitycare.com/provider**) has general information for providers such as forms, the *PDL*, and credentialing and re-credentialing information.

10 Enrollment and marketing rules

Overview

We want our members to make the best healthcare decisions possible, and when members ask for our assistance, we want to provide that assistance, so they make those decisions without undue influence. We recognize providers occupy a unique, trusted, and respected part of people's lives. Given the complexity of modern-day healthcare and the inherent difficulties communicating with some of the populations we serve, there are potentially serious pitfalls when providers try to assist in the decision-making- process. For that reason, we are committed to following strict enrollment and marketing guidelines and honoring the rules for all state healthcare programs.

Marketing policies

Summit Community Care providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that he or she select membership in a particular plan. The state marketing practice policies prohibit network providers from making any of the following false or misleading claims:

- The provider's office staff are employees or representatives of the state, county, or federal government.
- Summit Community Care is recommended or endorsed by any state or county agency, or any other organization.
- The state or county recommends that a prospective member enroll with a specific health plan.
- A prospective member or medical recipient loses Medicaid or other welfare benefits if the prospective member does not enroll with a specific Medicaid MCO.

These policies also prohibit network providers from taking the following actions:

- Making marketing presentations, advising or recommending to an eligible individual that they select membership in a specific Medicaid MCO.
- Offering or giving away any form of compensation, reward, or loan to a prospective member to induce or procure member enrollment in a specific Medicaid MCO.
- Engaging in direct marketing to members is designed to increase enrollment in a particular health plan. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of members originally obtained for enrollment purposes from confidential state or county data sources, or from the data sources of other contractors.
- Employing marketing practices that discriminate against potential members other than persons specifically excluded from coverage under our contract. Providers may not discriminate based on marital status, age, religion, sex, national origin, language, sexual orientation, ancestry, or pre-existing psychiatric problems or medical conditions, such as pregnancy, disability, or AIDS.
- Reproducing or signing an enrollment application for the member.
- Displaying materials only from the provider's contracted managed healthcare organizations and excluding others.

11 Appendix A – Forms

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Living Will

You can make a living will by completing this form. You can choose another form or use the one your doctor gives you. If you make a living will, give it to your Summit Community Care network provider. If you need help to understand or complete this form, call Member Services at 844-405-4295 (TTY 711).

I, (*Print your name here*) ____, am of sound mind. I want to have what I indicate here followed. I am writing this in the event something happens to me, and I cannot make decisions about my medical care. These instructions are to be used if I am not able to make decisions. I want my family and doctors to honor what I say here. These instructions will tell what I want to have done if 1) I am in a terminal condition (going to die), or 2) I am permanently unconscious and have brain damage that is not going to get better. If I am pregnant and my doctor knows it, then my instructions here will not be followed during the time I am still pregnant, and the baby is living.

TREATMENT I DO **NOT** WANT
I do not want (put your initials by the services you do not want):
_____Cardiac resuscitation (start my heart pumping after it has stopped)
_____Mechanical respiration (machine breathing for me if my lungs have stopped)
_____Tube feeding (a tube in my nose or stomach that will feed me)
_____Antibiotics (drugs that kill germs)
_____Hydration (water and other fluids)
_____Other (indicate what it is here)

TREATMENT I **DO** WANT
I want (put your initial by the services you do want):
_____Medical services
_____Pain relief
_____All treatment to keep me alive as long as possible
_____Other (indicate what it is here)
____

What I indicate here will happen unless I decide to change it or decide not to have a living will at all. I can change my living will anytime I wish. I just have to let my doctor know I want to change it or forgo a living will entirely.
Signature: ____
Date: ___________________
Address: ____

Statement of witness
I am not related to this person by blood or marriage. I know that I would not get any part of the person's estate when he or she dies. I am not a patient in the healthcare facility where this person is a patient. I am not a person who has a claim against any part of this person's estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is a patient, I am not involved in providing direct patient care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: ____
Date: ___________________
Address: ____

Durable Power of Attorney

You can name a durable power of attorney by filling out this form. You can use another form or use the one your doctor gives you. If you name a durable power of attorney, give it to your Summit Community Care network provider. If you need help to understand or complete this form, call Member Services at 844-405-4295 (TTY 711).

I, (*Name*) **__________________________________, want**

_____________________________________ **____,**

(*Name of person I want to carry out my wishes*) (*Person's address*)

to make treatment decisions for me if I cannot. This person can make decisions when I am in a coma, not mentally able to or so sick I just cannot tell anyone. If the person I named is not able to do this for me, then I name another person to do it for me. This person is

____ ____.

(*Name of second person I want to carry out my wishes*) (*Second person's address*)

TREATMENT I DO **NOT** WANT

I do not want (put your initials by the services you do not want):

_____Cardiac resuscitation (start my heart pumping after it has stopped)

_____Mechanical respiration (machine breathing for me if my lungs have stopped)

_____Tube feeding (a tube in my nose or stomach that will feed me)

_____Antibiotics (drugs that kill germs)

_____Hydration (water and other fluids)

_____Other (indicate what it is here)

____

TREATMENT I **DO** WANT

I want (put your initial by the services you do want):

_____Medical services

_____Pain relief

_____All treatment to keep me alive as long as possible

_____Other (indicate what it is here)

What I indicate here will happen unless I decide to change it or decide not to have a durable power of attorney at all. I can change my durable power of attorney anytime I wish. I just must let my doctor know if I want to change it or not have it at all.

Signature: ____

Date: ___________________

Address: ____

Statement of witness

I am not related to this person by blood or marriage. I know that I would not get any part of the person's estate when he or she dies. I am not a patient in the healthcare facility where this person is a patient. I am not a person who has a claim against any part of this person's estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is a patient, I am not involved in providing direct patient care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: ____ Date: ___________________

Address: ____

PASSE Incident Report Form

- Arkansas DHS provided document.

PASSE Incident Report Form

Type of report	_____ Initial Written	Date/Time: ______________________________
	_____ Follow-up	Date: ______________________________
	Final	Date: __________________________________

Incident Date: _________________________________ Incident Time: ___________________________
Injured Person Name: ____
Address: ____
Phone Numbers: ____
Age or Date of Birth: _______ Gender ______ Race:____________ Legal Status: ________________

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

Does Incident/injury require medical attention Yes: ______________________ No: ___________
Physician/Hospital Name: ____
Address: ____
Phone Numbers: ____

Designation of incident:
___Member to member ___Member to Staff ___ Self-inflected ___member to public ___Public to Member ___Other ___________________
Roles (relationship to subject) and Names of others involved

_____ ___________________________________ ___________________________________
Role Name Address and phone

______ ___________________________________ ___________________________________
Role Name Address and phone
(Continue on next page as needed)

Notifications (enter method, date and time when communicated as appropriate)
___Adult Protective Services Hotline (800-482-8049) ____
___Child Abuse Hotline (800-482-5964) ____
___ DHS PASSE Incident report line (501-371-1184) ____
___DHS PASSE Ombudsman
___Next of Kin ____
___ Responsible Party (if different from above: ____
___ Law Enforcement
___ Other____

PASSE Incident Report Form (page 2)

Type of report	_____ Initial Written	Date/Time: ______________________________
	_____ Follow-up	Date: ______________________________
	Final	Date: __________________________________

Clear, Concise description of incident

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

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

____ Pending investigation

____ Investigated with appropriate action/preventive plan attached

Additional information as needed:

Person submitting form: ______________________________________ Title: _______________

PASSE: _________________________ Phone Number: __________________ email: _____________

HCBS Provider: ___________________________ Contact: ___________________________________

Phone Number: ___________________________________ email: _____________________________

12 Appendix B – Clinical guidelines

As part of its quality improvement process, Summit Community Care adopts Non preventive and preventive clinical practice guidelines for acute and chronic medical and behavioral health conditions that are scientific and evidenced-based. This is determined by scientific evidence, review of government research sources, review of clinical or technical literature, involvement of board-certified practitioners from appropriate specialties or professional standards. Recognized sources of the evidenced-based guidelines include national organizations such as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), professional medical-specialty organizations such as the American Academy of Pediatrics (AAP), American College of Obstetrics and Gynecologists (ACOG), American Academy of Family Practice (AAFP) and voluntary health organizations as the American Diabetes Association (ADA) and American Cancer Society (ACS). The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Texas Implementation of Medication Algorithm (TIMA) and Texas Medicaid Algorithm Project (TMAP) are currently more specific sources recognized for behavioral health guidelines. Other sources that may be referenced in developing or updating behavioral health guidelines include organizations such as the Substance and Mental Health Services Administration (SMHSA) and National Institute of Mental Health (NIMH). The guidelines are based on valid and reliable clinical evidence, a consensus of healthcare professionals in a particular field and the needs of the members. The guidelines are adopted and approved in consultation with network healthcare professionals. They are reviewed and updated periodically as appropriate, but at least every two years. Summit Community Care will disseminate the guidelines to all affected providers and, upon request, to members and potential members. The Summit Community Care decisions regarding disease management, case management, utilization management, member education, coverage of services and other areas included in the guidelines, will be consistent with Summit Community Care guidelines. Data is gathered and monitored using HEDIS, ad hoc medical records review and other sources to measure performance against the guidelines and improve the clinical care process.

For a copy of the guidelines, visit **https://www.summitcommunitycare.com/provider** to print them from the website, or you can contact Provider Services at **844-462-0022** to receive a copy.

13 Appendix C – Agreement outlining minimum standards for PASSE HCBS providers

- Arkansas DHS provided document

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

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

This Agreement is based on former requirements under the CES waiver. Each PASSE must include the content of each of the sections although they may modify the format according to their individual manual specifications. These are minimum standards in addition to federal, state, and local statutes, acts and regulations that apply, and any other qualifications established by the PASSE.

Until PASSE HCBS providers are a registered and fully functional provider type in MMIS, the PASSE is responsible for the annual certification of CES Waiver Providers. All other provisions, except annual certification, outlined in this Agreement apply to all providers providing home and community-based services including the Arkansas Community Independence Program.

SECTION	100	Organizational/Management Requirements of PASSE Home and Community-Based Providers and Annual Certification Requirements
SECTION	200	Hiring Procedures and Personnel Record maintenance
SECTION	300	Incident Reporting
SECTION	400	Beneficiary and Legal Guardian Rights
SECTION	500	Beneficiary Health and Safety and Legal Rights

100 Organizational/management requirements and solicitation

Organizational requirements

Annual certification: The PASSE is responsible for the credentialing of PASSE home and community-based service (HCBS) providers.

All HCBS providers must be enrolled in Arkansas Medicaid as an HCBS provider. To enroll in Arkansas Medicaid as a PASSE Home and Community Based Service provider, the HCBS provider must be credentialed as such by the PASSE.

a. The PASSE must submit to DHS for approval the method by which the PASSE will credential HCBS providers.

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

c. The PASSE's credentialing process must be approved by DHS and include the following, at a minimum, for HCBS providers:

   i. Audit requirements;

   ii. Inspection requirements;

   iii. Complaint resolution process;

   iv. Performing provider requirements; and

   v. Any other information required for the PASSE to credential an HCBS provider as such.

1. Provider governing documents available for inspection: All governing documents, policies, procedures, or other equivalent operating documents of a PASSE HCBS provider shall always be readily available for PASSE and DHS inspection and review upon request.

2. Legal existence and good standing: A PASSE HCBS provider shall always be duly organized, validly existing and in good standing as a legal entity under the laws of the State of Arkansas, with the power and authority under the appropriate federal, state, or local statues to own and operate its business as presently conducted.

Management requirements

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

200 HIRING procedures & personnel record maintenance

Hiring procedures and required personnel records

A. Prior to employment

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

B. Post-employment

The PASSE HCBS provider shall obtain and verify within thirty (30) days of an applicant's employment:

1. A completed Adult Maltreatment Central Registry check (see A.C.A. § 12-12-1716, or any successor statutes), or a second submission request if a response has not been received. An Adult Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adult over the age of eighteen (18) that resides in a residence where a beneficiary is approved and permitted to stay overnight.

2. A completed Child Maltreatment Central Registry check (A.C.A. § 12-18-901 et. seq., or any successor statutes), or a second submission request if a response has not been received. A Child Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adult over the age of eighteen (18) that resides in a residence where a beneficiary is approved and permitted to stay overnight.

3. A successfully passed criminal background check for the employee, their spouse, and any children or other adult over eighteen (18) residing in a residence where a beneficiary is approved and permitted to stay overnight.

300 Incident reporting

Reportable incidents

PASSE HCBS providers must submit an incident report to the DHS PASSE Quality Assurance unit and the appropriate PASSE, using the reporting form via secure e-mail upon the occurrence of any one of the following events:

1. Death of beneficiary

2. The use of any restrictive intervention, including seclusion, or physical, chemical, or mechanical restraint on a beneficiary.

3. Suspected maltreatment or abuse of a beneficiary.

4. Any injury to a beneficiary that:

    - Requires the attention of an Emergency Medical Technician, a paramedic, or physician.
    - May cause death.
    - May result in a substantial permanent impairment.
    - Requires hospitalization.

5. Threatened or attempted suicide by a beneficiary.

6. The arrest of a beneficiary, or commission of any crime by a beneficiary.

7. Any situation in which the whereabouts of a beneficiary is unknown for more than two (2) hours (i.e., elopement and/or wandering), or where services are interrupted for more than two (2) hours.

8. Any event where a staff member threatens a beneficiary.

9. Unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary. *

10. Medication errors made by staff that cause or have the potential to cause serious injury or illness to a beneficiary, including, but not limited to, loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time, by the wrong route, and the administration of the wrong medication.

11. Any violation of a beneficiary's rights that jeopardizes the health, safety, or quality of life of the beneficiary.

12. Any incident involving property destruction by a beneficiary.

13. Vehicular accidents involving a beneficiary.

14. Biohazard incidents involving a beneficiary.

15. An arrest or conviction of a staff member providing direct care services.

16. Any use or possession of a non-prescribed medication or an illicit substance by a beneficiary.

17. Any other event that might have resulted in harm to a beneficiary or could have endangered the health, safety, or welfare of the beneficiary.

In addition to submitting incident reports for the reportable incidents described above to the DHS PASSE Quality Assurance unit using the reporting form via secure e-mail, PASSE HCBS providers are to also forward a copy of each incident report to the client's assigned PASSE. If the incident involves an employee of a PASSE HCBS provider and you are in network at multiple PASSEs, the incident must be sent all.

Incident reports involving unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary are considered sentinel events and will be investigated by the Department of Human Services.

In addition to sentinel events, the Department of Human Services will also investigate if the network provider and/or network provider staff is suspected to be at fault.

All other incidents will be investigated by the appropriate PASSE.

Reporting timeframes

A. Immediate reporting

Providers must report the following incidents to the DHS PASSE Quality Assurance unit emergency number (**501**) **371-1329** within one (1) hour of occurrence, regardless of hour as well as the on-call emergency number for the appropriate PASSE:

- A death not related to the natural course of the patient's illness
- Serious physical or psychological injury to a beneficiary

B. Incidents involving potential publicity

Incidents, regardless of category, that a PASSE HCBS provider should know might be of interest to the public and/or media must be immediately reported to the DHS PASSE Quality Assurance unit and the appropriate PASSE.

C. All other incident reports

Except as otherwise provided above in subsection A and B, all reportable incidents must be reported to the DHS PASSE Quality Assurance unit, and the appropriate PASSE, using the automated PASSE HCSB

Incident Report Form via secure e-mail no later than two (2) days following the incident. Any incident that occurs on a Friday is still considered timely if reported by the Monday immediately following.

Required incident report contents

A. Initial incident report: Each initial incident report filed by a PASSE HCBS provider must contain the following information:

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

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

B. Follow-up incident reports: Information that is not available at the time of the initial incident report filing must be submitted in follow-up or final incident reports. These reports should be submitted in the same manner as soon as the additional information becomes available.

- The initial report should be resubmitted with the “follow-up” or “final” report areas checked and dated in the appropriate space on the incident report form.

- The current date should precede the new information in the text/narrative sections to differentiate follow-up information from the information originally submitted.

- A new *PASSE Incident Report* form should be submitted for follow-up and final reports only when there is insufficient space on the original form. Whenever a new form is submitted, the date of the original written report must be included for cross-referencing.

Mandated reporters

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

400 Beneficiary and legal guardian rights

Beneficiary/guardian rights policy

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

Beneficiary rights

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

1. The right to be free from:
    - Physical abuse or neglect.
    - retaliation.
    - coercion.
    - humiliation.
    - financial exploitation.

    The PASSE HCBS provider must ensure that the application of corporal punishment to beneficiaries is prohibited. **Corporal punishment refers to the application of painful stimuli to the body to try to terminate behavior or as a penalty for behavior.**
2. The freedom to control their own financial resources.
3. The freedom to receive, purchase, possess, and use individual personal property. Any restriction on this right must be supported by an assessed need and justified in the beneficiary's person-centered service plan ("**PCSP**").

4. The freedom to make decisions affecting their life and access pertinent information actively and meaningfully in a timely manner to facilitate such decision making.

5. The right to privacy. Any restriction on this right must be supported by an assessed need and justified in the PCSP.

6. The right to choose a roommate when sharing a bedroom.

7. The freedom to associate and communicate publicly or privately with any person or group of people of the beneficiary's choice at any time. Any restriction on this right must be supported by an assessed need and justified in the PCSP.

8. The freedom to have visitors of their choosing at any time.

9. The freedom of religion.

10. The right to be free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment.

11. The opportunity to seek employment and work in competitive, integrated settings.

12. Freedom from being required to work without compensation.

13. The right to be treated with dignity and respect.

14. The right to receive due process.

    - PASSE HCBS providers must ensure beneficiaries have access to legal entities for appropriate and adequate representation, advocacy support services, and must adhere to research and ethics guidelines (45 CFR § 46.101 et. seq.).

    - PASSE HCBS provider rules may not contain provisions that result in unfair, arbitrary, or unreasonable treatment of a beneficiary.

15. The right to contest and appeal PASSE HCBS provider decisions affecting the beneficiary.

16. The right to request and receive an investigation in connection with an alleged infringement of a beneficiary's rights.

17. The freedom to access their own records, including information regarding how their funds are accessed and utilized and what services were billed for on the beneficiary's behalf. Additionally, all beneficiaries and legal guardians must be informed of how to access the beneficiary's service records and the PASSE HCBS provider must ensure that appropriate equipment is available for them to obtain such access.

    - Beneficiaries may not be prohibited from having access to their own service records unless a specific state law indicates otherwise.

18. The right to live in a manner that optimizes, but does not regiment, beneficiary initiative, autonomy, and independence in making life choices, including but not limited to:

   - Choice of HCBS providers
   - Service delivery
   - Release of information
   - Composition of the service delivery team
   - Involvement in research projects, if applicable
   - Daily activities
   - Physical environment
   - With whom to interact

19. Other legal and constitutional rights.

Financial safeguards

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

A. Financial safeguards and procedures

The PASSE HCBS provider must demonstrate that there is a system in place to protect the financial interests of all beneficiaries. PASSE HCBS provider personnel that have any involvement with beneficiary funds and the beneficiary, or their legal guardian must receive a copy of the PASSE HCBS provider's Financial Safeguards Policies and Procedures.

1. The PASSE HCBS provider is responsible for ensuring that each beneficiary's funds are used solely for the benefit of the beneficiary.

2. The PASSE HCBS provider must ensure that the beneficiary can receive the benefit of those items/services they are paying for. By way of illustration, if a beneficiary is paying for internet, the beneficiary should have a device with which to access the internet; if the beneficiary pays for a cell phone plan, then the beneficiary should have a functioning cell phone.

B. Access to financial records

Beneficiaries and their legal guardians must always have access to financial records concerning their account/funds.

C. Financial safeguards policy and procedures

The PASSE HCBS provider must implement policies that define:

1. How beneficiaries will provide informed consent for the expenditure of their funds.

2. How beneficiaries will access their financial records.

3. How beneficiary accounts/funds will be segregated and maintained for accounting purposes.

4. The safeguards and procedures in place to ensure that beneficiary funds are used only for designated and appropriate purposes.

5. How interest will be credited to the accounts of the beneficiaries, if applicable.

6. A mechanism that provides evidence that beneficiary funds were expended in the manner authorized.

D. Consent requirements

The PASSE HCBS provider shall obtain consent from the beneficiary or their legal guardian prior to implementing the following:

1. Limiting the amount of funds, a beneficiary may expend or invest in a specific instance.

2. Designating the amount, a beneficiary may expend or invest for a specific purpose.

3. Establishing time frames where a beneficiary is required to or prohibited from expending or investing their funds.

4. Delegating responsibility for expending or investing a beneficiary’s funds.

Restraints & restrictive intervention

A. Behavior management plan required

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

B. Definitions of restraints and interventions

1. "Physical restraint" or "personal restraint": the application of physical force without the use of any device (manually holding all or part of the body), for the purpose of restraining the free movement of a beneficiary's body. This does not include briefly holding, without undue force, a beneficiary to calm them or holding a beneficiary's hand to escort them safely from one area to another.

2. "Physical Intervention": the use of a manual technique intended to interrupt or stop a behavior from occurring.

3. "Restrictive intervention": procedures that restrict or limit a beneficiary's freedom of movement, restricts access to their property, prevents them from doing something they want to do, requires them to do something they do not want to do, or removes something they own or have earned. The definition would include the use of "time-out," in which a beneficiary is temporarily, for a specified period of time, removed from positive reinforcement or denied opportunity to obtain positive reinforcement for the purpose of providing the beneficiary with the opportunity to regain self-control. Under no circumstances may a beneficiary be physically prevented from leaving.

4. "Mechanical restraint": any physical apparatus or equipment used to limit or control a challenging behavior. This would include any apparatus or equipment that cannot be easily removed by the beneficiary, restricts the beneficiary's free movement or normal functioning, or restricts normal access to a portion or portions of the beneficiary's body.

    - *Under no circumstances are mechanical restraints permitted to be used on a beneficiary*.

5. "Chemical restraint": the use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition.

- *Under no circumstances are chemical restraints permitted to be used on a beneficiary*.

6. "Seclusion": the involuntary confinement of a beneficiary alone in a room or an area from which the beneficiary is physically prevented from having contact with others or leaving.

   - *Under no circumstances is seclusion permitted to be used on a beneficiary*.

C. Use of restraints and interventions

Permitted restraints and interventions may be used only when a challenging behavior exhibited by the beneficiary threatens the health or safety of the beneficiary or others. The use of restraints or interventions must be supported by a specific assessed need as justified in the beneficiary's PCSP, and only performed as provided in the beneficiary's behavior management plan.

1. Required prior counseling: Before a "time out," an absence from a specific social activity, or a temporary loss of personal possession is implemented, the beneficiary must first be counseled about the consequences of the behavior and the choices they can make.
2. Direct observation: A beneficiary must be continuously under direct visual and auditory observation by staff members during any use of restraints or interventions.

3. Specialized restraint and intervention training: All personnel who are involved in the use of restraints or interventions must receive training on and be qualified to perform, implement, and monitor the restraint or intervention as applicable. Additionally, personnel should receive training in behavior management techniques, and abuse and neglect laws, rules, regulations, and policies.

4. Restraint and intervention identification: The PASSE HCBS provider is required to advise all staff, families, and beneficiaries on how to recognize and report the unauthorized use of a restraint or restrictive intervention.

D. Required restraint and/or intervention PCSP information

Any PCSP and behavior management plan permitting the use of restraints or interventions must include the following information:

1. Identify the specific and individualized assessed need for restraint or intervention.

2. Document the positive interventions and supports used prior to any modifications to the PCSP that permits use of restraint or interventions.

3. Document the less intrusive methods of behavior modification that were attempted but did not work.

4. Include a clear description of the condition directly proportionate to the specific assessed need.

5. Include regular collection and review of data to measure the ongoing effectiveness of the modification to the PCSP that permitted the use of a restraint or intervention.

6. Include established time limits for periodic reviews to determine if the use of restraint or intervention is still necessary or can be terminated.

7. Include the informed consent of the beneficiary or legal guardian.

8. Include assurance that restraint or intervention will cause no harm to the beneficiary.

E. Emergency restraint

Personal restraints (use of staff member's body to prevent injury to the beneficiary or another person) are allowed in cases of emergency, even if a behavior management plan incorporating the use of restraints has not been developed and implemented. An **emergency** exists in the following situations:

1. The beneficiary has not responded to de-escalation or other positive behavior support strategies and the behavior continues to escalate.
2. The beneficiary is a danger to themselves or others.
3. The safety of the beneficiary and those nearby cannot be assured through positive behavior support strategies.

F. Reporting each incident where restraint or intervention was used

An incident report must be completed and submitted to DHS PASSE Quality Assurance unit and appropriate PASSE, in accordance with Section 300 herein no later than the end of the second business day following the date any restraint or restrictive intervention is administered. If the use of a restraint or restrictive intervention occurs more than three (3) times in any thirty (30) day period, permitted use of restraints and interventions must be discussed by the PCSP development team, addressed in the PCSP, and implemented pursuant to an appropriate behavior management plan.

Any use of restraint or intervention, whether permitted or prohibited, also must be documented in the beneficiary's daily service log, maintained it their service record, and must include the following information:

1. The behavior initiates the use of restraint or intervention.
2. The length of time the restraint or intervention was administered.
3. The name of the personnel that authorized the use of the restraint or intervention.
4. The names of all involved and outcomes of the restraint or intervention.

Medication logs

1. Prescription medications: Providers delivering direct care services must maintain medication logs detailing the administration of prescribed medications to the beneficiary. The prescribed medication logs must be readily available review, and document the following for each administration of a prescribed medication:
    - Name and dosage of the medication administered.
    - Route the medication was administered.
    - Date and time the medication was administered (recorded at the time of medication administration).
    - Initials of the staff administering or assisting with administering the medication.
    - Any side effects or adverse reactions to the medication.
    - Any errors in administering the medication.

2. PRN and over-the-counter medications: PASSE HCBS providers delivering direct care services must also maintain logs concerning the administration of PRN and over-the-counter medications. The logs for the administration of prescription PRN and over-the-counter medications must document the following:
    - How often the medication is used.
    - Date and time each medication was administered (recorded at the time of medication administration).
    - The circumstances in which the medication is used.
    - The symptom for which the medication was used.
    - The effectiveness of the medication.

3. Medication administration error reporting/charting: Any medication administration errors occurring or discovered must be recorded in the medication log and immediately reported to a supervisor. “Medication administration errors” include, but are not limited to, the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time or by the wrong route, the administration of the wrong medication, and the discovery of an unlocked medication lock box that is supposed to be locked at all times.
    - An incident report must be filed with DHS PASSE Quality Assurance unit and appropriate PASSE, in accordance with Section 300 for any medication administration error that caused or had the potential to cause serious injury or illness to a beneficiary.

4. Required oversight documentation: Each PASSE HCBS provider delivering direct care services must ensure that supervisory level staff review on at least a monthly basis all beneficiary medication logs to determine if:
    - All medications were administered accurately as prescribed.

- The medication is effectively addressing the reason for which it was prescribed.
- Any side effects are noted, reported, and being managed appropriately.

Daily service activity logs

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

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

Beneficiary service records

A. Required service record documentation

Each PASSE HCBS provider delivering direct care services to a beneficiary must establish a service record for the beneficiary. At a minimum, the service record file must contain:

1. A copy of the PCSP
2. Behavior management plan with proper beneficiary/legal guardian approval, if applicable
3. Daily service activity logs
4. Fully approved medication management plan and Medication logs, or signed election to self-administer medication if applicable
5. Fully executed copy of lease, residency agreement, or other form of written agreement that provides protections that address eviction processes and appeals comparable to those provided under a landlord-tenant law
6. Any documentation providing additional individuals with access to a beneficiary's service record

7. Guardianship Order, if applicable

C. <u>Beneficiary records maintenance & storage retention requirements</u>

1. Confidentiality: A PASSE HCBS provider shall maintain complete service records/files and treat all information related to beneficiaries as confidential. Access to beneficiary service files must be limited to only those staff members who have a need to know the information contained in the records of the beneficiary. The only individuals that may access a beneficiary's files and records are:

    - The beneficiary.
    - The legal guardian of the beneficiary, if applicable.
    - Professional staff providing direct care or care coordination services to the beneficiary.
    - Authorized Provider administrative staff.
    - Any other individual authorized by the beneficiary or their legal guardian.

    Adult beneficiaries who are legally competent shall have the right to decide whether their family will be involved in planning and implementing their PCSP, and a signed release or document shall be present in their service record either granting permission for family involvement or declining family involvement.

2. *HIPAA* regulations: Each PASSE HCBS provider shall ensure that information that is used for reporting or billing shall be shared according to confidentiality guidelines that recognize applicable regulatory requirements such as the *Health Insurance Portability and Accountability Act* ("*HIPAA*").

3. Electronic and paper records/file maintenance: Electronic service records are acceptable. Paper and electronic service records must be uniformly organized and easily accessible. A list of the order of the service record information shall either be present in each beneficiary's service record or provided to the DHS PASSE Quality Assurance unit and appropriate PASSE upon request. The documents in active service records should be organized in a systematic fashion. An indexing and filing system must be maintained for all service records.

4. Storage location: The location of the files/service records, and the information contained therein, must be controlled from a central location.

5. Direct care staff access: The PASSE HCBS provider shall ensure all direct care and care coordination staff has adequate access to the beneficiary's file/service record including, current PCSP and other pertinent information necessary to ensure the beneficiary's health, welfare, and safety (i.e., name and telephone number of physician(s), emergency contact information, insurance information, etc.).

6. Record/file retention: Each PASSE HCBS provider must retain all files/services records for five (5) years from the date of service or until all audit questions or review issues, appeals hearings, investigations or administrative or judicial litigation to which the files/services records may relate are finally concluded, whichever period is later. Failure to furnish medical records upon request may result in sanctions being imposed. Federal legislation further requires that any accounting of private healthcare information ("PHI") or *HIPAA* polices, or complaints must be retained for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

7. Access sheets: Access sheets shall be in the front of the service record to maintain confidentiality according to 5 U.S.C. § 552a. If there is a signed release for a list of authorized persons to review the service record, only those not listed will need to sign the access sheet with date, title, reason for reviewing, and signature. If there is not a signed release for authorized persons to review, all persons must sign the access sheet whenever the service record is reviewed, or any material is placed in the service record.

Training requirements

1. First aid training: Within thirty (30) days of hiring, all staff that may be required to provide emergency direct care services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including how to perform CPR, apply the Heimlich maneuver, stop/slow bleeding, etc.

    - The course must provide a certificate of completion that can be maintained in the staff's personnel file.
    - Any services provided by a staff person prior to receiving the above described First Aid Training can only be performed in a training role, under the supervision of another staff person that has already had the required First Aid Training.
    - Training Certification must be maintained and kept up to date throughout any staff member providing services.

2. Beneficiary specific training: Prior to beginning service delivery, staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supportive living services required pursuant to the beneficiary's PCSP, including, but not limited to:

- General training on beneficiary's PCSP
- Behavior management techniques/programming;
- Medication administration and management;
- Setting-specific emergency and evacuation procedures
- Appropriate and productive community integration activities; and
- Training specific to certain medical needs.

Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must be maintained in the personnel file of the supportive living staff member. This type of individualized, beneficiary-specific training shall be required each time a beneficiary's PCSP is updated, amended, or renewed.

3. Other required training: Staff must receive appropriate training on the following topics at least once every two (2) calendar years:

   - *HIPAA* Policies and Procedures
   - Procedures for Incident Reporting
   - Emergency and Evacuation Procedures
   - Introduction to Behavior Management
   - Arkansas Guardianship statutes
   - Arkansas Abuse of Adult statutes
   - Arkansas Child Maltreatment Act
   - Nurse Practice Act
   - Appeals Procedure for Individuals Served by the Program
   - Beneficiary Financial Safeguards
   - Community Integration Training
   - Procedures for Preventing and Reporting Maltreatment of Children and Adults
   - Other topics are where circumstances dictate staff should receive training to ensure the health, safety, and welfare of the beneficiary.

   Documentation evidencing that training on the topics has been completed must be maintained in the staff member's personnel file.

Beneficiary accessibility requirements

PASSE HCBS provider owned/leased/rented residential settings must be fully accessible by the beneficiary, compatible with the services being provided to the beneficiary, and compatible with the

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

Safe and comfortable environment

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

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

Emergency and evacuation procedures

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

A. There shall be written emergency procedures for:

   1. Fires.
   2. Natural disasters.
   3. Utility failures
   4. Medical emergencies

5. Safety during violent or other threatening situations

Additionally, the emergency procedures must satisfy the requirements of applicable authorities and contain practices appropriate for the locale (example: nuclear evacuations for those living near a nuclear plant).

B. The PASSE HCBS provider shall maintain an emergency alarm system for each type of drill (fire and tornado).

C. Beneficiaries, as appropriate, must be educated and trained about emergency and evacuation procedures.

D. Evacuation procedures must address:

1. When evacuation is appropriate.
2. Complete evacuation from the physical facility.
3. The safety of evacuees.
4. Accounting for all persons involved.
5. Temporary shelter, when applicable.
6. Identification of essential services.
7. Continuation of essential services.
8. Emergency phone numbers.
9. Notification of the appropriate emergency authorities.

Safety equipment

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

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

Required independence and integration

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

A. PASSE HCBS providers must take reasonable steps to ensure that beneficiaries are safe and secure in their homes and communities, considering the beneficiary's informed and expressed

choices.

B. Participant risk and safety considerations shall be identified, and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.

C. Beneficiaries shall be allowed free use of all space within the group living setting/alternative living site with due regard for privacy, personal possessions of other residents/staff, and reasonable house rules.

D. Settings must be able to provide beneficiaries access to community resources and be in a safe and accessible location. Beneficiaries must have access to the community in which they are being served. The site shall assure adequate/normal interaction with the community as a group AND as an individual.

- This can be achieved through transportation or through local community resources.

E. The living and dining areas must be provided with normalized furnishings for the usual functions of daily living and social activities.

F. The kitchen shall have equipment, utensils, and supplies to properly store, prepare, and serve three (3) meals a day. Beneficiaries must have access to food at any time. Any modification to this requirement must be based on an assessed need and documented in the beneficiary's PCSP.

G. Bedroom areas are required to meet the following:

1. Shall be arranged so that privacy is assured for beneficiaries. Sole access to these rooms cannot be through a bathroom or other bedrooms. Bedrooms must be equipped with a functioning lock with only appropriate staff having keys.

2. Beneficiaries must have a choice of roommate when shared by one or more individuals. The PASSE HCBS provider must actively address the need to designate space for privacy and individual beneficiary interests.

3. Physical arrangements shall be compatible with the physical needs of the individuals.

4. Each beneficiary shall have an individual bed. Each bed must have a clean, adequate, comfortable mattress.

   a. Beds are of suitable dimensions to accommodate the beneficiary who is using it. Mattresses must be waterproof, as necessary.

b. Each beneficiary must have a suitable pillow, pillowcase, sheets, blanket, and spread.

c. Bedding must be appropriate to the season and beneficiary's personal preferences. Bed linens must be replaced with clean linens at least weekly.

5. Bedroom furnishings for beneficiaries shall include shelf space, individual chest or dresser space, and a mirror. An enclosed closet space adequate for the belongings of each beneficiary must be provided.

6. Eighty (80) square feet per beneficiary in multi-sleeping rooms; one hundred (100) square feet in single bedrooms.

H. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

I. Bathroom areas are required to meet the following criteria:

1. Sole access may not be through another beneficiary's bedroom. Commodes, tubs, and showers used by beneficiaries must provide individual privacy.
2. A minimum of one commode and sink is provided for every four (4) beneficiaries. Lavatories and commode fixtures are designed and installed in an accessible manner so that they are usable by the beneficiaries living in the residential setting.
3. A minimum of one tub or shower is provided for every eight (8) beneficiaries.
4. Must be well ventilated by natural or mechanical methods.

<u>Home and Community Based Services (HCBS) settings requirements</u>

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

1. Be chosen by the beneficiary from among setting options including non-disability specific settings (as well as an independent setting), and an option for a private unit in a residential setting.
    a. Choice must be identified/included in the beneficiary's PCSP.
    b. Choice must be based on the beneficiary's needs, preferences and, for residential settings, resources available for room and board.
2. Ensure a beneficiary's rights of privacy, dignity and respect and freedom from coercion and restraint.

3. Must optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
4. Facilitate beneficiary choice regarding services and supports and who provides them.
5. The setting must be integrated in and support full access to the greater community by the beneficiary, including the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as beneficiaries not receiving CES Waiver services.
6. The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities, and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.
7. Each beneficiary has privacy in their sleeping or living unit, which must include the following:
    i. Units have entrance doors lockable by the beneficiary, with only appropriate staff having keys to doors.
    ii. Beneficiaries sharing units have a choice of roommates in that setting.
    iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

8. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
9. Beneficiaries can have visitors of their choosing at any time.
10. The setting is physically accessible to the beneficiary.
11. Any modification of the additional conditions specified in items 6 through 10 above must be justified in the beneficiary's PCSP. The following requirements must be documented in the beneficiary's PCSP:
    i. Identify a specific and individualized assessed need.
    ii. Document the positive interventions and supports used prior to any modifications to the PCSP.
    iii. Document less intrusive methods of meeting the need that have been tried but did not work.
    iv. Include a clear description of the condition directly proportionate to the specific assessed need.
    v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii. Include the informed consent of the beneficiary.

Include an assurance that interventions and supports will cause no harm to the beneficiary.

ARKANSAS PASSE Incident Report Form

Type of Report
☐ **Initial Written** **Date/Time:** ______________________
☐ **Follow-Up** **Date:** ______________
☐ **Final** **Date:** ______________

☐ **APC LLC** (DBA Summit) 1-844-462-0022 ArkansasQuality@anthem.com
☐ **Empower** 866-261-1286 Incident.Reporting@empowerhcs.com
☐ **Arkansas Total Care** 866-282-6280 Incident@ArkansasTotalCare.com

Incident Date: ______________ Incident Time: __________
Injured Person's Name: ____
Address: ____
Phone Number(s): ____
Age or Date of Birth: ______________
Gender: _____ Race: ___________________________
Legal Status: ____

Incident Type:
☐ Death; Suspected Cause? ____
☐ Suicidal Behaviors ☐ Rape
☐ Maltreatment/Abuse/Exploitation:
☐ Neglect ☐ Verbal ☐ Physical ☐ Sexual ☐ Other; ______________________
☐ Missing Client ☐ Injury ☐ Disturbance ☐ Property Destruction ☐ Theft ☐ Arrest
☐ Other; ____

Does Incident/Injury Require Medical Attention? ☐ Yes ☐ No
Physician/Hospital Name: ____
Address: ____
Phone Numbers: ________________________________

Designation of Incident:
☐ Member to Member ☐ Member to Staff ☐ Self-inflected ☐ Member to Public ☐ Public to Member
☐ Other; ____

Roles (Relationship to Subject) and Names of Others Involved:

Role	Name	Address and Phone

(Continue, if needed, in the Additional Information as Needed section, on the next page.)

Notifications (Enter method, date and time when communicated as appropriate.)
☐ Adult Protective Services Hotline (1-800-482-8049): ______________________
☐ Child Abuse Hotline (1-800-482-5964): ______________________________
☐ DHS PASSE Incident report line (501-371-1329 Fax 501-371-1474): ______________
☐ DHS PASSE Ombudsman: ____
☐ Next of Kin: ____
☐ Responsible Party (if different from above): __________________________
☐ Law Enforcement: ____
☐ Other: ____

ARKANSAS PASSE Incident Report Form		
Type of Report	☐ **Initial Written** ☐ **Follow-Up** ☐ **Final**	**Date of Incident:** ____________________ **Time of Incident:** ____________________ **Place of Incident:** ____________________

Clear, Concise Description of Incident:

Should/Could Incident Have Been Prevented/Anticipated? ☐ Yes ☐ No (If yes, please explain.):

Findings/Outcome/Disposition (When appropriate include corrective action or preventive plans for future.)

☐ Pending Investigation

☐ Investigated with Appropriate Action/Preventive Plan Attached

Additional Information as Needed:

Person Submitting Form: ____________________ Title: ____________________

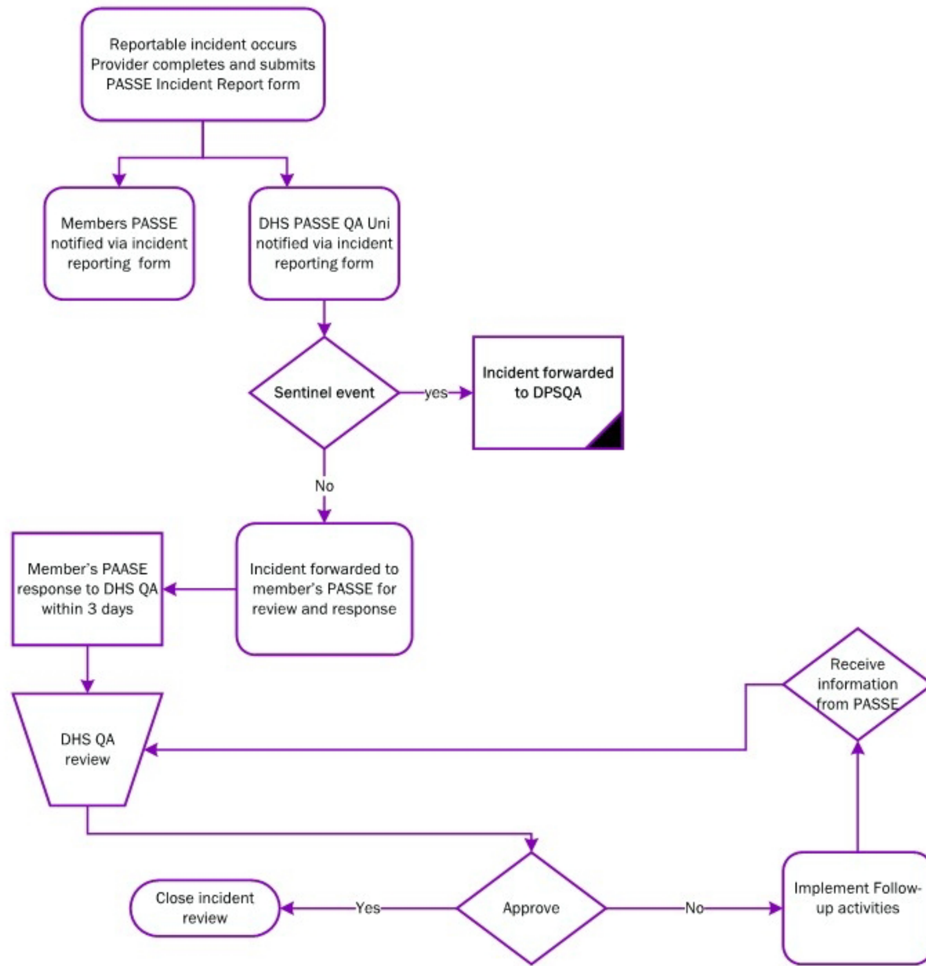
PASSE: ____________________ Phone Number: ____________________ Email: ____________________

HCBS Provider: ____________________ Contact: ____________________

Phone Number: ____________________ Email: ____________________

Division of Medical Services
Innovation and Delivery System Reform
P.O. Box 1437, Slot S401 · Little Rock, AR 72203-1437
501-682-8292 · Fax: 501-682-1197

Arkansas DHS PASSE
Quality Assurance
Incident Report Form
(2/27/2019)



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

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

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

Summit
COMMUNITY CARE