Program of All-inclusive Care for the Elderly (PACE)
Provider Manual
TABLE OF CONTENTS

Introduction .................................................................................................................... 4
Overview of PACE ........................................................................................................... 5
The Role of the Community Based Primary Care Physician in Pace ....................... 7
The Role of the Specialist in PACE ............................................................................... 11
The Role of Non-Physician Healthcare Providers in Pace ........................................ 12
Essential ArchCare Senior Life/ Pace Contact Information ...................................... 13
Important Member Information ................................................................................. 14
Medical Management .................................................................................................. 16
PACE Logistics and Care Coordination ...................................................................... 19
Quality Parameters for Primary Care Physicians ..................................................... 21
Credentialing and Re-Credentialing Information ....................................................... 22
Billing / Claims Information ......................................................................................... 24
Medical Records .......................................................................................................... 32
Fraud, Waste and Abuse ............................................................................................. 33
HIPAA ........................................................................................................................... 34
The Provider and Adverse Determinations ............................................................... 36
APPENDIX

    ArchCare Senior Life Provider Addition/Change Request Form ...................... 37
    Definitions ............................................................................................................ 38
    PACE Bill of Rights ............................................................................................... 40
    Quick Reference Guide ......................................................................................... 43
Legal and Administrative Requirements

Disclaimer

The information provided in this manual is intended to be informative and to assist Providers in navigating the various aspects of participation with the ArchCare Senior Life PACE program. Unless otherwise specified in the Provider Agreement, the information contained in this manual is not binding upon ArchCare Senior Life and is subject to change. ArchCare Senior Life will make reasonable efforts to notify Providers of changes to the content of this manual.

This manual may be updated at any time and is subject to change. In the event of an inconsistency between information contained in this manual and the Provider Agreement between you or your facility and ArchCare Senior Life, the Agreement shall govern.

In the event of a material change to the Provider Manual, ArchCare Senior Life will make all reasonable efforts to notify you in advance of such changes through Provider bulletins, Provider newsletters, and other mailings. In such cases, the most recently published information shall supersede all previous information and be considered the current directive. The manual is not intended to be a complete statement of all ArchCare Senior Life Plan policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially-targeted communications.
Introduction

This manual is designed to be a guide and reference for Providers who participate in the ArchCare Senior Life PACE program (ASL). ArchCare Senior Life is designed to manage the care of member’s 55 or older who are living in the community with physical and or cognitive disabilities through a PACE program. This program provides community based care and services that allow these people to remain in the community and lead a fulfilling life, who otherwise would need to receive their care in a nursing home.

Community based Providers participate in this program in different ways. Community based primary care physicians continue to provide medical care to their patients who become members of the program. In addition, they play a key role as a member of PACE’s interdisciplinary care team (IDT) to help formulate an integrated care plan for their patients. The care plan is designed to insure their patients receive non-medical services that are necessary to resolve problems related to activities of daily living so they can remain in the community as long as possible; and help them to participate in their physician’s medical treatment plan to the highest degree possible. Specialists play a more traditional role as consultants to the primary care physician to assess patients referred to them and treat these patients when necessary. Non-physician Providers also play a more tradition role in working with the primary care physician and the other IDT members to manage patients enrolled in the PACE program who require their services.

As with other insurers, the ArchCare Senior Life PACE program has Federal and State requirements that need to be complied with and internal processes and procedures that need to be followed to insure high quality care for their members and high quality service for its Providers. This manual attempts to explain what PACE is; the different roles Providers play when they participate in PACE; processes and procedures that need to be followed to comply with ArchCare and Federal and State requirements; how to contact ArchCare Senior Life; and how to utilize services available for Providers to insure they receive the highest quality of customer service possible.
AN OVERVIEW OF PACE

PACE stands for Program of All-Inclusive Care for the Elderly. It is a national program sponsored by the Federal government through Medicare and the State governments through Medicaid. It was developed for people 55 or older who either have Medicaid, Medicare and Medicaid (dual eligibles), or Medicare only and are willing to spend down their assets to qualify for Medicaid or pay privately; who were assessed as being eligible for nursing home placement according to the standards established by the State in which they reside; but with the appropriate services and care can continue to live safely in the community. In New York, nursing home eligibility is defined as having long term care needs of 120 days or more.

The model of care is built around an interdisciplinary team (IDT) which includes a primary care physician, nurse, social worker, physical therapist, occupational therapist, recreational therapist, dietician, center director, transportation coordinator, personal care worker and home care coordinator. Each member is assessed twice a year by the team. Based on the assessments, member problems are identified and the team builds an integrated care plan to resolve them.

The PACE program provides all the benefits that Medicare and Medicaid provide to its members at no cost if they have Medicaid or are dual eligible and at the discretion of the IDT can provide additional benefits when deemed necessary for the member. Core benefits include:

<table>
<thead>
<tr>
<th>Medical Care Services</th>
<th>Long-Term Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>Transportation</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>Adult Day Health Care</td>
</tr>
<tr>
<td>Hospital Care</td>
<td>Nursing Care</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Social Work</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Physical and Occupational Therapy</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Home Care</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Audiology, Dentistry, Optometry, Podiatry</td>
</tr>
</tbody>
</table>
To be eligible to enroll as an ArchCare Senior Life member, an individual must be:

1. 55 years of age or older;

2. A resident of New York (Manhattan), Bronx or Richmond counties;

3. Eligible for nursing home level of care based on an established criteria for New York State;

4. Eligible for Medicaid; have Medicaid; have Medicare and Medicaid or have Medicare and be willing to pay privately;

5. Able to live safely in the community with the services provided by the PACE program;

6. ArchCare Senior Life (ASL) has expanded criteria to include patients who are hearing impaired and those who have intellectual and developmental disabilities who meet the qualifications outlined above. In addition ASL has a unique program to work with patients that meet the eligibility criteria who have Parkinson’s disease.

7. Expected to need the long term care services of the plan for at least 120 days.

When a member is enrolled in ArchCare Senior Life, we become the sole payer for all of the member’s care and services. Services are available 24 hours a day, 7 days a week, and 365 days a year. Many services such as meals, recreational therapy, physical therapy and Adult Day Health Care can be provided in ArchCare Senior Life’s PACE centers. Services that are not provided at the centers will be provided in the home or by our network of contracted Providers, such as you, in consultation with our interdisciplinary team.

This Provider Manual is meant to assist you in working with our members within the framework of ArchCare Senior Life’s policies and procedures. Familiarizing yourself with and adhering to the procedures outlined in this Manual will help ensure a mutually beneficial, productive relationship in caring for our members.
THE ROLE OF THE COMMUNITY BASED PRIMARY CARE PHYSICIAN IN PACE

Originally Federal regulations required that PACE employ primary care physicians to care for PACE members. More recently Federal regulations have been changed to allow community based primary care physicians to provide care for PACE members if the member had been receiving care from the physician prior to joining PACE and wants to continue receiving care from that physician. Based on this change in regulations ArchCare Senior Life (ASL) has obtained a waiver from the Federal Government permitting it to contract with community based primary care physicians (CBPCP) to provide primary care services to members who choose to stay with their personal primary care physician when enrolling in PACE.

PACE regulations require that each member is managed by an interdisciplinary team (IDT), which includes the primary care physician. The waiver allows the CBPCP to directly interact with the other members of the IDT including a nurse, social worker, physical and occupational therapists, dietician and other non-physician care providers. PACE regulations provide specific guidelines with regard to CBPCP participation in the PACE program, member assessments and physician orders. In addition, ASL has developed requirements that define communication and documentation issues necessary to insure high quality care for their members.

Federal Pace Regulations

Guidelines

1. The community physician must have provided medical care to the member prior to the member’s enrollment in the PACE Program.

2. The community physician must contract with ASL to participate in the PACE program.

3. The community physician, as a member of the IDT, must collaborate with the other members of the IDT concerning the member (their patient) to develop an integrated care plan for the member. A new care plan must be formulated for the member at least twice a year or more often if there is a significant change in the member’s health status, such as a hospital admission.

4. The physician’s contribution to the member’s integrated care plan includes an assessment which provides the medical diagnoses and medical treatment plan for their patient. The integrated care plan is designed to assist the member in overcoming problems that create poor health behaviors and prevent them from complying with the physician’s medical treatment plan, and/or functioning safely in the community.

5. Each member is assigned a Home Care Nurse (HCN) to manage their care and work directly with the member’s community based primary care physician.
Assessments

1. The community physician must see the member at least four times a year. During these visits, two assessments must be done. The initial one is done when their patient first joins PACE and then a reassessment is done every six months. These assessments provide information for the IDT care planning process. An ASL Nurse Practitioner (NP) will be assigned to a CBPCP for the purpose of performing initial and semiannual assessments on their patients who become PACE members.

2. After completion of the assessment the NP will make arrangements to review the assessment with the CBPCP at their office, modify it as necessary and ensure the CBPCP signs it and places a copy in their patient’s medical record.

3. In addition the NP will place a signed copy of the assessment in the member’s medical record at the PACE Center to which the member is assigned.

4. The CBPCP is required to reassess a member who is discharged home from the hospital within 10 working days based on a significant change in their health status and the need for the IDT to have new information with which to develop a new integrated care plan. The ArchCare NP will assist the CBPCP in performing this reassessment as noted under Item 1 above.

Physician Orders

1. PACE regulations require the physician to review the care plan and if in agreement, signs and returns it to the PACE Center to which the member is attached.

2. New York State requires signed physician orders for the care plan implementation that covers home care services or other required treatment, within 30 days of receiving the care plan.

3. Orders and Care Plans will be brought to the CBPCP for his/her review and signature by the ASL Home Care Nurse (HCN) assigned to their patients who become PACE members.
Archcare Senior Life Requirements

Utilization Review and the use of Specialists

1. ASL has a brief Prior Authorization List for specific services, treatments, equipment and or evaluations (see Medical Management section). ASL’s Medical Management Department provides authorizations for these items upon the physician’s request. Please review the list and when prior authorization is required, provide the Medical Management Department with the appropriate clinical information to justify the authorization request.

2. No referrals or notifications are necessary for the use of network specialists.

3. If there is a need to use out-of-network specialists, Medical Management must be notified so they can determine the validity of the request and if deemed valid, reach out to the specialist to join the ASL network or negotiate a rate to see the member.

4. The physician’s office should notify ArchCare PACE staff about any consults or tests ordered for the member so the staff can assist the office in: scheduling appointments, arranging for transportation and escort services, ensuring the appointment is kept and follow up on obtaining consultation reports for the physician to review.

Care Transitions

1. If your patient, who is a PACE member, is discharged home following a hospitalization, his/her care should be discussed with the care coordinator or HCN managing their care within 24 hrs of discharge to review discharge diagnoses, instructions and medications, and if deemed necessary seen in the office to minimize the potential for re-hospitalization within 90 days after discharge. As noted above, the member must be seen within 24 hrs but no later than 2 business days after discharge for a reassessment based on a significant change in their health status and the need for information for the IDT to develop a new integrated care plan.

2. Post hospitalization, if the member is discharged to a skilled nursing facility (SNF) the CBPCP should review and comment on information provided by the member’s home care nurse related to the care plan developed by the SNF care team in conjunction with the HCN.

Communication

1. The CBPCP must notify the IDT through the member’s HCN of any changes in the medical treatment plan (medications, wound care, infections, consults) so physician orders and the current care plan can be adjusted.

2. The CBPCP needs to respond to requests from and appropriately collaborate with HCN for member care management within 2 hours for urgent issues, and within 24 hours for non-urgent issues.
3. The CBPCP must respond to requests and appropriately collaborate with the PACE Medical Director and/or other members of the IDT to develop or modify care plans for their patient on a timely basis; respond to calls and participate in review discussions within 48 hours of initial contact for an issue not requiring immediate attention, and within 12 hours for an issue requiring immediate attention.

4. The CBPCP must respond to and collaborate with the Clinical Pharmacist with regard to medication issues that require changes in the medication regimen, consideration of alternative medications or justification for continued use within 14 days of initial notification of an issue.

5. The CBPCP, upon receipt of a NP assessment of their patient, will review the document and if necessary make corrections, then sign it and maintain the assessment in the patient’s medical record.

ASL believes that complying with these regulations and requirements will significantly enhance the quality of care and the care coordination and management processes for the member. Physicians who comply with these regulations and work appropriately with ASL will be entitled to a quality bonus in addition to the case rate they receive for providing office care.
THE ROLE OF THE SPECIALIST IN PACE

Specialists who are in the ArchCare Senior Life PACE (ASL) network do not require a referral form to evaluate and or treat an ASL member. A request for a consultation will be made by the PACE Central Logistics Unit (CLU) regardless of which primary care physician (PCP) requests the appointment. This unit will obtain an appointment from the requested specialist; arrange for member transportation to and from the specialist’s office; and send information with the member including the reason for the consultation, member demographic information, a copy of the member’s card, contact and billing information and a “Quick Result Form” to be returned with the member prior to the completion of a formal consultation note. The unit will also inform the referring PCP’s office about the time of the appointment, arrange for a return visit to the PCP after the consultation and assist in making arrangements for any testing or imaging studies requested by the specialist.

Please be aware that ASL has a brief Prior Authorization List for specific treatments, equipment and or evaluations (see Medical Management section). Its Medical Management Department provides authorizations for these items upon the physician’s request. Please review the list and when prior authorization is required, make sure to provide the Medical Management Department with the appropriate clinical information to justify the authorization request. If after a visit you request a test, treatment or imaging study that is on this List please obtain an authorization from the Medical Management Department (see Essential Contact Information) prior to requesting that the CLU arranges for it.

If you are an out of network specialist (do not participate with ASL) and the member has been referred to you and you do not have ASL Letter of Agreement (LOA) from Provider Services, you must contact this department immediately to obtain one. This must be done prior to seeing the member to insure appropriate post visit management of the member’s needs and appropriate reimbursement.
THE ROLE OF NON-PHYSICIAN HEALTHCARE PROVIDERS IN PACE

All non-physician healthcare Providers providing the following services to PACE members must be in the ASL network. The following is a list of non-physician network Providers and the services they provide:

- DENTAL
- VISION
- AUDIOMETERY
- DURABLE MEDICAL EQUIPMENT
- TRANSPORTATION
- PERSONAL EMERGENCY RESPONSE (PERS)
- MEALS
- SOCIAL AND ENVIRONMENTAL

A request for a consultation, service or equipment will be made by the PACE Central Logistics Unit (CLU) regardless of which primary care physician (PCP) made the request. This unit will arrange for an appointment for the member if necessary, transportation to and from the appropriate office and send information with the member including the reason for the consultation, member demographic information, a copy of the member’s card, contact and billing information and a “Quick Result Form” to be returned with the member prior to the completion of a formal consultation or service note. If there is a request for durable medical equipment (DME) that is on the Prior Authorization List, the DME provider should obtain authorization through the Medical Management Department before providing the member with the equipment to insure appropriate reimbursement.

If a referral is made by a Community Based Primary Care Physician for the following services outside of a PACE Center, the Provider who receives the request must contact the Medical Management Department and obtain prior authorization for the requested service:

- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Pulmonary and Cardiac Rehabilitation

If prior authorization is obtained the CLU will arrange for an appointment for the member, transportation to and from the appropriate office and send information with the member including the reason for the consultation, member demographic information, a copy of the member’s card, contact and billing information and a “Quick Result Form” to be returned with the member prior to the completion of a formal service or consultation note.
ESSENTIAL ARCHCARE SENIOR LIFE/ PACE CONTACT INFORMATION

Administrative Office/Plan Address  
1432 Fifth Avenue  
New York, New York 10035

Central Logistics Unit: 855-720-9268

Customer Service 866-263-9083  TTY/TDD 711
24 hour answering service available after business hours and weekends

Utilization Review – Prior Authorization  
TBD

Medical Management Department 646-289-7700

Provider Services:
Telephone 866-263-9083
Fax Inquiries 646-417-7157

Compliance Hotline:  
(Fraud and Abuse Prevention)  
Telephone 800-443-0463

Claims:
Telephone 866-263-9083

Emergency Services:  
If the member is presenting in an emergency room, please contact ArchCare Senior Life immediately at 866-263-9083

TriState Benefits Solution:  
Claims Inquiry Telephone 866-479-5050

Pharmacy Services:  
General Inquiries 866-412-5435

Pharmacy Prior Authorizations:
Phone 855-344-0930 (TTY: 711)
24 hours a day, seven days a week
Fax 855-633-7673
Mail  
CVS Caremark Part D Services  
MC109, PO Box 52000  
Phoenix, AZ 85072-2000

Forms & additional information:  
www.ArchCareSeniorLife.org
IMPORTANT MEMBER INFORMATION

Member Identification

Every ArchCare Senior Life member receives an identification card that will detail the member’s name and identification number. This card identifies them as an ArchCare Senior Life member and should be presented to physicians and other Providers when seeking healthcare services. If the appointment for the requested consultation or service is made by the PACE Central Logistics Unit a copy of this card will be sent with the member as part of an information packet. The information packet also includes the reason for the consultation or requested service, member demographic information, contact and billing information, and a “Quick Result Form” to be returned with the member prior to the completion of a formal consultation or service note.

Regardless of whether a member has an identification card, Providers should verify member eligibility at the time of service to ensure s/he is enrolled in ArchCare Senior Life. Failure to do so may affect claims payment.

To confirm member eligibility, please contact Customer Service at 866-263-9083.
Reimbursement

Payment for services rendered is subject to verification that:

1. The member was enrolled in ArchCare Senior Life at the time the service was provided; and,
2. The Provider was compliant with ArchCare Senior Life Prior Authorization policies at the time of service.

Medicare and Medicaid will not be responsible for claims for the member while they are enrolled as a member of ArchCare Senior Life. All claims for services provided to ArchCare Senior Life members must be submitted to ArchCare Senior Life. Please see Billing / Claims Information. The claims submission address can also be found under Essential Contact Information.

Member’s Rights

When enrolled in a PACE program members have certain rights and protections. The PACE program must fully explain these rights to all members or someone acting on their behalf in a way that they can understand at the time they join. As a Provider, you have the responsibility to respect every member’s rights. Please see Appendix A for an overview of the PACE members’ rights.
MEDICAL MANAGEMENT

Utilization Review

The Utilization Review (“UM”) Program is designed to evaluate medical necessity and manage the quality and cost of specific health care services delivered to members of the ArchCare Senior Life PACE (ASL). All services authorized by the utilization review staff are evaluated either prospectively, concurrently, or retrospectively to determine medical necessity based on standard criteria. This program is designed to ensure that:

1. Services are medically necessary, consistent with the assigned member’s diagnoses, and are delivered at appropriate levels of care.
2. Services are provided by ASL contracted Providers and that the utilization review staff is notified immediately to discuss the use of non-contracted Providers based on services that are not available through contracted Providers.
3. Hospital admissions and length of stay are justified.
4. Services are not over-utilized or under-utilized.
5. Continuity and coordination of care is monitored.
6. Guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate. ASL utilizes standard criteria, such as InterQual Criteria, National Coverage Decisions, the Medicare Benefit Policy Manual, Local Coverage Determinations and current literature to assess all requests for determination of medical necessity. All criteria are reviewed by the Quality Improvement Committee on an annual basis.
7. New technology is evaluated based on Medicare and Medicaid reviews and review of studies that determine its application and effectiveness.
8. There is coordination of thorough and timely investigations and responses to Provider Appeals (see Provider and Adverse Determinations section).

Prior Authorization

The Medical Management Department through utilization review provides authorizations for specific services, procedures, tests and equipment upon a Providers’ request. Prior authorization is based upon the clinical documentation that supports medical necessity for the requested item. Services, procedures and equipment that require prior authorization have been summarized on the Prior Authorization List that is distributed to the Provider network. Contact the Medical Management Department staff at 646-289-7700 for a requested item on the List.
## Prior Authorization List

**ArchCare Senior Life**

*Services listed below require Prior Authorization from ArchCare. Please allow 5 business days for approval of standard authorizations and 24-48 hours for urgent requests.*

<table>
<thead>
<tr>
<th>Durable Medical Equipment</th>
<th>Rehabilitation Services - Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custom Shoes / Orthotics</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>C-PAP Machines</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Hospital Bed</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>Hoyer Lift</td>
<td>Pulmonary &amp; Cardiac Rehabilitative</td>
</tr>
<tr>
<td>Insulin Pumps</td>
<td>Therapy</td>
</tr>
<tr>
<td>Prosthetics- Major Limbs</td>
<td></td>
</tr>
<tr>
<td>Specialty mattresses</td>
<td></td>
</tr>
<tr>
<td>Wheelchairs (motorized, customized &amp; scooters)</td>
<td>Radiology</td>
</tr>
<tr>
<td>Wound Pumps</td>
<td>MRI, Functional MRI, MRA, PET scan</td>
</tr>
<tr>
<td>Bathroom Safety Devices</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Admissions</th>
<th>Transplant Evaluation &amp; Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Facilities, Skilled Nursing Facilities</td>
<td>Out-of-Network and Out-of-Area Services</td>
</tr>
<tr>
<td>Psychiatric Health Care Facilities</td>
<td>Surgery/ Admissions/Testing at non-participating facility</td>
</tr>
<tr>
<td>- Elective Admissions</td>
<td>Visits to non-participating Providers</td>
</tr>
<tr>
<td>- Urgent / Emergent Admissions *</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Rehabilitation Facilities</td>
<td></td>
</tr>
</tbody>
</table>

*Does not require prior authorization but notification of health plan within 24-48 hours of admission

<table>
<thead>
<tr>
<th>All cosmetic procedures (if medically necessary-listed below)</th>
<th>Investigational / Experimental Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Abdominoplasty</td>
<td></td>
</tr>
<tr>
<td>- Blepharoplasty</td>
<td></td>
</tr>
<tr>
<td>- Keloid &amp; Scar Revisions</td>
<td></td>
</tr>
<tr>
<td>- Mammoplasty, Reduction or Augmentation</td>
<td></td>
</tr>
<tr>
<td>- Surgical Treatment of Gynecomastia</td>
<td></td>
</tr>
<tr>
<td>- ENT Procedures (Rhinoplasty, Septoplasty, Uvoluplasty &amp; LAUP)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Services</th>
<th>Social &amp; Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>PERS</td>
</tr>
<tr>
<td>Ambulatory Surgeries</td>
<td>Meals</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Extermination</td>
</tr>
<tr>
<td>Outpatient Behavioral Health</td>
<td>House Cleaning</td>
</tr>
<tr>
<td>Outpatient Alcohol &amp; Substance abuse</td>
<td>Handy-man services (painting, carpentry, trash removal, etc....)</td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Transportation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Therapy</td>
<td></td>
</tr>
<tr>
<td>Pharmokinetic Testing</td>
<td></td>
</tr>
<tr>
<td>Audiology Equipment</td>
<td></td>
</tr>
<tr>
<td>Hyperbaric O2 Therapy</td>
<td></td>
</tr>
<tr>
<td>Skilled Home Care Services including Home Infusions</td>
<td></td>
</tr>
</tbody>
</table>

**Note: Some formulary medications may require prior authorization.**
Urgent and Emergency Care

ArchCare Senior Life provides coverage for the treatment of an emergency medical condition, which is defined by CMS as a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Inpatient and outpatient emergency health services are covered both inside and outside of the ASL service area. Prior authorization is not required for emergency care. In the event of an emergency, ASL instructs its members to seek immediate care, or call 911 for assistance. ASL will not deny payment if an ASL contracted health care Provider instructs a member to seek emergency services.

Enrollment in ASL includes coverage for post-stabilization care, defined as non-emergency services needed to ensure the member remains stabilized after an emergency. In the post-stabilization period, for services on the ASL Prior authorization list, Providers should only provide services authorized by the Medical Management Department. Unauthorized services will not be paid by ArchCare Senior Life unless it is an emergency or ArchCare Senior Life fails to respond to an authorization request within one hour of being contacted for urgently needed or post-stabilization services.

Urgently needed services are defined as those conditions which require immediate medical attention due to unexpected illness or injury. Fevers, abdominal pain, nausea and vomiting and difficulty urinating are some examples of situations requiring urgently needed services.

Urgent care services are covered for members when they are temporarily outside of the ASL service area. Providers must notify ASL within 24 hours or the next business day of providing emergency or urgent services to an ASL member, or if the member is admitted to a hospital.

Members are encouraged to carry their ArchCare Senior Life identification card at all times and to notify their care manager or Provider should they need urgent or emergency care.
PACE LOGISTICS AND CARE COORDINATION

Office Appointments, Transportation, Documents and Orders

There are a number of workflows that are routine for PACE but not for the Community Based Primary Care Physician (CBPCP) and their office staff. Not understanding the PACE process results in duplication of effort and or miscommunication leading to frustration of all parties involved in the management of the member. Federal regulations require PACE to keep a medical record for each member at the PACE site to which they are assigned regardless of whether there is a medical record in the CBPCP office. With this in mind, a key logistical issue is sending orders for the CBPCP to sign, placing a signed copy in the CBPCP chart and one in the PACE Center record. Another is moving notes and other documentation to and from the CBPCP office that need to be placed in both the CBPCP medical record and the member’s medical record in the PACE Center. PACE is accountable for making member appointments for routine follow up visits (even to the CBPCP office), specialty referrals, laboratory and imaging studies, and for elective procedures. PACE is also accountable for arranging member transportation for appointments, ensuring the member attended the scheduled appointment and obtaining results for review by the primary care physician.

In an effort to seamlessly manage these issues in conjunction with the CBPCP office staff, a centralized unit has been set up to manage all of these work flows. Centralizing order and document management prevents lost and or duplication of orders and documentation; it creates a centralized point for document retrieval and office communication; maintains receipts of orders and documents and disburses them to the appropriate offices and centers for filing. Centralization ensures effective communication because there is always someone present to answer the phone and pick up messages or faxes; provide guidance to the offices and troubleshoot issues and complaints.

A general orientation will be given by the PACE Home Care Nurse (HCN) assigned to the CBPCP office and the unit Director with regard to processes the office staff needs to follow for scheduling appointments for return visits and consultations; diagnostic tests and imaging studies; arranging for transportation and escort services; ensuring appointments are kept; documentation management; and following up on obtaining consultation reports for physician review. The unit contact number is 855-720-9268. It is also located in the Essential Numbers section of this manual.
Assessments, Care Plans and Care Coordination

PACE regulations require that a patient have an initial assessment (history and physical, medical diagnoses and medical treatment plan) when they become a member and a semiannual assessment thereafter by their primary care physician as part of the semiannual care plan development for each member. ASL provides a Nurse Practitioner (NP) to assist the CBPCP with this process. The NP will perform this assessment for the CBPCP’s PACE patients. After the assessment is completed, the NP will arrange to meet with the CBPCP to review it. Once the assessment is reviewed, and if necessary edited by the CBPCP, it must be signed and a copy must be placed in the CBPCP’s medical record for the member. A copy will also be placed in the PACE member’s record in the Center. Information from this assessment will be used along with information from the assessments performed by the other members of the Interdisciplinary Team (IDT) to create the member’s semiannual care plan.

The NP will represent the CBPCP at the IDT meetings for care plan development. After the care plan is developed it will be brought to the CBPCP by the Home Care Nurse (HCN) for review and signature along with the orders necessary to implement it, which also will require the CBPCP’s signature.

Each member is assigned to a HCN. Every attempt will be made to assign all of a CBPCP’s PACE members to one HCN. Care coordination and management to resolve problems and achieve goals outlined on the care plan is an ongoing process that is primarily managed through the HCN. The HCN will visit the CBPCP office biweekly. Their role includes educating the office staff on the appropriate procedures for utilization management, referral management, transportation management and notification for medication changes. The HCN is accountable for reviewing the member’s initial care plan with the CBPCP and subsequent changes in the care plan related to semiannual assessments and/or significant changes in the member’s health status (e.g. after discharge from a hospital or SNF); obtaining PCP signoff on the plan; a signature for the attendance at the IDT meeting, and a signature for the orders necessary to implement the care plan.

The HCN is also accountable for discussing member issues related to interim IDT discussions or from the PACE morning report with the CBPCP either in person or by phone. On a monthly basis the HCN is accountable for bringing orders to the CBPCP’s office from the central unit that require the PCP’s signature and bringing signed orders back to the central unit. On a monthly basis the HCN is accountable for reviewing all the CBPCP’s PACE members with the CBPCP with regard to changes in diagnoses, medications and treatment plans; care plan intervention results; laboratory, specialty referral and imaging results; and ensuring this information is placed in the progress note section of the member’s medical record at the PACE Center.

In addition to office visits every two weeks, the HCN should accompany any of the CBPCP’s members who are classified as severe or high risk to their office visit with the CBPCP to ensure the member understands and complies with the treatment plan offered at the time of the visit.
QUALITY PARAMETERS FOR COMMUNITY BASED PRIMARY CARE PHYSICIANS

Federal and state requirements related to service delivery in the PACE program require the Interdisciplinary Team (IDT) to identify member problems and complications, determine appropriate treatment goals, select care interventions and evaluate the effectiveness of care on an individual and program basis. This activity is the foundation for all of ArchCare Senior Life’s Quality Assurance Performance Improvement Program (QAPI) parameters. Each year the ASL Quality Management Committee develops a written QAPI plan for its program that deals with the elements noted above. Throughout the year plan components are tracked and reported on a quarterly, semiannual and annual basis both internally and to the Centers for Medicare and Medicaid Services (CMS) and the New York State Department of Health (NYSDOH).

Some of the plan’s quality parameters require input from or management by the Community Based Primary Care Physicians (CBPCP). ASL feels that meeting these parameter targets is essential for providing high quality service and care to its members. Based on this concept, ASL has established a Quality Bonus for CBPCP’s that can be achieved by successfully assisting ASL in achieving the targets set for some of the QAPI parameters. The CBPCP Quality Bonus structure with the quality parameters and targets is found in Exhibit D in the CBPCP contract.

Some of these parameters include tracking the infections acquired by their PACE members (UTI, wound, pneumonia, etc.) and their treatment outcomes and providing this information to the Home Care Nurse (HCN) who comes to their office and is assigned to the member. Additional examples include:

- Tracking falls reported by members that resulted in the need for medical intervention and relaying this information to the HCN.
- Ensuring that 85% of PACE members in the practice have a vaccination on an annual basis for influenza and 90% have been vaccinated for pneumonia.
- Ensuring that 95% of their PACE members have had a discussion related to advanced directives and at a minimum have a healthcare proxy.

Other parameters include:

- Timely responsiveness to requests by the HCN related to member care management, orders and review of care plans
- Responsiveness to the ASL Clinical Pharmacist with regard to medication reviews related to their member
- Timely review of the member’s semiannual assessment with the Nurse Practitioner assigned to assist with this process
- Timely submission of encounter data (superbills) related to each office visit with their member who is participating in PACE
- Achieving a satisfactory score on a member satisfaction survey.

Achieving the quality bonus is a reflection of the quality of care PACE members are receiving in your practice.
CREDENTIALING AND RE-CREDENTIALING INFORMATION

Initial Credentialing

Each practitioner, facility or ancillary Provider must complete a standard application form when applying for initial participation in the ArchCare Senior Life Network. This application may be a state-mandated form or a standard form created by or deemed acceptable by ArchCare Senior Life for practitioners, facilities and ancillary practitioners. The Council for Affordable Quality Healthcare (“CAQH”), a universal credentialing data source is utilized. CAQH is building the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their web site at www.CAQH.org.

ArchCare will verify those elements related to an applicant’s legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred and eighty (180) calendar-day period prior to the Credentialing Committee making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, ArchCare Senior Life will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners (Providers)

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>License to practice in the state(s) in which the practitioner will be treating Covered Individuals.</td>
</tr>
<tr>
<td>Medicare and Medicaid Certification</td>
</tr>
<tr>
<td>Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.</td>
</tr>
<tr>
<td>DEA, CDS and state controlled substance certificates</td>
</tr>
<tr>
<td>Note: The DEA/CDS must be valid in the state(s) in which practitioner will be treating Covered Individuals. Practitioners who see members in more than one state must have a DEA/CDS for each</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Malpractice claims history</td>
</tr>
<tr>
<td>Board certification or highest level of medical training or education</td>
</tr>
<tr>
<td>Work history</td>
</tr>
<tr>
<td>State or Federal license sanctions or limitations</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
<tr>
<td>National Practitioner Data Bank report</td>
</tr>
</tbody>
</table>
B. Facility and Ancillary (Health Delivery Organizations)

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation, if applicable</td>
</tr>
<tr>
<td>License to practice, if applicable</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Medicare and Medicaid certification</td>
</tr>
<tr>
<td>Department of Health Survey Results or recognized accrediting organization certification</td>
</tr>
<tr>
<td>License sanctions or limitations, if applicable</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
</tbody>
</table>

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner’s or facility and ancillary practitioner’s licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner’s, facility or ancillary’s professional conduct and competence. This information is reviewed in order to assess whether practitioners, facility and ancillary’s continue to meet ArchCare Senior Life’s credentialing standards.

During the re-credentialing process, ArchCare Senior Life will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements. All applicable practitioners and HDOs in the network within the scope of ArchCare Senior Life’s Credentialing Program are required to be re-credentialed every three (3) years unless otherwise required by contract or state regulations.

To support certain credentialing standards between the re-credentialing cycles, ArchCare Senior Life has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General (“OIG”)
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management (“OPM”)
4. State licensing Boards/Agencies
5. National Practitioners Data Bank (NPDB)
BILLING / CLAIMS INFORMATION

All providers are required to bill encounters thirty days after the service date, but no later than one hundred and eighty days after the service date as prescribed in the provider contract. All encounters when possible should be submitted electronically.

**PAYER ID: 31144**

ArchCare accepts electronic claim submissions for professional (837P), institutional (837I) and (837D) dental. Contact your clearinghouse to initiate the process to forward ArchCare claims to Ability (formerly Emdeon) or Change HealthCare (also formerly Emdeon).

Ability will provide the electronic requirements and set-up instructions. Providers should call 866-924-4634 Ext 4) or go to [www.emdeon.com](http://www.emdeon.com) for additional information.

**OR**

Enroll your office for Online Claim submission with MD On-line (a free online service for professional Providers who do not have claims submission software.) Visit [www.tbsmdol.com](http://www.tbsmdol.com) to register on line or call 888-499-5465 (a representative is available to assist you between the hours of 8:30AM to 6PM/EST.)

Dental claims will only be accepted through Change HealthCare at [www.changehealthcare.com](http://www.changehealthcare.com) or call 877-363-3666.

*Some Third-Party clearinghouses may be used but they will need to have affiliation with either Ability or Change Health. Please discuss this affiliation with your clearinghouse to ensure claims will be delivered.

**Paper Claims:**

Your paper claims must be submitted on typed, redlined CMS-1500 or UB-04 claim forms and mail to:

ArchCare Senior Life

c/o TriState Benefit Solutions

619 Oak Street

Cincinnati, OH 45206

Failure to send claims to this address, may result in delayed claims processing and/or rejected claims. Please ensure that all your claims are submitted timely, are complete and all required data elements are present, are correct, and valid for the service date to avoid delays in claims processing or denial of your claims.

**Claim Submission Tips:**

- Use the Member ID or HIC number for the Insured ID Number. (Use the entire number including any zero’s or letters)
- Ensure the correct date of birth is on the claim.
- Ensure both first and last names are spelled correctly.
- When submitting a corrected or voided claim please reference the ORIGINAL claim number (ICN/DCN) Failure to reference original claim will cause delays in claims processing.
- All ICD-10 diagnosis codes must be reported on the claim, as applicable, and must be submitted with the required level of specificity.
- All DME Claims must include the referring Physician NPI and the applicable ICD-10 code.
Claim Reconsideration

If you disagree with ArchCare’s claim determination, you have the right to request a reconsideration. Requests for reconsideration must be filed in writing within 60 calendar days, from initial claim determination.

Non-contracted Providers must also sign and submit a waiver of liability statement. Written appeals, along with any pertinent documentation, must be submitted to:

ArchCare Senior Life
33 Irving Place, 11th Floor
New York, NY 10003
Attention: Provider Appeal

Please visit our website for Model of Care training, compliance, and additional Provider information: www.archcareseniorlife.org

Please note that all encounters must be complete and if not will be rejected for missing information, the provider has sixty day days from the Explanation of Payment (EOP) to resubmit the encounter. Hint: All resubmitted UB-04 encounter should have 327 as the Type of Bill (TOB). The CBPCP will use a separate 837P for all services being reimbursed outside of capitation. Examples: vaccines, in-office surgeries, etc....

Professional claims: 837P/CMS 1500 (02/2012) or its successor
Which providers can use this form:
• Physicians
• Independent Laboratories
• Free standing Radiology
• Transportation
• Social & Environmental
• Durable Medical Equipment

Institutional claims: 837I/UB-04 or its successor
• Home Care Agencies
• Dialysis Centers
• Ambulatory Surgery Centers
• Skilled Nursing Facilities
• Acute Care/General Hospital

835 Health Care Claim Payment/Advice:
As the provider you do have the option to receive an Electronic Remit (835) from TriState Benefit Solutions (TBS). TBS only sends remits to our partnered clearinghouses: Change HealthCare and Ability.

How to register:
1) Register with clearinghouse to allow the receiving of the Electronic Remit (835)
2) Register with TBS to start producing Electronic Remits email Chris Ott Chris.Ott@Trihealth.com
Request for Claims Review

[ ] ArchCare Advantage  [ ] ArchCare Community Life  [ ] ArchCare Senior Life

Date: ______________________  
From:__________________________________________________________

Requestor:  [ ] Service Provider  [ ] Billing Company

Provider Name (please print): ______________________________________________________________
NPI#: ___________________________________  TIN #: _______________________________
Provider System ID#: _______________________  DOS: ________________________________
Billing Company Name: __________________________________________________________________
Representative’s Name:___________________________  Contact Information:_____________________

Multiple Members provide a spreadsheet with following data elements:

Spreadsheet attached: [ ] Yes  or  [ ] No

Member Name: __________________________________________________      ID#:_________________
Reason for review:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Expected Resolution:
[ ] Waive Timely Filing/Reconsideration (Director Signature Required) ________________________
[ ] Reprocess claim to reimburse per contract
[ ] Service authorized: Authorization #___________________________________________________
[ ] Other:___________________________________________________________________________
Review Conclusion:

[  ] Uphold Initial Claim Determination  [  ] Fully Favorable  [  ] Partially Favorable

Rationale:____________________________________________________________________________
_______________________________________________________________________________________
______________________________________________________________________________________

<table>
<thead>
<tr>
<th>Date Completed</th>
<th>Reimbursed Correctly or Reprocessed</th>
<th>Check#</th>
<th>Amount</th>
<th>Date of Check</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date Returned to requester: _______________
Participation Request Form
**This is not an Application**

Date: ____________

Please complete the Provider Participation Request Form and fax it to our office at 646-417-7157. Once your request has been reviewed for network needs, you will be notified either by mail, or by an ArchCare Provider Relations Representative. You are required to submit a current copy of your W-9 with this form.

Name of Provider/Group/Facility:_______________________________________________________
Contact Name: ____________________________
Phone: (    ) _____- ______ Fax: (    ) _____- ______ Email: ________________
NYS Lic#:_______________________                           TIN/EIN#:______________________

Check the line(s) of business you are applying for:
□ ArchCare Advantage (SNP)  □ ArchCare Senior Life (PACE)  □ ArchCare Community Life (MLTC)

Requesting participation as a (check all that apply):
□ PCP   □ Specialist   □ Both   □ Ancillary   □ Facility
Specialty: ___________________________ Board certified? □ Y □ N
Subspecialty: _________________________ Board certified? □ Y □ N

Contract Type (Check all that apply):
□ Individual NPI#:_______________________   □ Group/Facility NPI#: _______________________
Medicare#:_______________________________   Medicaid#:_______________________________

Are you currently providing services, or serviced an ArchCare Member in the past several months?
□ Y □ N

Services provided at: □ Nursing homes    □ Community □ other

Name of the Facility where services are rendered:________________________________________
Are you registered with CAQH? □ Y □ N   If yes, please provide CAQH ID:
Practice location(s): include Suite #, City, county, State, and Zip code (Please use additional page if needed)

1. ________________________________________________________________

2. ________________________________________________________________

Office hours: M: _____ T: _____ W: _____ Thu: _____ Fri: _____ Sat: _____ Sun: ______
(All Primary Care Physicians (PCP) must have a minimum of 16 hours at each practice site listed.)

Languages Spoken by Provider: _______________________________________________________

Handicapped accessible  Yes/No (circle one)

Accessible by public transportation?

After-hours coverage?
**Provider Information Update Form**

INSTRUCTIONS: To provide us with updated information (e.g., change in address, telephone number, email, fax number, etc.) please complete and fax this form as instructed. Type or print your information on this form. If a question does not apply, write “N/A” in the field. A separate form will be needed for each Provider.

Check the appropriate box:  □ Participating Provider  □ Non-Participating Provider
Check the appropriate box:  □ Changing information  □ Adding information

A W9 Form must be submitted for all billing address update

Line of Business:

- □ ArchCare Advantage  □ ArchCare Senior Life  □ ArchCare Community Life

<table>
<thead>
<tr>
<th>Date of Request</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Name</td>
<td></td>
</tr>
<tr>
<td>Provider Name</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
<tr>
<td>Email address</td>
<td></td>
</tr>
<tr>
<td>Tax ID</td>
<td></td>
</tr>
<tr>
<td>NPI</td>
<td></td>
</tr>
</tbody>
</table>

Type of change or addition
Check the box that applies

- ☐ Primary Address  ☐ Secondary Address  ☐ Billing Address
- ☐ Telephone  ☐ Email  ☐ Fax  ☐ Other _______________________

Enter the new information

Provider Signature
In receiving this form from the physician or entity, ArchCare relies on the trust of all the following statements:

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

Please submit request to:

ArchCare
Provider Relations Department
33 Irving Place, 11th Floor
New York, NY 10003
Fax: 646-417-7157
MEDICAL RECORDS

Maintenance and Retention of Medical Records

Providers must maintain adequate medical records for all ArchCare Senior Life (ASL) members treated by the Provider. Subject to all applicable statutory and legal privacy and confidentiality requirements, these medical records must remain available to each physician and other health professionals treating the member. In addition, upon request, the medical records must be available to ASL for review to determine whether the medical record and quality of services provided to the member was appropriate. Records should be maintained during the term of this agreement and for ten (10) years thereafter. The Provider must comply with all applicable state and federal law regarding access to these records. Disposal of any medical records by the Provider during this time period is permitted only upon prior written approval by ASL and the NYSDOH. Records involving matters in litigation shall be kept for a permitted period of time only upon prior written approval by ArchCare Senior Life and NYSDOH. Microfilm or electronic copies of records may be substituted for the originals with the prior written approval of ASL and the NYSDOH, provided that the microfilming procedures are reliable and are supported by an adequate retrieval system.

Access to and Audit of Records

At all times during the period that the ASL contract is active and for a period of ten (10) years thereafter, Providers must provide ASL, all authorized representatives of the state and federal governments and to appropriate individuals with knowledge of financial records (including independent public auditors) full access to its records which pertain to services performed and determination of amounts payable under this agreement. The Provider must permit ASL representatives to examine, audit and copy such records at the site at which they are located. Such access shall include both announced and unannounced inspections and on-site audit.

The Provider must promptly notify ASL of any request for access to any records maintained pursuant to their contract with ASL. All provisions of your Agreement with ASL relating to access and audit of records shall survive the termination of the Agreement and be binding until the expiration of the record retention period.
FRAUD, WASTE AND ABUSE

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

- Submission of false information for the purpose of obtaining greater compensation than that to which the Provider is legally entitled (i.e. up coding or unbundling of charges)
- Billing for services not rendered or billing in advance of care
- Knowingly demanding or collecting any compensation in addition to claims submitted for covered services (except where permitted by law)
- Ordering or furnishing inappropriate, improper, unnecessary or excessive care services or supplies
- Failing to maintain or furnish, for audit and investigative purposes, sufficient documentation on the extent of care and services rendered to members
- Offering or accepting inducements to influence members to join the plan or to use or avoid using a particular service
- Submitting bills or accepting payment for care, services or supplies rendered by a Provider who has been disqualified from participation in the Medicare or Medicaid programs

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

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

ArchCare Senior Life is concerned with protecting member privacy and is committed to complying with the Health Insurance and Portability Act (HIPAA) privacy regulations. Generally, covered health plans and covered Providers are not required to obtain individual member consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities such as: care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement fall into this category. If you have further concerns, please contact Customer Service at 866-263-9083.(should this be customer service or Provider Services?)

HITECH Act

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

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

Under the HITECH Act, business associates are now responsible for complying with the provisions and regulations of HIPAA and are directly answerable to the government for HIPAA breaches. Business associates are now also directly liable for civil and criminal penalties. This increased statutory liability for business associates under HIPAA will likely result in the necessity of updating business associate and vendor lists as well as renegotiating business associate agreements. In addition, business associates will most likely incur costs associated with bringing themselves into direct HIPAA compliance.

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

- When the breach happened, when the event was discovered, and a brief statement about what happened
- What type of PHI was breached
- Things that the individual can do in order “to protect themselves from potential harm resulting from the breach”
- What corrective actions and investigation the covered entity is doing to prevent future breaches and mitigate losses; and contact information for the individual to use in case of any questions.
In addition to disclosure accounting, the individual is also entitled to receive a copy of his or her electronic health record, if they request; this information may be sent to the individual, or another person designated by individual.

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

An Adverse Determination is defined as a decision not to provide or pay for a requested service, treatment or equipment in whole or in part or a decision to discontinue or reduce a service that has been requested by a provider on behalf of a member. This is a utilization review decision that can only be made by a physician who is licensed to practice medicine in the state of New York. The information the reviewing physician receives from the requesting provider is used to determine the medical necessity for the requested service, treatment or equipment. The reviewing physician must base his or her decision on nationally excepted guidelines such as the Medicare coverage guidelines, Medicare manual references, InterQual guidelines, the approved Evidence of Coverage provisions and on the current literature that is relevant to the requested service, treatment or equipment.

If the provider’s request is denied, an adverse determination, the provider has the following recourse. Prior to denying a request the reviewing physician, a Medical Director, will attempt to contact the requesting provider and discuss the case. If the Medical Director has not attempted to discuss the case with the requesting provider or was unable to contact the provider after three attempts, the provider has an opportunity to provide additional information to the Medical Director and request a reconsideration review of the adverse decision. The reconsideration review will occur within one business day of the physician request and will be conducted by the Medical Director involved in the original decision. If the Medical Director upholds his or her decision to deny, written notification will be sent to the provider and the member with the decision and the reason for it.

If the provider has discussed the case with the Medical Director and disagrees with his/her determination to deny, they may request a Standard Appeal. Your request and the information you provided will be reviewed by a different Medical Director than the one who reviewed your initial request and denied it. We’ll give you a written decision on a standard appeal within 30 days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. You have 60 days from the time you receive the written notification of an adverse determination to initiate an appeal.

If you believe the health of your patient could be seriously harmed by waiting up to 30 days for a decision you can request an Expedited Appeal – We’ll give you a decision on an expedited appeal within 72 hours after we get your request for an appeal.
APPENDIX A

ArchCare Senior Life Provider Addition/Change Request Form

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

Check the appropriate box:

☐ Change of Information* ☐ Credentialing Request

<table>
<thead>
<tr>
<th>Date of Request</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Name</td>
<td></td>
</tr>
<tr>
<td>Provider Name</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Board Certification ☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Tax ID</td>
<td></td>
</tr>
<tr>
<td>NPI</td>
<td></td>
</tr>
<tr>
<td>Primary Office Location</td>
<td></td>
</tr>
<tr>
<td>Secondary Office Location</td>
<td></td>
</tr>
<tr>
<td>Provider Signature</td>
<td></td>
</tr>
</tbody>
</table>

*Requests for change of demographic information will be reflected in ArchCare Senior Life within 48 hours. A representative will contact you within that timeframe to advise when the change has taken effect.

In receiving this form from the physician or entity, ArchCare Senior Life relies on the truth of all the following statement:

All information entered is accurate and complete, and that if any of that information changes, Provider will notify ArchCare Senior Life of any such change within 30 days.

By submitting this form, Provider agrees to abide by all Medicare statutes, rules, and policies.

Please submit request form to:

ArchCare Senior Life / PACE
Attention: Credentialing Department
33 Irving Place, 11th Floor
New York, NY 10003
Fax: 646-417-7157
DEFINITIONS

I. **Enrollment Agreement** is the document issued to a member by ArchCare Senior Life that describes the covered services the member is entitled to receive as a member of ArchCare Senior Life; and its obligations to arrange for the delivery of those services to ArchCare Senior Life members who are eligible for such services pursuant to the terms of Plan’s contract with the New York State Department of Health and Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services.

II. **Covered Service** is defined as those services which are medically indicated and which Members are entitled to receive under the terms of the Enrollment Agreement.

III. **DOH** is defined as the New York State Department of Health.

IV. An **Emergency** medical condition is defined as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in:
   a) Serious jeopardy to the health of the individual;
   b) Serious impairment to bodily functions; or
   c) Serious dysfunction of any organ or part.

V. **CMS** is defined as the Centers for Medicare and Medicaid Services.

VI. **Medically Necessary Services** are those health care services that are covered in the members’ enrollment agreement and:
   a) Provide for the diagnosis, prevention, or direct care of a medical condition;
   b) Are appropriate and necessary, for the diagnosis, prevention, or treatment of a medical condition and could not be omitted without adversely affecting the Member’s condition
   c) Are within standards of good medical practice recognized within the organized medical community
   d) Are appropriate to and consistent with the Member’s diagnosis and (except for Emergency Services or Urgent Services) their care plan
   e) Would be likely to materially improve or to help in maintaining the Member’s physical condition
   f) Would be likely to materially improve or to help in maintaining the Member’s ability to engage in essential activities of daily living
   g) Are not primarily for the convenience of the Member or his/her family, his/her physician, or another care Provider
   h) Are the most appropriate and economical level and source of care or supply that can be provided safely.

and whose provision is based on guidelines, standards, and criteria such as InterQual Criteria, National Coverage Decisions, Medicare Benefit Policy Manual and Local Coverage Determinations and review of appropriate literature related to the requested service.
VII. **Member** is defined as any person who is eligible to receive Covered Services under the eligibility criteria set by DOH and is enrolled in ArchCare Senior Life.

VIII. **Interdisciplinary Team** is defined as a group of health professionals or caregivers composed of the primary care physician, registered nurse, social worker, physical therapist, occupational therapist, recreational therapist, activity coordinator, dietitian, PACE Center manager, home health care coordinator, home health aides/personal care attendants, and drivers.

IX. **PACE** is defined as the Program of All-inclusive Care for the Elderly. It offers a benefit plan to frail seniors who are nursing home eligible who live at home with the support of PACE services. PACE is an integrated comprehensive program that combines the services of an adult day center, home health care, medical outpatient clinic or office care, and a network of specialty care Providers including inpatient hospital and nursing home care when needed.

X. **Participating Agency** is defined as an agency or health care Provider that has signed an ArchCare Senior Life Service Agreement.

XI. **Primary Care Physician** is defined as any physician, professional service corporation or partnership who or which has agreed to provide specific primary health services to Members and to coordinate the overall health care of Members as their primary care physician.

XII. A **Provider** is defined as Providers of individual services who are contracted vendors. The Provider must meet applicable New York state licensure, certification, or registration requirements in which they practice, and meet ArchCare Senior Life’s credentialing criteria.

XIII. **Quality Assurance Performance Improvement (QAPI):** ArchCare Senior Life has a quality assurance performance improvement committee consisting of its program director, director of member services, Medical Director and other clinical and non-clinical professional staff as deemed appropriate. All Contracted Service Providers are encouraged to participate in Quality Assessment.
The PACE Member Bill of Rights

**They have the right** to be treated with respect.

**They have the right** to be treated with dignity and respect at all times and to have all their care kept private, and to get compassionate, considerate care.

**They have the right:**
- To get all of their health care in a safe, clean environment
- To be free from harm. This includes physical or mental abuse, neglect, physical punishment, being placed by themselves against their will, and any physical or chemical restraint that is used on them for discipline or convenience of staff that they do not need to treat their medical symptoms or to prevent injury
- To be encouraged to use their rights in the PACE program
- To get help, if they need it, to use the Medicare and Medicaid complaint and appeal processes, and their civil and other legal rights
- To be encouraged and helped in talking to PACE staff about changes in policy and services they think should be made
- To use a telephone while at the PACE Center

**They have the right:**
- To not have to do work or services for the PACE program

**They have a right to protection against discrimination.**
Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot be discriminated against because of their:
- Race /Ethnicity and National Origin
- Religion
- Age
- Sex
- Mental or physical ability
- Sexual Orientation
- Source of payment for their health care *(For example, Medicare or Medicaid)*. If they think they have been discriminated against for any of these reasons, they should contact a staff member at the PACE program to help them resolve their problem. If they have any questions, they can call the Office for Civil Rights at 800-368-1019. TTY users should call 800-537-7697.

**They have a right to information and assistance.**
They have the right to get accurate, easy-to-understand information and to have someone help them make informed health care decisions.

**They have the right:**
- To have someone help them if they have a language or communication barrier so they can understand all information given to them
- To have the PACE program interpret the information into their preferred language
They have a right to a choice of Providers.
They have the right to choose a health care Provider within the PACE program’s network and to get quality health care. Women have the right to get services from a qualified women’s health care specialist for routine or preventive women’s health care services.

They have a right to access emergency services.
They have the right to get emergency services when and where they need them without the PACE program’s approval. A medical emergency is when they think their health is in serious danger—when every second counts. They may have a bad injury, sudden illness or an illness quickly getting much worse. They can get emergency care anywhere in the United States.

They have a right to participate in treatment decisions.
They have the right to fully participate in all decisions related to their health care. If they cannot fully participate in their treatment decisions or they want to have someone they trust help them, they have the right to choose that person to act on their behalf.

They have the right:
- To have all treatment options explained to them in a language they understand, to be fully informed of their health status and how well they are doing, and to make health care decisions. This includes the right not to get treatment or take medications. If they choose not to get treatment, they must be told how this will affect their health.
- To have the PACE program help them create an advance directive. An advance directive is a written document that says how they want medical decisions to be made in case they cannot speak for themselves. They should give it to the person who will carry out their instructions and make health care decisions for them.
- To participate in making and carrying out their plan of care. They can ask for their plan of care to be reviewed at any time.
- To be given advance notice, in writing, of any plan to move them to another treatment setting and the reason they are being moved.
They have a right to have their health information kept private.
They have the right to talk with health care Providers in private and to have their personal health care information kept private as protected under State and Federal laws. They have the right to look at and receive copies of their medical records.

They can also be assured that:
- All of the information in their health record, including information contained in an automated data bank is treated in a confidential manner at all times
- Their written consent will be required and obtained before any information is released to any person not otherwise authorized under law to receive it
- They have the right to provide written consent that limits the degree of information and the persons to whom information may be given

There is a member privacy rule that gives them more access to their own medical records and more control over how their personal health information is used. If they have any questions about this privacy rule, please call the Office for Civil Rights at 800-368-1019. TTY users should call 800-537-7697. They also have the right to confidentiality in the treatment, payment, and health care operations, provided that such use or disclosure is consistent with other applicable requirements of the HIPAA Privacy Rule.

They have a right to file a complaint.
They have a right to complain about the services they receive or that they need and don’t receive, the quality of their care, or any other concerns or problems they have with their PACE program. They have the right to a fair and timely process for resolving concerns with their PACE program. They have the right:

- To a full explanation of the complaint process
- To be encouraged and helped to freely explain their complaints to PACE staff and outside representatives of their choice. They must not be harmed in any way for telling someone their concerns. This includes being punished, threatened, or discriminated against
- To appeal any treatment decision by the PACE program, staff, or contractors

They have a right to leave the program.
If, for any reason, they do not feel that the PACE program is what they want, they have the right to leave the program at any time.
<table>
<thead>
<tr>
<th>ArchCare Senior Life Quick Reference Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Eligibility</strong></td>
</tr>
<tr>
<td><strong>Care Management</strong></td>
</tr>
<tr>
<td><strong>Central Logistics Unit</strong></td>
</tr>
<tr>
<td><strong>ED Visits &amp; Hospitalization Reporting after hours &amp; Weekends</strong></td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
</tr>
</tbody>
</table>
| **Claims Submission** | **Submitting Claims Electronically:**  
For all electronic claims, ArchCare utilizes the Emdeon clearing house and Ability (MD On-line), a free online service for non-facility Providers who do not have claims submission software. Claims submitted electronically receive a status report indicating the claims are accepted, rejected and/or pending.  
Claims submitted electronically must include:  
1. The ArchCare Payer ID: 31144  
2. ArchCare Senior Life Member ID Number  
3. National Provider Identifier (NPI)  
To sign up for electronic billing with Emdeon, Provider must contact their software vendor and request that their ArchCare claims be submitted through Emdeon. Providers can also direct their current clearing house to forward claims to Emdeon. To sign up or to get additional information visit [www.emdeon.com](http://www.emdeon.com) or call 866-924-4634, option #4.  
To enroll your office for online claim submission with Ability (MD-Online), visit [www.tbsmdol.com](http://www.tbsmdol.com) or call 888-499-5465.  
**Submit paper claims to:**  
ArchCare Senior Life  
C/O TriState Benefit Solutions  
619 Oak Street  
Cincinnati, OH 45206  
Telephone: 866-479-5050  
**Note for Group Practices and Facilities: When submitting claims, please ensure separate billing NPI and Provider NPI numbers are entered in the appropriate fields.** |
| **Claims Reconsideration** | Please submit Claims Review Form must be receive within 60 days of the EOP, if received after the 60 days no further action will be taken. Send to: ArchCare Senior Life C/O Claims Reconsideration 33 Irving Place, 11th Floor New York, NY 10003 |
| **Provider Relations** | 33 Irving Place, 11th Floor New York, NY 10003 Telephone 800-373-3177 or 855-467-9351 Fax 646-417-7157 |
| **Pharmacy Services** | 866-412-5435 |
| **Carekinesis M-F** | 888-974-2763 |
| **Carekinesis After hours & Weekends** | 877-350-4523 |
| **Pharmacy Prior Authorizations** | Telephone: 855-344-0930 (TTY: 711) 24 hours a day, 7 days a week Fax: 855-633-7673 Mail: CVS Caremark Part D Services, MC109, PO Box 52000 Phoenix, AZ 85072-2000 Forms & additional information: [www.ArchCareSeniorLife.org](http://www.ArchCareSeniorLife.org) |