archcare Advantage
HMO Special Needs Plan

ArchCare Advantage
Provider Manual

September 2021

KEEPING OUR MEMBERS HEALTHY IN THE PLACE THEY CALL HOME
THROUGH PARTNERSHIP WITH OUR PROVIDERS

Dear Provider,

We at ArchCare are pleased to present this Provider Manual. It is designed to answer your questions about ArchCare Advantage and its services and to better understand our policies and procedures as it pertains to our Providers.

This manual will give you comprehensive information about our different departments, services and your roles and responsibilities as a provider. Periodic updates will be available to you so you may stay current and you may contact Provider Relations by phone at 800-373-3177 or ProviderRelations@archcare.org. We welcome your feedback, questions and comments.

ArchCare Advantage stands poised to coordinate high quality care with exceptional outcomes for our Members. Our commitment to this partnership with our providers will assist us in delivering this care and achieving these outcomes.

We look forward to working with you.

Sincerely,

ArchCare

Contents

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 Advantage program. Unless otherwise specified in the Provider Agreement, the information contained in this manual is not binding upon ArchCare Advantage and is subject to change.

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 Advantage, the Agreement shall govern.

In the event of a material change to the Provider Manual, ArchCare Advantage will make all reasonable efforts to notify you in advance of such changes through Provider Educational Series, 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 Advantage policies and procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially-targeted communication.

INTRODUCTION

Welcome and thank you for participating in ArchCare Advantage. With ArchCare Advantage HMO Special Needs Plan, you and your loved ones have the peace of mind of knowing that someone is focused on your health needs 24 hours a day, whether you live at home or in one of our participating nursing homes.

ArchCare Advantage is an Institutional Special Needs Plan with members living both at home, in the community and in nursing homes. As long as you require a nursing home level of care, our plan can help you with your very special needs, regardless of where you reside.

ArchCare Advantage covers everything traditional Medicare does and more, including personalized care coordination and attention to your particular health challenges, and solid, ongoing preventive care to keep you healthy and out of the hospital. Your ArchCare Advantage care manager will get to know you and your family, monitor your health and manage every detail of your care to keep you healthy and living life to its fullest wherever you call home.

This manual services as guide to ArchCare Advantage's policies and procedures that govern the ArchCare Advantage Plan members, services and providers. Please keep this manual in a convenient, accessible location and use it when applicable. This Manual is also available on the ArchCare Advantage website www.Archcare.org .

Its contents are subject to periodic updates and modifications in compliance with federal and state regulations and ArchCare Advantage policy changes.
If you or your staff has any questions about the policies and procedures in this Manual, please contact the ArchCare Advantage Provider Relations Department at 800-373-3177.

OVERVIEW

ArchCare Advantage is a HMO Special Needs Plan Program is a Coordinated Care plan with a Medicare contract. ArchCare Advantage is a specialized Medicare Advantage Plan (a Medicare Advantage "Special Needs Plan"), which means its benefits are designed for people with special health care needs. ArchCare Advantage is designed specifically for people who live in an institution (like a nursing home) or who need a level of care that is usually provided in a nursing home.

Our plan includes access to a network of providers who specialize in treating patients who need this level of nursing care. As a member of the plan, you get specially tailored benefits and have all your care coordinated through our plan.

Mission Statement: *The Mission of ArchCare Advantage is to foster and provide faith based holistic care to frail and vulnerable people unable to fully care for themselves. Through shared commitments, ArchCare seeks to improve the quality of the lives of those individuals and their families.*

What is special needs plan and how does it work?

A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be any one of the following:

1. An institutionalized individual,
2. A dual eligible, or
3. An individual with a severe or disabling chronic condition, as specified by CMS.

A SNP may be any type of MA CCP, including either a local or regional preferred provider organization (i.e., LPPO or RPPO) plan, a health maintenance organization (HMO) plan, or an HMO Point-of-Service (HMO-POS) plan.

Eligibility Requirements: An individual must:

1. have both Medicare Part A and Medicare Part B.
2. live in our geographic service area.
3. have a United States citizenship or are lawfully present in the United States.
4. not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
5. must meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the specialized needs of people who need a level of care that is usually provided in a nursing home.

To be eligible for our plan, you must meet one of the two requirements listed below.

1. You live in one of our network nursing homes. Call Member Services and ask us to send you a list (phone numbers are printed on the back cover of this booklet).
2. Or you live at home and New York State has certified that you need the type of care that is usually provided in a nursing home.

ArchCare Advantage is committed to bringing people and resources together to better plan and delivers accessible, high quality, cost effective health care services. ArchCare Advantage has developed a network of area providers who are able to provide the services our Members may require while enrolled. The providers in the network have been selected and credentialed by ArchCare Advantage to assure our Members the best possible care. When an individual enrolls in ArchCare Advantage they are required to use providers in the ArchCare Advantage network and also obtain authorization from their Care Management Team.

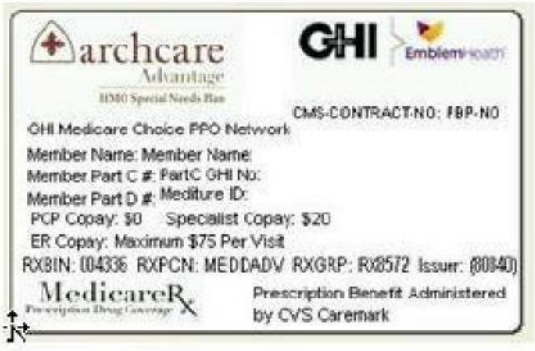
SERVICE AREA:

- Bronx
- Kings
- New York
- Putnam
- Queens
- Richmond
- Westchester
- Dutchess
- Orange
- Onondaga

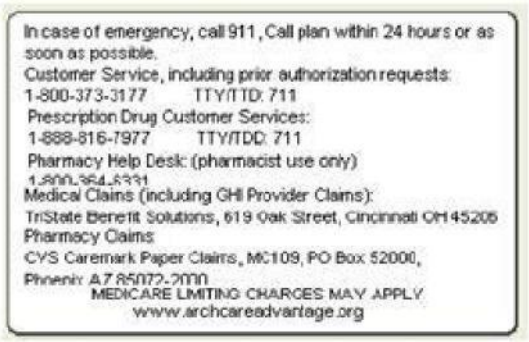
IDENTIFICATION CARD

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

Sample Front of Card



Sample Back of Card



Members should present their cards to you at the time of services.

All providers must verify a Member's eligibility at the time of service. All Members are instructed to present their membership card each time they obtain medical services. Please note that ArchCare Advantage may not be able to retrieve membership cards from Members when they disenroll or lose coverage, a membership card alone is not a guarantee of eligibility.

To verify Membership eligibility:

- Contact Customer Service at 800-373-3177 and speak with a representative.
- Capitated providers or providers with ongoing authorizations (i.e. Personal Care Workers, etc.) can consult their Membership roster for the present month to ensure Member appears on their list. If the Member is on the capitation list, the provider has received the monthly capitation payment for Member

COVERED SERVICES AND BENEFITS

Services for Members of ArchCare Advantage and their respective coverage rules:

Service	Coverage Rules
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Ambulance services Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$100 copay for Medicare covered Ground Ambulance Services. $250 copay for Medicare covered Air Ambulance Services.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Breast cancer screening (mammograms) Covered services include: 1. One baseline mammogram between the ages of 35 and 39 2 One screening mammogram every 12 months for women age 40 and older 3.Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	There is no coinsurance, copayment, or deductible for Medicare-covered Cardiac rehabilitation services.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) 2. We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral. Therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: 1. For all women: Pap tests and pelvic exams are covered once every 24 months. 2. If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: 1. We cover only manual manipulation of the spine to correct subluxation	There is no coinsurance, copayment, or deductible for Medicare-covered Chiropractic services.

Colorectal cancer screening For people 50 and older, the following are covered: 1. Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: 1. Guaiac-based fecal occult blood test (gFOBT) 2. Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: 1. Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: 1. Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.

Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: Non-Routine, Diagnostic, Restorative, Endodontics / Periodontics / Extractions, Prosthodontics, Other Oral / Maxillofacial Surgery, Other Services) **– Medicare Covered Benefits**	There is no coinsurance, copayment, or deductible for Medicare-covered Dental services.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.

Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users). Covered services include: 1. Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. 2. For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. 3. Diabetes self-management training is covered under certain conditions.	*Authorization rules may apply. There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes self-management training. You pay 20% of the cost for the Medicare-covered durable medical equipment and prosthetics. You pay 20% of the cost for the Medicare-covered diabetic supplies and diabetic therapeutic shoes or inserts.
Durable medical equipment (DME) and related supplies	*Authorization rules may apply.

Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, and hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.ArchCare.org. Generally, ArchCare Advantage (HMO SNP) covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to ArchCare	You pay 20% of the cost for the Medicare-covered durable medical equipment.

Advantage (HMO SNP) and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.) If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition.	
Emergency care Emergency care refers to services that are: 1. Furnished by a provider qualified to furnish emergency services, and 2. Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	$90 copay for Medicare covered care services. If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. If you receive emergency care at an out-of-network hospital and need inpatient care After your emergency condition is stabilized, you must have your inpatient care at the out- of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	There is no coinsurance, copayment, or deductible for Medicare-covered benefits.

HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: 1. One screening exam every 12 months For women who are pregnant, we cover: 1. Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.

Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: 1. Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) 2. Physical therapy, occupational therapy, and speech therapy 3. Medical and social services 4. Medical equipment and supplies	*Authorization rules may apply. There is no coinsurance, copayment, or deductible for the Medicare-covered home health agency care.

Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered Services include: 1. Drugs for symptom control and pain relief 2. Short-term respite care 3. Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: 1. If you obtain the covered services from a network provider, you only pay the plan cost- sharing amount for in-network services.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not ArchCare Advantage (HMO SNP).

2. If you obtain the covered services from an outof-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by ArchCare Advantage (HMO SNP) but are not covered by Medicare Part A or B: ArchCare Advantage (HMO SNP) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services	
Immunizations Covered Medicare Part B services include: 1. Pneumonia vaccine 2. Flu shots, once a year in the fall or winter 3.Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B 4. Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: 1. Semi-private room (or a private room if medically necessary) 2. Meals including special diets 3. Regular nursing services 4. Costs of special care units (such as intensive care or coronary care units) 5. Drugs and medications	*Authorization is required for elective or scheduled admissions. Referral is required for inpatient hospital-acute services. A per admission deductible is applied once during the defined benefit period. The Plan covers 90 days each benefit period. In 2019 the amounts you pay for each benefit period are: Days 1-60: $1,364 deductible for each benefit period Days 61-90: $341 per day for each benefit period

6. Lab tests 7. X-rays and other radiology services 8. Necessary surgical and medical supplies 9. Use of appliances, such as wheelchairs 10. Operating and recovery room costs 11. Physical, occupational, and speech language therapy 12. Inpatient substance abuse services 13. Under certain conditions, the following types of transplants are covered: corneal, kidney, kidneypancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If ArchCare Advantage (HMO SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. 14. Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. 15. Physician services Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. Covered services include mental health care services that require a hospital stay. You are covered up to a 190-day	Days 91-150: $682 per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) A benefit period begins when you are admitted to the hospital and ends when you are discharged. If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the costsharing you would pay at a network hospital. Except in an emergency, your doctor must tell us that you are going to be admitted to the hospital.

lifetime limit for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.	
Inpatient mental health care Covered services include mental health care services that require a hospital stay. You are covered up to a 190-day lifetime limit for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.	*Authorization is required for elective or scheduled admissions. A per admission deductible is applied once during the defined benefit period. The Plan covers 90 days each benefit period. In 2018 the amounts you pay for each benefit period are: Days 1-60: $1,364 deductible for each benefit period Days 61-90: $341 per day for each benefit period Days 91-150: $682 per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) A benefit period begins when you are admitted to the hospital and ends when you are discharged.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: 1. Physician services 2. Diagnostic tests (like lab tests) 3. X-ray, radium, and isotope therapy including technician materials and services 4. Surgical dressings 5. Splints, casts and other devices used to reduce fractures and dislocations 6. Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body	*Authorization rules may apply. You pay 20% of the cost for the inpatient services covered during a non-covered inpatient stay, except there is no copayment, coinsurance or deductible for physical therapy, occupational therapy and speech therapy

organ, including replacement or repairs of such devices 7. Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition 8. Physical therapy, speech therapy, and occupational therapy.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: 1. Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services 2. Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan 3. Clotting factors you give yourself by injection if you have hemophilia 4. Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant 5. Injectable osteoporosis drugs, if you are homebound,	*Authorization rules may apply. You pay 20% of the cost for the Medicare covered Part B prescription drugs.

have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug 6. Antigens 7. Certain oral anti-cancer drugs and anti-nausea drugs 8. Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Procrit ®) 9. Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: 1. X-rays 2. Radiation (radium and isotope) therapy including technician materials and supplies 3. Surgical supplies, such as dressings 4. Splints, casts and other devices used to reduce fractures and dislocations 5. Laboratory tests 6. Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. 7. Other outpatient diagnostic tests	*Authorization rules may apply. You pay 20% of the cost of the Medicare covered outpatient diagnostic tests, therapeutic services, and supplies.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: 1. Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery 2. Laboratory and diagnostic tests billed by the hospital 3. Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it	*Authorization rules may apply $100 maximum copay for outpatient surgery.

4. X-rays and other radiology services billed by the hospital 5. Medical supplies such as splints and casts 6. Certain drugs and biologicals that you can't give yourself Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week	
Outpatient mental health care* Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	*Authorization rules may apply. There is no copay for outpatient mental healthcare.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$100 maximum copayment for Medicare covered Outpatient Rehabilitation Services. Items requiring authorization: Hyperbaric therapies, outpatient surgery
Outpatient substance abuse services Covered services include individual and group outpatient therapy visits.	You pay 20% of the cost of the Medicare covered outpatient substance abuse services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers * Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for	*Authorization rules may apply. $100 copay for Medicare-covered outpatient surgery services

outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	
Partial hospitalization services **"**Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Note: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	You pay 20% of the cost of the Medicare covered partial hospitalization program services
Physician/Practitioner services, including doctor's office visits Covered services include: 1. Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location 2. Consultation, diagnosis, and treatment by a specialist 3. Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment 4. Second opinion by another network provider prior to surgery 5. Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	$0 copay for primary care physician/practitioner $0 copay for Medicare-covered specialist physician/practitioner services, including doctor's office visits
Podiatry services Covered services include: 1. Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). 2. Routine foot care for members with certain medical conditions affecting the lower limbs. 3. Routine foot care for members not having certain medical conditions affecting the lower limbs.	$0 copay for routine foot care. Routine foot care for members not having certain medical conditions affecting the lower limbs is limited to 2 visits every three months.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: 1. Digital rectal exam 2. Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.

Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	*Authorization rules may apply. You pay 20% of the cost of the Medicarecovered prosthetic devices and related supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	There is no copayment, coinsurance or deductible for the Medicare-covered pulmonary rehabilitation services.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. Eligible members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.

must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease and conditions Covered services include: 1. Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. 2. Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area) 3. Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) 4. Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) 5. Home dialysis equipment and supplies 6. Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	There is no copayment, coinsurance, or deductible for the Medicare-covered kidney disease education services. You pay 20% of the cost of the Medicarecovered renal dialysis and other services to treat kidney disease and conditions.
Skilled nursing facility (SNF) care No hospital stay required. You are covered for up to 100 days for each benefit period. Covered services include but are not limited to: 1. Semiprivate room (or a private room if medically	*Authorization rules may apply. Coverage limited to 100 days for each benefit period. No prior hospital stay is required. The amounts you pay for each benefit period

necessary) 2. Meals, including special diets 3. Skilled nursing services 4. Physical therapy, occupational therapy, and speech therapy 5. Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) 6. Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. 7. Medical and surgical supplies ordinarily provided by SNFs 8. Laboratory tests ordinarily provided by SNFs 9. X-rays and other radiology services ordinarily provided by SNFs 10. Use of appliances such as wheelchairs ordinarily provided by SNFs 11. Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). A SNF where your spouse is living at the time you leave the hospital.	are: Days 1-20: You pay nothing. Days 21-100: You pay nothing. Days 100+: Not covered. There is no copayment, coinsurance, or deductible for the Medicare-covered additional professional services.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Urgently needed services Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by outof-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Not covered outside the United States and its territories except under limited circumstances.	There is no coinsurance, copayment, or deductible for the Medicare-covered urgently needed care.
Vision care Covered services include: 1. Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. 2. For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older. 3. For people with diabetes, screening for diabetic retinopathy is covered once per year. 4. One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	$0 copay for Medicare-covered vision care services You pay 20% of the cost of the Medicare covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. Important: We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

NON-COVERED SERVICES

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.

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Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home.	✓	
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic surgery or procedures		✓ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures.	✓	
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Home-delivered meals	✓	
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Routine hearing exams, hearing aids, or exams to fit hearing aids.	✓	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Acupuncture	✓	
Naturopath services (uses natural or alternative treatments).	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

MEMBER RIGHTS AND RESPONSIBILITIES:

- Members have the Right to receive medically necessary care;
- Members have the Right to timely access to care and services;
- Members have the Right to privacy about their medical record and when Members get treatment;
- Members have the Right to get information on available treatment options and alternatives presented in a manner and language Members understand;
- Members have the Right to get information in a language Members understand, Members can get oral translation services free of charge;
- Members have the Right to get information necessary to give informed consent before the start of treatment;
- Members have the Right to be treated with respect and dignity;
- Members have the Right to get a copy of their medical records and ask that the records be amended or corrected;
- Members have the Right to take part in decisions about their health care, including the right to refuse treatment and make advance directives;
- Members have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Members have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Members have the Right to be told where, when and how to get the services Members need from their Special Needs Plan plan, including how Members can get covered benefits from out-of-network providers if they are not available in the plan network;
- Members have the Right to complain to the New York State Department of Health or their Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate; and,
- Members have the Right to appoint someone to speak for Members about their care and treatment.

In order to obtain maximum benefits from ArchCare Advantage, Members have the following **responsibilities**:

- To provide accurate and complete health information regarding past illnesses, hospitalizations, medications taken, allergies, and other details as needed to their care providers;
- To tell about their care needs and concerns and to ask questions to be sure they understand their care plan and can follow through on self-care;
- To access care for covered services through ArchCare Advantage Providers (except in emergency situations), and to obtain necessary approvals from their Primary Care Provider or the Member's Care Management Team before receiving a covered service;
- To keep appointments as scheduled or request an appointment change;
- To notify ArchCare Advantage if they plan to move or will be out of town for an extended period of time;
- To notify ArchCare Advantage of any change which may affect the Plan's ability to provide care to the Member, i.e., doctor contact, address, phone number, in Member admission, new health related issues, primary care giver, etc. ;
- To respect the rights and safety of all those involved in Member care and to assist ArchCare Advantage in maintaining a safe home environment; and,
- To make all required payments to the plan.

NON ENGLISH SPEAKING MEMBERS

ArchCare Advantage celebrates the diversity of its Members as we serve multicultural areas throughout ten counties. To ensure Members and potential Members who speak a language other than English can access the information they need, have their questions answered, and obtain all needed services, ArchCare Advantage will provide translation/interpretation services at no cost to the Member or Member's family.

ArchCare Advantage employs bilingual enrollment and care management staff who speak the languages spoken in these communities and whose names will be available via an updated internal list of bilingual employees and/or will provide a skilled interpreter. ArchCare Advantage will maintain a list of qualified interpreters with contact information, qualifications and availability. If other language skills are needed, ArchCare Advantage has access to an oral interpretation service, "Language Line Services." The Language Line is accessible at 1-888-808-9008, 24-hours a day, 365 days per year. It is staffed by medically certified interpreters who speak 170 languages.

Contracted providers are expected to meet the language needs of the Member.

IMPAIRED MEMBERS

In compliance with the Americans with Disabilities Act requirements, ArchCare Advantage accommodates impaired Members.

For Members with visual impairments, ArchCare Advantage provides printed materials in large print formats, and in an audio medium. Staff will also read ArchCare Advantage materials aloud and explain them verbally for Members who are blind or have low-vision.

Staff can communicate over the telephone with Members with hearing impairments using the NYS Relay Service for TTY (dial **711**) connectivity. Sign language interpreters will also be made available as necessary for the hearing or speech impaired.

For Members with physical or developmental disabilities and who have difficulty manipulating printed materials, staff may assist in holding materials and turning pages as needed.

Contracted providers are also required to meet the needs of impaired ArchCare Advantage Members.

CARE MANAGEMENT

Care Management is the "core" of ArchCare Advantage. This process ensures consistent oversight, coordination and support to Members and their families in accessing covered and coordinated services. The Care Plan, completed after assessment and enrollment of the Member, is mutually agreed upon with the Member and the PCP, and is reviewed and revised over time in response to the changing needs of the Member. ArchCare Advantage is dedicated to the provision of services which will enable Members to remain safe and secure in their place of residence.

Upon enrollment the coordination of the Member's care will begin with a Care Management Team (CMT) which includes a Registered Nurse, Member Services Representatives, the Medical Director, a Nurse Practitioner, and the Member's PCP. Together, they will collaborate on the established Care Plan with the Member, and their formal and informal supports to ensure that the Member receives the appropriate level of services. The team provides education for the Member and caregiver including but not limited to: health prevention/maintenance, life planning, various disease processes, and accessing benefits and community resources. If, at any time the CMT notices a change in the Member, or the Member tells the CMT about changes in his/her health status, CMT will address the problem and confer with the Primary Care Physician or Nurse Practitioner.

Providers partner with the CMT by supplying the services ordered in the Care Plan which maximize Member care and satisfaction.

Objectives of the Care Management Team:

- Ensure primary accountability for care management, from enrollment and continuing through transition to the CMT;
- Establish effective systems to ensure consistent oversight of care and service expectation that are met across all service provision;
- Establish protocols for routine and event monitoring; i.e.; hospitalization, short/long term nursing home placement, new diagnosis, major social environmental changes, increasing frequency of falls, pain management, or change in cognitive status;
- Establish standards for documentation and practice; and,
- Apply cost management protocols to be a prudent buyer of service and a prudent provider of service. Contact with Members/Families/Caregivers:
- Members/families/caregivers are instructed to contact the CMT if they have any questions, concerns, compliments, or complaints related to vendors. They should not contact the vendors directly.
- Members/families/caregivers who contact vendors for service issues; i.e.; aide change, item promised not delivered etc., should be told to contact the CMT, and the vendor should inform the CMT that they have been contacted.

COORDINATION OF SERVICES

The Care Manager is the main point of contact and will help coordinate covered and non-covered services. The Care Manager coordinates with the D/C Planner during Care Transitions to ensure a seamless transition to the next level of care. The Care Manager communicate with Interdisciplinary team which include the Primary Care Provider, Nurse Practitioner, and other ancillary Providers. Ensure that the member receive a telephonic post discharge assessment and ensure that follow up appointments are made

ASSESSMENTS OF MEMBERS

Within the first 90 days of enrollment and at least annually, thereafter all ArchCare Advantage members receive an in-person comprehensive assessment in their residence administered by trained qualified RNs, PAs or NPs using a standard assessment tool. These assessments are used to develop the Individualized Care Plan for ArchCare members.

AUTHORIZATION PROCESS

The Medical Management Department through utilization review provides authorizations for specific services, procedures, tests and equipment upon a Provider's request. Prior authorization is based upon the clinical documentation that supports medical necessity for there quested 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 1-800-373-3177 for a requested item on the List.

Prior Authorization List

ArchCare Advantage

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.

Durable Medical Equipment - CustomShoes/Orthotics - C-PAPMachines - Hospital Bed - Hoyer Lift - Insulin Pumps - Prosthetics- Major Limbs Specialty mattresses - Wheelchairs(motorized, customized& scooters) - Wound Pumps - Bathroom Safety Devices	Rehabilitation Services – Outpatient - Physical Therapy - Occupational Therapy - Speech Therapy - Pulmonary & Cardiac Rehabilitative therapy
Inpatient Admissions - AcuteCareFacilities - SkilledNursingFacilities - Psychiatric Health Care Facilitates - Elective Admissions - Urgent/ Emergent Admissions*	Radiology - MRI - Functional MRI, MRA, PET scan - Bathroom Safety Devices
Out-of-Network and Out-of-Area Services - Surgery/Admissions/Testing at non-participatingfacility - Visits to non-participating Providers - Comprehensive Rehabilitation Facilities	

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

Investigational / Experimental Treatment	
All cosmetic procedures (if medically necessary) - Abdominoplasty - Blepharoplasty - Keloid & Scar Revisions - Mammoplasty, Reduction or Augmentation - Ventral Hernias - Surgical Treatment of Gynecomastia - ENT Procedures (Rhinoplasty, Septoplasty, Uvoluplasty & LAUP) - Mastopexy - Otoplasty - Varicose Veins Treatment	OutpatientServices - Acupuncture - Ambulatory Surgeries - Chiropractic Services - Outpatient Behavioral Health - Outpatient Alcohol & Substance abuse - Podiatry
Social &Environmental - PERS - Meals - Extermination - House Cleaning - Handyman services (painting, carpentry, trash removal, etc.)	Other Services - Radiation Therapy - Pharmokinetic Testing - Audiology Equipment Hyperbaric O2 Therapy - Skilled Home Care Services including Home Infusions

Note: Some formulary medications may require prior authorization

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.

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. A Standard Appeal

The request and the information provided will be reviewed by a different Medical Director than the one who reviewed the initial request and provided the determination.

A written decision on a standard appeal will be provided within 30 days following receipt.

A decision might take longer if there is an extension requested. If the plan requests an extension, the Provider will be notified with an explanation.

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.

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CREDENTIALING AND RECREDENTIALING

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

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

Physician and Health Care Providers

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

Facility Credentialing

- Medicare and/or Medicaid license
- Copy of New York State Operating License
- Copy of Insurance Certificate
- Copy of any accreditations and/or surveys
- A copy of any notice of disciplinary actions taken within the past five years by the New York State Department of Health or other government agency that regulates the services by the provider;
- A copy of any notice of sanctions imposed upon the provider within the past five years by the Medicare or Medicaid program;

Skilled Nursing Facility Credentialing

- Medicare, Medicaid or JCAHO accreditation
- NYSDOH Cash Assessment Letter/Benchmark Rate Letter
- Copy of License
- Copy of Insurance Certificate
- State Survey and any Plan of Correction

A provider has the right to appeal a Peer Review and Credentialing Sub-Committee decision that has negatively impacted the provider. ArchCare Advantage complies with all state and federal mandates with respect to appeals for providers terminated or rejected from the ArchCare Advantage Provider Network. ArchCare Advantage notifies the provider in writing of the reason for the denial, suspension and termination. Terminated or rejected providers may submit a request for an appeal as outlined in the letter of rejection/termination sent by ArchCare Advantage. In addition, the request for appeal must be received by ArchCare Advantage within ten (10) days of the date of the rejection/termination letter. Upon receipt of the letter by ArchCare Advantage, the appeal is forwarded to the ArchCare Advantage Peer Review Committee for review and further processing ArchCare Advantage will ensure that the majority of the hearing panel members are peers of the affected physician.

Provider Monitoring & Evaluation

ArchCare Advantage, DOH, CMS and their designees shall each have the right, during provider's normal operating hours, and at any other time a contractor function or activity is being conducted, to monitor and evaluate, through inspection or other means, provider's performance, including, but not limited to, the quality, appropriateness, access to service and timeliness of services provided under the provider contract.

All providers are required to cooperate with and provide reasonable assistance to ArchCare Advantage, DOH, CMS and their designee in the monitoring and evaluation of the services provided a copy of any notice of disciplinary actions taken within the past five years by the New York State Department of Health or other government agency that regulates the services by the provider; under the provider contract.

A copy of any notice of sanctions imposed upon the provider within the past five years by the Medicare or Medicaid program; the credentialing process is considered complete when the credentialing committee approves the credentialing application. Once the credentialing process has been completed, and an executed contract is received and countersigned, the physician or health care provider will be considered participating. The physician or health care provider will use their NPI (National Provider Identification) number as their "provider number".

Delegated Credentialing

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

Medical Record

As part of the re-credentialing process ArchCare Advantage will review on a quarterly basis medical quality and utilization management data on an aggregate basis. This tracking and reporting of data supports analysis of trends and outliers across sites and within specific service areas. Pharmaceutical management and utilization practices is tracked and discussed quarterly by the Medical Director. ArchCare Advantage newly hired Provider's and mid-level practitioners receive competency and orientation checklist which is reviewed and signed off by the Medical Director. The ArchCare Advantage Medical Director administers and completes the competency evaluation initially and is on-going.

Prior to the physician date for re-credentialing, a provider relations representative will contact the Medical Director of ArchCare Advantage to determine current performance evaluations and job competencies meet standards for re-credentialing.

Provider Information

Providers are responsible for contacting ArchCare Advantage to report any changes in their practice. It is

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

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

Please use the "Provider Addition/Change Request" Form in the Important Phone Numbers and Form Section.

Adverse Credentialing Determination Appeals As a network provider, you have the right to:

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

Requests for Additional Information

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

ArchCare Advantage
Attention: Credentialing Department
205 Lexington Ave, 8th Flr
New York, NY 11016

PROVIDER NETWORK AND PROVIDER RELATIONS

The Provider Relations Department of ArchCare Advantage establishes, maintains, and supports the provider network. The Provider Relations Department is responsible for provider recruitment, contracting, credentialing and re-credentialing. Once providers join the network, Provider Relations staff orients them to ArchCare Advantage's program, policies and procedures and keeps them up-to-date on information regarding the HMO SNP. In addition, Provider Relations staff reviews and updates all contracts as needed and investigates and resolves all contract provider-related complaints.

PROVIDER NOTICES

ArchCare Advantage contacts individual providers as needed to maximize care and service to Members, and oversees contractual requirements. Staff contacts providers by telephone, email and fax. Provider Relations staff will send providers information regarding any important changes in our policies and procedures to keep all providers up-to-date.

RE-CREDENTIALING

All contracted providers are re-credentialed every 3 years. The re-credentialing process requires the provider to send updated information. ArchCare Advantage will also perform a review of provider PI Indicators which may include the following:

▯ Member/family complaints
▯ Information from QAPI activities ▯ Member satisfaction surveys

The provider is notified in writing of the re-credentialing decision if it is denied. The provider is informed at

that time in writing of their right to appeal the decision.

PROVIDER RIGHTS AND RESPONSIBLITIES

Provider Rights:

ArchCare Advantage's providers can act within the scope of their license to advise or advocate for Members on the following issues:

- Health status of Care Plan options that would include providing sufficient information to the Member to decide among various service options.
- Filing a complaint or making a report of comment to an appropriate governmental body regarding ArchCare Advantage policies, if the provider believes that the policies negatively impact the quality of, or access to care.

Provider Responsibilities:

ArchCare Advantage's provider's responsibilities include:

- Provision of quality care within the scope of practice as defined by ArchCare Advantage and in accordance with ArchCare Advantage's access, quality and participation standards;
- Adherence to ArchCare Advantage's clinical guidelines;
- Provide care to Members without regard to age, race, sex, religious background, national origin, disability and sexual orientation, source of payment, veteran status, claims experience, social status, health status, or marital status;
- Comply with Americans with Disabilities Act (ADA) guidelines set forth by the Department of Health;
- Maintenance of proper billing practices with submission of claims that are verifiable electronically by telephonic systems such as Santrax, CellTrack, HHAeXchange, SanData, etc., for service hour provision as available and can be accessed at any time by ArchCare Advantage.
- Maintain Member confidentiality and maintain PHI in compliance with HIPAA regulations;
- Report the abuse of Members immediately to Provider Relations at 855-373.3177.

The following are types of elder abuse/maltreatment/neglect to which all health care providers must be alert for:

- **Physical Abuse** – The infliction of injury, confinement, or punishment that results in physical harm to the person. Examples include:
  - Hitting pushing, pinching, shaking or shoving the person;
  - Restraining the person;
  - Using too hot or too cold bath water during care;
  - Improper use of medications.
- **Sexual abuse** – Any sexual contact that results from threat, force, or the inability of the person to give consent, including but not limited to, assault, rape, or sexual harassment. Examples include:
  - Intimately and inappropriately touching a member during bathing, dressing or any care necessary for the patient that is NOT indicated for treatment or care to that patient;
  - Male/female patient, family or staff fondling a confused patient;
  - Any sexual activity where both parties cannot or do not give full consent;
  - Exposing the member/taking away the member's privacy.
- **Psychological/Emotional Abuse** – The threat of injury, confinement, punishment, verbal intimidation or humiliation which may result in mental harm such as anxiety or depression. Examples include:
  - Ignoring the member;
  - Using baby talk/demeaning language;
  - Prohibiting free choice;
  - Threatening the member;
  - Exposing the member/taking away the member's privacy.

- **Neglect** – There are two types of neglect:
    - **Active Neglect** – The willful deprivation of goods or services which are necessary to maintain physical or mental health. Examples:
        - Purposely withholding food or other items;
        - Not assisting a participant who needs or requests help;
        - Knowingly postponing care because of some personal activity;
        - Not delivering mail or messages promptly and confidentially;
    - **Passive Neglect** – The deprivation of goods and services without conscious intent to inflict physical or emotional distress. Examples:
        - Failure to fulfill a caretaking obligation including abandonment or isolation, denial of food, shelter, clothing, medical assistance or personal needs, or the withholding of necessary medications or assistive devices (e.g. hearing aids, glasses).
- **Financial Abuse (Misappropriation of Funds)** – Improper conduct with or without informed consent of the resident that results in monetary, person or other benefit, gain, or profit for the perpetrator, or monetary or personal loss for the member. Examples:
    - Stealing or helping oneself to the resident's property;
    - Not treating reports of theft seriously;
    - Not returning change after making purchases for the patient;
    - Borrowing from one resident for another without permission.

Abuse Prevention – ISTRIPP

I – Identify suspected incidents
S – Screen new employees
T – Train on abuse and prevention
R – Report to DOH
I – Investigate Events
P – Prevent by supervising and care planning
P – Protect member during investigation

Reporting

If a Provider suspects Member abuse, the Provider must immediately notify Provider Relations at 800.373.3177 and the Member's CMT. In addition, Providers must initiate the proper notifications to an agency or authority that are required by the law in effect at the time. For example, in New York City, providers must report Member abuse to Adult Protective Services at (212) 630-1853.

All Providers are required to:

- Comply with all regulatory and professional standards of practice and are responsible to acquire physician orders whenever required by regulation or local, state or federal law as well as for determination of medical necessity and/or 3rd party reimbursement. The Case Manager/Team may assist in obtaining orders if the Provider has been unsuccessful.
- Notify ArchCare Advantage immediately whenever there is identification of a clinical issue of serious concern, change in Member status, refusal of service, inability to access Member's home, or inability to provide service for any reason.
- Communicate verbally and in writing on a timely basis regarding the nature and extent of services provided to the Member and the Member's progress and status.
- Cooperate with ArchCare Advantage on any grievance, appeal, or incident investigations as required. Incident reports must be submitted to ArchCare Advantage within 10 working days of request.
- Communicate to ArchCare Advantage complaint made by or on behalf of the Member.
- Cooperate with ArchCare Advantage's quality assurance and improvement programs (QAPI) as needed.
- Assure that all Provider's employees and agents involved in direct contact with Members carry proper Agency identification.
- Notify ArchCare Advantage of the provision of any unauthorized urgent services within 48 hours.
- Prior to the addition of any new Provider owner, director, employee, agent, contractor or referral source, and on a monthly basis thereafter, Provider shall confirm that such individuals and entities are not Excluded by checking the excluded parties lists maintained by the New York State Office of the Medicaid Inspector General, the United States Department of Health and Human Services Office of Inspector General, and the United States General Services Administration;

In addition:

DME and Medical Supply Providers are responsible for:

- Verifying primary payor coverage and eligibility prior to delivery;
- Acquiring physician orders whenever required by regulation or local, state or federal law as well as for determination of medical necessity and/or 3 party reimbursement;
- Exhausting all other payment sources prior to billing ArchCare Advantage; and,
- Timely delivery of requested products.

Note: It is the responsibility of the provider to determine whether Medicare covers the item or service being billed. If the service or item is covered or if the provider does not know if the service or item is covered, the provider must first submit a claim to Medicare, as ArchCare Advantage is always the payer of last resort. If the item is normally covered by Medicare but the Provider has prior information that Medicare will not reimburse due to duplicate or excessive deliveries, the information should be communicated to the ArchCare Advantage Case Manager prior to delivery.

ARCHCARE ADVANTAGE'S RESPONSIBILTIES TO PROVIDERS

ArchCare Advantage recognizes its obligation to assure providers the following:

- Comprehensive plan training and orientation programs;
- Timely and on-going communication from knowledgeable staff;
- Assistance with Primary Care Physician issues; i.e., order signing etc.;
- Timely payment for covered services rendered to Members;
- Timely responses to questions or concerns;
- Assistance with complex Member issues;

- Timely resolution of grievances and appeals; and,
- Constructive feedback on performance and utilization.

PROVIDER CONFIDENTIALITY

ArchCare Advantage respects its relationship with providers. Implicit in this agreement are the values of maintaining confidentiality, non-disclosure and return of trade secrets and intellectual property of ArchCare Advantage and the providers. Breaches of those values by either ArchCare Advantage or its providers must be reported immediately to the other party, whether or not the breach was intentional. Providers will sign a confidentiality agreement form as part of the credentialing process.

MEDICAL RECORDS

Medical records are documents that contain information about the Members' medical treatments. To safeguard their privacy, this information can only be released with the Members written consent or if required by law. In compliance with federal and state requirements, providers should:

- Maintain confidentiality policies based on good practices and legal requirements;
- Require all employees to sign a confidentiality statement as well as to adhere to Standards of Conduct that prohibit the release of a Members' personal identifiable health information;
- Release identifiable Member information only when consent is provided; and,
- Obtain Member consent to use his/her identifiable information for general treatment, coordination of care, quality assessment, utilization review, fraud detection, or accreditation purposes. Member-identifiable information used for any other purpose requires clear and specific consent from the Member.

Maintenance and Retention of Medical Records

- Providers must maintain adequate medical records for all Archcare Advantage 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 Archcare Advantage 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 Archcare Advantage and the NYSDOH. Records involving matters in litigation shall be kept for a permitted period of time only upon prior written approval by Archcare Advantage and NYSDOH. Microfilm or electronic copies of records may be substituted for the originals with the prior written approval of Archcare Advantage 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 Archcare Advantage contract is active and for a period of ten (10) years thereafter, Providers must provide Archcare Advantage, 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 Archcare Advantage 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 Archcare Advantage of any request for access to any records maintained pursuant to their contract with Archcare Advantage. All provisions of your Agreement with Archcare Advantage 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.

NON DISCLOSURE

Providers and employees, agents or independent contractors of the Provider (deemed to be the provider) may not disclose to third parties ArchCare Advantage trade secret and/or intellectual properties, whether such information is marked confidential without the prior written consent of ArchCare Advantage. The provider must take reasonable steps to safeguard ArchCare Advantage's trade secret and intellectual property to prevent unauthorized or improper use or copying.

RETURN OF TRADE SECRET AND INTELLECTUAL PROPERTY

Upon termination of the Provider Agreement for any reason, the provider promises to return (or destroy at the option of ArchCare Advantage) any and all ArchCare Advantage's trade secret and intellectual property that can reasonably be returned or destroyed to ArchCare Advantage or designee.

TERMINATION OF PROVIDER AGREEMENT

Termination by ArchCare Advantage

ArchCare Advantage may at its option, terminate the Agreement immediately and without notice to the Provider in the event of: a) conduct by the Provider or employee(s) which in the judgment of ArchCare Advantage poses and imminent harm to the Member; b) the provider cannot deliver the services authorized for the Member; c) a determination by ArchCare Advantage that the provider or the provider employees or agents have committed fraud; d) a final determination that the state licensing board or other governmental agency has found that the provider has been suspended, terminated or denied approval to participate in the New York State Medicaid Program.

Termination by the Provider

If ArchCare Advantage defaults in the performance of any material duty or obligation hereunder, the provider, at their option may give ArchCare Advantage written notice identifying the alleged default or breach and if ArchCare Advantage does not cure such default or breach within 30 calendar days, provider at their option, may terminate the Agreement per the terms of the provider agreement and upon written notice to ArchCare Advantage.

When a provider leaves the plan for reasons other than fraud, loss of license, or other final disciplinary action impairing the ability to practice, ArchCare Advantage will authorize our Member to continue an ongoing course of treatment for a period of up to ninety (90) days. The request for continuation of care will be authorized provided that the request is agreed to or made by the Member, and the provider agrees to accept ArchCare Advantage's reimbursement rates as payment in full. The provider must also agree to adhere to ArchCare Advantage's quality assurance requirements, abide by policies and procedures, and supply ArchCare Advantage with the necessary medical information and encounter data related to the Member's care. The Medical Director along with the CMT and the family/caregiver of the Member will assist with and coordinate the transition of care plan.

PROVIDER PARTICIPATION IN ARCHCARE ADVANTAGE

ArchCare Advantage values its relationship with our providers and the perspective that both parties bring to maximizing care and efficient operations. Informal access is always available to providers through the Provider Relations Department. ArchCare Advantage welcomes input and participation by providers through internal committee involvement and completion of provider satisfaction surveys.

COMMITTEE PARTICIPATION

Providers are selected to participate in committee activities. ArchCare Advantage's committees, such

as the Quality and Utilization Management Committee, explores care and operational quality indicators. No provider may review any case in which their agency or self is professionally involved as it is noted to be a conflict of interest. When reviewing cases, the provider makes decisions only on the appropriateness of care and service. ArchCare Advantage requires staff and committee participants to sign a Conflict of Interest statement on an annual basis. ArchCare Advantage will exclude providers who refuse to sign the conflict of interest statement.

PROVIDER SATISFACTION SURVEY PARTICIPATION

Provider input is welcomed at all times. ArchCare Advantage also conducts periodic surveys of provider satisfaction. Results will be used to determine system and operational improvements to maximize clinical outcomes and operational effectiveness.

GENERAL BILLING AND CLAIM SUBMISSION REQUIREMENTS

Payment for services rendered is subject to verification that the member was enrolled in ArchCare Advantage at the time the services was provided and to the provider's compliance with the ArchCare Advantage Clinical Services and prior authorization policies at the time of service.
Providers must verify member eligibility at the time of service to ensure the member is enrolled in ArchCare Advantage. Failure to do so may affect claims payment. Note, however, that members may retroactively lose their eligibility with ArchCare Advantage after the date of service. Therefore, verification of eligibility is not a guarantee of payment by ArchCare Advantage.

SUBMITTING CLAIMS ELECTRONICALLY

Through the partnership with Peak TPA, claims may be submitted electronically through 4 clearinghouses: Smart Data Solutions, Change Healthcare, Ability, and Trizetto. Claims submitted electronically receive status reports indicating the claims are accepted, rejected and/or pending.
Claims submitted electronically must include:

1. The ArchCare Payer ID Number 27034 on each claim.
2. A complete ArchCare Advantage Member ID Number.
3. A National Provider Identifier (NPI).

To sign up for electronic billing please contact a clearinghouse directly.

- Smart Data Solutions 855.297.4436 https://sdata.us/contact/
- Change Healthcare 800.494.3188 info@mdsmed.com
- Ability 888.558.0569 https://www.abilitynetwork.com/about/contact/
- TriZetto 800.969.3666 providersales@cognizant.com

Additional software vendors and clearinghouses may transmit claims. Providers should verify transmission with vendor prior to claim submission to ensure timely receipt and accurate processing of claims.

SUBMMITTING PAPER CLAIMS

All paper claims must be submitted to:

ArchCare Advantage
PeakTPA
P.O. Box 21631
Eagan, MN 55121

Note for group practices and facilities: When submitting claims, please ensure separate billing NPI and provider NPI numbers are entered in the appropriate fields. Office visit claims submitted for the group practice, with the group practice NPI number instead of the individual NPI number for the servicing provider, cannot be processed.

CLAIMS SUBMISSION AND ENCOUNTER DATA

ArchCare is required to report encounter data to New York State, CMS and other regulatory agencies, which lists the types and number of healthcare services members receive. Encounter data is essential for claims processing and utilization reporting as well as for complying with the reporting requirements of CMS, New York State and other governmental and regulatory agencies. It is essential that this information be submitted in a timely and accurate manner.
For participating providers who are paid on a fee-for-service basis, the claim usually provides the encounter data ArchCare requires. In addition, participating ArchCare providers reimbursed on a capitated basis are still

required to submit claims so that encounter data is reported to ArchCare.

REQUIRED DATA ELEMENTS AND CLAIM FORMS

Prior to being adjudicated, all claims are reviewed within the ArchCare Claims Department for completeness and correctness of the data elements required for processing payments, reporting and data entry into the ArchCare Advantage claims processing system. If the following information is missing from the claim, the claim is not 'clean' and will be rejected:

Data Element	CMS 1500	UB-04
Patient Name	X	X
Patient Date of Birth	X	X
Patient Address	X	X
Patient Gender	X	X
ArchCare Advantage Member ID Number	X	X
Coordination of Benefits (COB / other insured's medical insurance coverage information.)	X	X
Date(s) of Service	X	X
ICD – 9 Diagnosis Code(s) including 4th and 5th digit, when required	X	X
CPT- 4 Procedure Code(s)	X	X
HCPCS Code(s)	X	X
Service Code Modifier(s), when required	X	X
Place of Service	X	
Service Units	X	X
Charges per Service and total charges	X	X
Provider Name	X	X
Provider Address / Phone Number	X	X
National Provider Identifier - NPI	X	X
Tax ID Number	X	X
ArchCare Advantage Payer ID Number 27034 **– for EDI Claims Only**	X	X
Hospital / Facility Name and Address		X
Type of Bill		X
Admission Date and Type		X
Patient Discharge Status Code		X
Condition Code(s)		X
Occurrence Codes and Dates		X
Value Code(s)		X

Revenue Code(s) and corresponding CPT / HCPCS Code(s)		X
Health Insurance Prospective Payment System (HIPPS) Rate Code(s), when required		X
Principal, Admitting, and Other ICD – 9 Diagnosis Codes including 4th and 5th digit, when required		X
Present on Admission (POA) indicator, as applicable		X

REQUIREMENTS FOR BILLING BY FACILITIES (SKILLED NURSING FACILITY (SNF) AND HOME HEALTH (HH) AGENCIES)

Facility claims must be submitted on the UB-04 or on electronic media (837I):

- Report the name and NPI of the attending provider in Field 76.
- Professional services that are not part of the facility claim should be billed on a CMS 1500 form or on electronic media (837P).

TIME FRAMES FOR CLAIM SUBMISSION, ADJUDICATION AND PAYMENT TIMELY CLAIM SUBMISSION

Providers should submit all claims within thirty (30) days of the date of service for prompt adjudication and payment. Claims must be submitted within one hundred twenty (120) days from the date of service or within the time period set forth in the provider's agreement with ArchCare Advantage. Claims submitted outside of aforementioned timeframes will not be paid except under the reasons outlined in the Late Claim Submission below. In no event will ArchCare Advantage pay claims submitted more than one year from the date of service.

LATE CLAIM SUBMISSION

In certain circumstances, ArchCare Advantage will process claims submitted after the time period required under the provider's agreement with ArchCare Advantage. Please note that 'unclean' claims that are returned to the provider for necessary information are adjudicated according to the original date of service. They do not fall into the category of exceptions to the time period required.

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

Reason for Delay	
Litigation involving payment of the claim	Within ninety (90) calendar days from the time the submission came within the provider's control
Medicare or other third party processing delays affecting the claim	Within thirty (30) calendar days from the time the submission came within the provider's control
Delay in member eligibility determination	Within thirty (30) calendar days from the time of notification of eligibility (submit with documentation substantiating the delay)
Member's Enrollment with ArchCare Advantage was not known on the date of service	Within ninety (90) days from the time the member's enrollment is verified. Providers must make diligent attempts to determine the member's coverage with the Plan.

COORDINATION OF BENEFITS (COB)
Coordination of Benefits (COB) ensures that the proper payers are held responsible for the cost of healthcare services and is one (1) of the factors that can help hold down copayments. ArchCare Advantage follows all standard guidelines for COB. Members are asked to provide information about other medical health insurance plans under which they are covered.

ARCHCARE ADVANTAGE IS ALWAYS THE SECONDARY PAYER IN THE FOLLOWING CIRCUMSTANCES

- Workers compensation
- Automobile medical
- No-fault or liability auto insurance

ARCHCARE ADVANTAGE DOES NOT PAY FOR SERVICES PROVIDED UNDER THE FOLLOWING CIRCUMSTANCES WHEN THERE IS COB

- The Department of Veterans Affairs (VA) or other VA facilities (except for certain emergency hospital services)
- When VA-authorized services are provided at a non-VA hospital or by a non-VA provider ArchCare Advantage will use the same guidelines as Medicare for the determination of primary and secondary payer. As a result, ArchCare Advantage is the secondary payer for all of the cases listed above as well as for the following:
- Most Employer Group Health Plans (EGHP)
- Most EGHPs for disabled members
- All benefits payable under an EGHP in the case of individuals who are entitled to benefits solely or partly on the basis of end stage renal disease (ESRD) during a period of thirty (30) months. (This applies to all services, not just ESRD. If the individual entitlement changes from ESRD to over sixty-five (65) or disability, the coordination period will continue.)

EXPLANATION OF PAYMENT (EOP)
The EOP describes how claims for services rendered to ArchCare Advantage members were reviewed. It details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim.
The EOP includes the following elements (see Appendix A for a sample of the EOP):

- Payer's Name
- Vendor Name and Identification (ID) Number
- Provider Name and Identification (ID) Number
- Patient's Name
- Member's Identification (ID) Number
- Claim Date of Service
- Service
- Total Billed Charges
- Allowed Amount
- Explanation for Denied Charges
- Amount Applied to Deductible
- Co-payment/Co-insurance Amount
- Total Payment Made and to Whom

The EOP is arranged by vendor by provider. Each claim represented on an EOP may be comprised of multiple

rows of text. The line number indicated to the left of the date of service identifies the beginning and end of a particular claim. Key fields that indicate payment amounts and denials are as follows:

- **Paid Claim Lines**: If the "Paid Amount" field reads greater than zero (0), the claim line was paid in the amount indicated.
- **Denied Claim Lines**: If the "Not Covered" field is greater than zero (0) and equal to the charged amount, the service was denied.
- **Claim Processed as a Capitated Service**: If the "Paid Amount" field is zero (0), but the EOP Explanation Codes is '171' – Capitated Covered Services, the service was processed as a Capitated Service.
- **End of Claim**: Each claim is summarized by a claim total. If there are multiple claims for a single member, the EOP also summarizes the total amount paid for that member.

ELECTRONIC REMITTANCE & ELECTRONIC FUND TRANSFER

Electronic Remittance Advice are accessible online through Payspan Health. To establish an account, follow the information here: https://www.payspanhealth.com/NPS/Support/Index Or call 877-331-7154, Option 1. Electronic Fund Transfer (EFT) Accounts are also established and maintained via Payspan account.

CLAIM STATUS INQUIRIES, CLAIM RECONSIDERATION AND APPEAL PROCESS

Claim Status Inquiries

Providers may call Provider Services at 800-373-3177 to request claim status. Providers can view claim status online using the Peak provider portal. If you are a network provider and require assistance with the Peak provider portal, email: providerportal@peak.cpstn.com

Requests for Reconsideration of a Claim or Appeal

Please note that the process described here does not apply to utilization management determinations concerning medical necessity. See appropriate section for information on medical management appeals.
A provider may be dissatisfied with a decision made by ArchCare Advantage regarding a claim determination. Some of the common reasons include, but are not limited to:

- Claim was incorrectly processed
- Denial of a service / claim
- Denial for the untimely submission of claim(s)
- Failure to obtain prior authorization

Providers who are dissatisfied with a claim determination made by ArchCare Advantage must submit a written request for review and reconsideration with all supporting documentation **within sixty (60) business days** from ArchCare Advantage's initial date of action that led to the dispute, to the following address:

ArchCare Advantage
205 Lexington Avenue, 8th Floor
New York, NY 10016
Attention: Provider Disputes

Provide a clear explanation of the basis upon which you believe the initial determination/action is incorrect along with all supporting documentation and a copy of the Explanation of Payment (EOP) or include:

- The provider's identification number
- The provider's contact information
- The Member's name and ArchCare Advantage's Member identification number
- Date(s) of service
- The ArchCare Advantage claim(s) number
- A copy of the original claim or corrected claim, if applicable

ArchCare Advantage will investigate all written requests for review and reconsideration and issue a written

explanation stating that the claim has been either reprocessed or the initial denial has been upheld within **60 calendar days** from the date of receipt of the provider's request for review and reconsideration.
ArchCare Advantage will not review or reconsider claim determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and reconsideration after the **60 business day** time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services irrespective of the merits of the underlying dispute if the request for review and reconsideration is not timely filed. In such cases providers may not bill members for services rendered.

Corrected Claim Submission
Corrected Claims must be submitted within 60 days from the original adjudication date. When submitting a correction to a previously submitted claim, re-submit the entire claim with the corrected/updated information. (i.e., diagnosis codes, procedure codes, dates of service, etc.). Remember to identify that the claim is a resubmission by checking the appropriate code on either an electronic claim or paper claim form.
What is a Corrected Claim?
If a claim is submitted and later found to contain errors or incorrect information, certain data elements can be corrected and/or added and it can resubmitted to ArchCare within the appropriate timeframe for consideration. This resubmission is a corrected claim. The data elements that can be corrected or added are:

- Diagnosis code
- Number of Units
- Revenue code
- Total Charges
- Dates of service
- Procedure codes
- Modifiers
- Place of service
- Late charges
- Member information
- Provider information

Overpayments
Provider Identification
Notice and Correction of Payment Errors. Providers shall notify ArchCare of any overpayments or payments made in error within ten (10) business days of becoming aware of such overpayments or erroneous payments, and return or arrange for the return of any such overpayment or payment made in error.
Providers with overpayments must voluntarily submit a refund check made payable to ArchCare within 30 calendar days from the date of becoming aware.
Refund check should be mailed to:

Archcare Advantage
205 Lexington Avenue, 8th Floor
New York, NY 10016
Attention: Provider Disputes

Plan Identification
ArchCare Advantage periodically reviews payments made to providers to ensure the accuracy of claim payment pursuant to the terms of the provider contract or as part of its continuing utilization review and fraud control programs. In doing so, ArchCare Advantage may identify instances when we have overpaid a provider for certain services. When this happens, ArchCare Advantage provides notice to the provider and recoups the overpayment consistent with Section 3224-b of the New York State Insurance Law.
ArchCare Advantage will not pursue overpayment recovery efforts for claims older than twenty-four (24)

months after the date of the original payment to a provider unless the overpayment is:

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

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

Notice of Overpayments before Seeking Recovery

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

If You Agree That We Have Overpaid You

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

Refund check should be mailed to:

ArchCare Advantage
205 Lexington Avenue, 8th Floor
New York, NY 10016
Attention: Provider Disputes

If You Disagree that We Overpaid You

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

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

If You Fail to Respond to Our Notice of Overpayment

If a provider fails to dispute a request for repayment concerning an overpayment determination made by ArchCare Advantage within 30 calendar days from the date the overpayment notice was mailed by ArchCare Advantage, the provider will have acknowledged and accepted the amount requested by ArchCare Advantage. ArchCare Advantage will offset the amount outstanding against current and future claim remittance(s) until the full amount is recovered by ArchCare Advantage.

NOTIFYING ARCHCARE WHEN CHANGING OR UPDATING INFORMATION

A notification must be sent to Provider Relations 15 days in advance of the following:

- Change of Staff
- Change of Office Location, phone, fax or email
- Change in tax status or billing information (new W – 9 must be filed)

ArchCare Provider Relations Contact Information:
Email: ProviderRelations@Archcare.org
Phone: 800-373-3177
Fax: 646-417-7167

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COMPLAINTS, GRIEVANCES, APPEALS AND COMPLIMENTS

ArchCare Advantage strives to achieve Member satisfaction at all times. Systems have been implemented to accept, investigate and make a determination and handle appeals for all grievances and to report compliments in compliance with all regulatory requirements. ArchCare Advantage offers assistance to Members and their representatives in all phases of the grievance, appeal and compliance process.

ArchCare Advantage will try to resolve any complaint that a Member may have. ArchCare Advantage will try to solve complaints over the telephone, especially if these complaints are because of misinformation, a misunderstanding or a lack of information. However, if the complaint cannot be resolved in this manner, a more formal Member grievance review process is available.

COMPLAINTS AND GRIEVANCES

The regulatory definition of grievance is "any expression of dissatisfaction" regarding care and treatment that does not involve change in scope of duration of services and includes all issues previously thought of as complaints.

- A grievance can be verbal or written.
- A grievance can be filed by a Member, family/caregiver, friend or provider on behalf of the Member.
- A grievance can be made to one of the CMT, or any other ArchCare Advantage Member.
- Grievances are tracked by a formal mechanism.
- Attempts are made to rectify grievances immediately or within required time frames, based on the nature of the issue.
- The initial determination notice includes an explanation of the reasons for the decision.
- A Member who is dissatisfied with the outcome of the grievance determination may request a 2nd review by filing a grievance appeal.
- All grievances are submitted in a report to the NYS Department of Health on a quarterly basis.

APPEALS

- An appeal can be verbal or written.
- An appeal can be filed by a Member, family/caregiver, friend or provider on behalf of the Member.
- The request for an appeal must be received within 60 days after the receipt of the notice of grievance decision.
- During the appeal process, the Member may present their case in person and may also review the medical record that is part of the appeal.
- Appeals are tracked by a formal mechanism.
- Appeal decisions are made within required time frames, based on the nature of the issue.
- Appeal determinations are made by someone other than the person making the initial determination.
- The appeal determination notice includes an explanation of the reasons for the decision including any clinical rationale, as appropriate.
- A report of all appeals is submitted to the NYS Department of Health on a quarterly basis.

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT

With the advice and participation of the ArchCare Advantage Quality Committees, the Quality Management Department assesses the delivery of services and determines if and when improvements are needed. When indicated, corrective action plans are directed toward individual providers, medical groups, or facilities. In addition, ArchCare Advantage's Quality Management Program focuses on several key projects yearly, aimed at improving the delivery system as a whole. Project interventions may be administrative or clinical in nature.

PROVIDER PERFORMANCE & CREDENTIALING

ArchCare Advantage fully credentials all physicians and allied health providers. The process is comprehensive and includes verification of the provider's credentials.
Provider performance measures include, but are not limited to: Member related grievances, appointment availability, adherence to clinical guidelines, and compliance to the medical record documentation improvement projects. These measures are constantly reviewed. Time sensitive credentialing documents such as copies of license registration, and malpractice insurance must be updated, as necessary. Overall cooperation with mandated requirements that assists ArchCare Advantage to keep individual provider files current at all times is appreciated. A site visit may also be performed based in the provider's specialty.

When concerns about the quality of care given Members occur, a medical record review or incident report may be required as part of the investigation. After investigating the concern the incident may be directed to the Quality Management Committee and the committee may direct the Director of Quality Management to continue to monitor the situation, or it may require that a corrective action plan be implemented. Incident Reports that are requested must be submitted to the Director of Quality Management. The committee may instruct the Director of Quality Management to continue to monitor the situation, or it may require that a corrective action plan be implemented. Incident Reports that are requested must be submitted within two business days of the request.

ArchCare Advantage's guidelines for access to care for its Members are in compliance with the Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) access requirements.

QUALITY INDICATORS

Providers are measured on a number of performance measures that are continuously tracked. Some of these measures are outlined below.

Appointments

Providers must accommodate the following types of appointments within the indicated time frames:

- Preventative care appointments within 15 days of request
- Routine care appointments within 4 weeks of request
- Urgent care appointments within 24 hours of request
- Non-urgent sick visit appointments within 48-72 hours of request
- Appointments for specialty care within 7 calendar days
- Placement for personal care within 24 hours of request

Additionally, providers must maintain a mechanism for 24 hour/7 day Member telephone access and office coverage to respond to emergencies for their Members as they arise, and be able to render decisions based on the nature of the emergency. Emergent conditions are those conditions whose onset are acute and may occur with or without a prior medical history of the condition. Pre-recorded referral to a hospital

Emergency Department does not constitute appropriate 24 hour/7 day coverage.
On the day of an appointment, a Member should not wait more than thirty (30) minutes past their scheduled appointment time. If an emergency arises for the provider and the wait time is more than thirty (30) minutes, the Member must be notified of the delay and given the opportunity to reschedule cancelled appointments.

Telephone Response

Telephone response to a Member calls to the office should be handled by a physician or designated office staff as appropriate to the situation.

- Emergency conditions should receive immediate response;
- Urgent conditions should be responded to within 4 hours;
- Semi-urgent conditions should be responded to during the current day;
- Routine conditions should be responded to within 2 working days; and,
- After hour calls whose nature is not completely clear, should receive a response within 30 minutes.

QAPI WORKPLAN

A comprehensive QAPI plan has been designed to meet the goals of ArchCare Advantage in providing high quality services consistent with professional practice and within regulatory standards and achieving positive Member outcomes. All of this is done within a fiscally responsible environment.
Copies of ArchCare Advantage's QAPI Plan are available from the Director of Quality Management. The QAPI Plan includes the following:

- The plan involves all ArchCare Advantage employees, providers, Members and their support systems in our CQI efforts.
- The plan is to systematically improve, monitor, and evaluate the care provided and to maximize Member satisfaction.
- The plan defines ArchCare Advantage's objects and includes the operational components designed to support desired outcomes.
- Provider performance plays a key role in the QAPI Plan that includes quality of services, identification and correction of issues, and outcomes.
- A multi-disciplinary team performs, reviews, and analyzes evaluations and makes recommendations for additional targeted studies, CQI, and Member/provider satisfaction.
- Ultimate oversight of ArchCare Advantage's QAPI Plan is the responsibility of the Board of Directors of ArchCare Advantage.

COMPLIANCE & FRAUD WASTE AND ABUSE

Overview

ArchCare Advantage is committed to preventing and detecting fraud, waste and abuse. As an ArchCare Advantage contracted provider, you have specific responsibilities in the areas of compliance, fraud, waste and abuse. Here is a short list reviewing some key responsibilities relating to the ArchCare Advantage Compliance Program.

Training

Compliance and Fraud, Waste and Abuse training is a CMS and New York State Department of Health ("DOH") requirement for provider staff who are involved with the administration or delivery of Medicaid benefits. Provider staff must complete this training within 90 days of hire, and on an annual basis. Proof of your completion of this training must be made available to the ArchCare Advantage Compliance Department, upon request.

Audit Cooperation

It is the responsibility of provider staff to cooperate with ArchCare Advantage, and any of its subsidiaries or affiliates as necessary, to support ArchCare Advantage in carrying out its monitoring responsibilities, including but not limited to, allowing ArchCare Advantage to inspect, evaluate and audit your provider's books and records.

Record Retention

The provider must maintain its books and records relating to its services, for a period of at least ten (10) years, or longer as otherwise required by law [C.F.R. § 423.505(d)].

OIG/GSA, OMIG and EPLS Exclusion List Process

Providers must verify that they have researched and will continue to monitor and ensure none of its employees, vendors or contractors are excluded from the:

- OIG exclusion list database;
- OMIG excluded provider list; and
- EPLS excluded provider list

These checks must be conducted at least monthly.

Code of Conduct

CMS and DOH requires providers have in place, or adopt a plan, which includes the adoption of a code of conduct, to detect, prevent, and correct fraud, waste and abuse in the delivery of its services.
Provider staff, including physicians, licensed professionals, billing and other staff, are required to read the ArchCare Advantage Code of Conduct and agree to abide by the standards specified in the Code, and/or adopt and follow a code of conduct, compliance program, and compliance policies particular to its own organization that reflects a commitment to detecting, preventing, and correcting non-compliance with Medicare and Medicaid requirements in the delivery of their Medicare and Medicaid services, including detecting, preventing, and correcting fraud, waste, and abuse.

Reporting of Suspected Non-Compliance, Fraud, Waste and Abuse

All are required to report any suspected non-compliance and/or potential fraud, waste or abuse of any of CMS's or DOH's rules and regulations as soon as one becomes aware of it, to ArchCare Advantage's Compliance Hotline at 800-443-0463**, or the ArchCare Advantage compliance email at ComplianceReport@archcare.org.**

Remember, there is an assurance of anonymity and non-retaliation in the reporting process, and confidentiality to the extent reasonably possible. You can also contact any one of the **Compliance Resources** listed here:

- New York State Medicaid Fraud Hotline 1-877-87-FRAUD

Examples of practices that are considered fraud, waste and abuse which are prohibited by ArchCare Advantage, and require immediate reporting, include, but are not limited to:

- Submission of false information for the purpose of obtaining greater compensation than what the provider is entitled to;
- Billing for services not rendered;
- Billing for services prior to the rendering of the service;
- Knowingly demanding or collecting any compensation in addition to claims submitted for covered services;
- Submission of false information to obtain authorization for services;
- Ordering or furnishing inappropriate, medically unnecessary or excessive care or services;
- Practicing beyond the scope of licensure for that entity, or practicing after one's license has been suspended or revoked;
- Failing to furnish or maintain sufficient documentation on the extent of care and service to Members for audit and/or investigative purposes; and,
- Submitting bills or accepting payment for care, services, or supplies rendered by a provider who has been disqualified from participation in the Medicaid Program.

When calling the ArchCare Advantage Compliance Hotline or emailing the ArchCare Advantage Compliance Reporting email address:

- You have an assurance of anonymity and non-retaliation in the reporting process, and confidentiality to the extent reasonably possible.
- You have an obligation to disclose any action or situation that is, or may appear to be, a conflict of interest that would make it difficult for you to perform your work objectively or effectively.
- If you suspect issues of non-compliance or potential fraud, waste and abuse, you must report the issue to your supervisor or any other resources available to you, including the resources below.

Reminder: It is illegal for a provider to retaliate against an employee who makes a good-faith report of suspected fraud, waste, or abuse, or cooperates in an investigation.

False Claims Act

Scope of the False Claims Act:

The False Claims Act (the "FCA") is a federal law (31 U.S.C. § 3279) that is intended to prevent fraud in federally funded programs such as Medicare and Medicaid. The FCA makes it illegal to knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government. Under the FCA, the term "knowingly" means acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the truth.

FCA Penalties

The federal government may impose harsh penalties under the FCA. These penalties include "treble damages" (damages equal to three times the amount of the false claims) and civil penalties of up to $11,000 per claim. Individuals or organizations violating the FCA may also be excluded from participating in federal programs.

Potential FCA Violations

Knowingly submitting claims to ArchCare Advantage for services not actually provided. Examples of the type of conduct that may violate the FCA include the following:

- Submitting a claim for DME or Supplies when delivery was refused by the member;
- Submitting a claim for 2-man transportation, as authorized, but providing 1 man; and
- Submitting a claim for a service not provided.

The FCA's Qui Tam Provisions

The FCA contains a *qui tam*, or whistleblower, provision that permits individuals with knowledge of false claims activity to file a lawsuit on behalf of the federal government.

The FCA's Prohibition on Retaliation

The FCA prohibits retaliation against employees for filing a qui tam lawsuit or otherwise assisting in the prosecution of an FCA claim. Under the FCA, employees who are the subject of such retaliation may be awarded reinstatement, back pay and other compensation. ArchCare Advantage's False Claims Act Policy strictly prohibits any form of retaliation against employees for filing or assisting in the prosecution of an FCA case.

State Laws Punishing False Claims and Statements

There are a number of New York State laws punishing the submission of false claims and the making of false statements:

- Article 175 of the Penal Law makes it a misdemeanor to make or cause to make a false entry in a business record, improperly alter a business record, omit making a true entry in a business record when obligated to do so, prevent another person from making a true entry in a business record or cause another person to omit making a true entry in a business record. If the activity involves the commission of another crime it is punishable as a felony.
- Article 175 of the Penal Law also makes it a misdemeanor to knowingly file a false instrument with a government agency. If the instrument is filed with the intent to defraud the government, the activity is punishable as a felony.
- Article 176 of the Penal Law makes it a misdemeanor to commit a "fraudulent insurance act," which is defined, among other things, as knowingly and with the intent to defraud, presenting or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds $1,000, the crime is punishable as a felony.
- Article 177 of the Penal Law makes it a misdemeanor to engage in "health care fraud," which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year period exceeds $3,000, the crime is punishable as a felony.

FRAUD, WASTE AND ABUSE SUMMARY

Providers must comply with federal laws and regulations designed to prevent fraud, waste and abuse, but not limited to,

- 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.

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 Advantage abides by a zero-tolerance against non-compliance.

HEALTH INSURANCE AND PORTABILITY ACT (HIPAA)

Archcare Advantage is concerned with protecting member privacy and is committed to complying with the HIPAA privacy regulations. Generally, covered health plans and covered Providers are not required to obtain individual member consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities such as: care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement fall into this category. If you have further concerns, please contact ArchCare Compliance Hotline at 800-443- 0463.

HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH (HITECH Act)

The 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 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:

1. When the breach happened, when the event was discovered, and a brief statement about what happened
2. What type of PHI was breached?
3. Things that the individual can do in order "to protect themselves from potential harm resulting from the breach"
4. 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.
5. 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.

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ARCHCARE ADVANTAGE/PROVIDER PARTNERSHIP

ArchCare Advantage views every vendor as a partner in care. Our staff works with provider staff to facilitate the right services, in the right place, with the right amount of services/hours based upon individual Member needs. Selected vendors also participate in committee work and quality improvement initiatives.

When providers identify clients they feel will both qualify for and benefit from the unique services that ArchCare Advantage provides, we ask that you contact us and make a referral.

The steps for a provider to make a referral:

- Call Member Services at 800.373.3177, or,
- Fax a referral to 646-289-7791.

A copy of an ArchCare Advantage Referral form is included below.

After receiving a referral the Assessment process begins. An Enrollment Specialist will contact the potential applicant and provide information. The Enrollment RN will make a visit and do a detailed assessment, prepare an initial plan of care and communicate with the Member's PCP. Once completed, the outcome of the enrollment will be communicated to the referral source.

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EMERGENCY AND DISASTER PREPAREDNESS

ArchCare Advantage has a formal plan for emergency and disaster preparedness (EPP). The EPP is designed to respond to weather and other natural disaster, industrial disasters, damage to office structures, communications and other technical disasters, personnel actions, medical events and terrorist threats and activities.

As part of our EPP, a priority status will be assigned to every Member at enrollment with an update as needed but no less than 180 days.
Level 1 are high risk and need uninterrupted services;
Level 2 are moderate risk and may need some assist during an emergency situation; and
Level 3 are low risk and need services; they have family support who can provide care in an emergency situation

Senior management will confirm an emergency and direct appropriate action to be taken. In the event of an emergency, providers will be contacted by ArchCare Advantage staff with specific instructions.

Providers are expected to notify ArchCare Advantage if they experience emergencies of disasters along with procedures, until normal operations have been restored.

IMPORTANT PHONE NUMBERS AND FORMS

Main Number: 1-800-373-3177
To be used for:

- Claim Inquiries – General
- Request for Authorizations
- Provider Services – contracts; billing; educational material; other general inquiries

Email Address:
ProviderRelations@archcare.org

Member Services: 1-800-373-3177
To be used for:

- Care team inquiries
- Authorization requests questions

Enrollment: 1-800-373-3177
To be used for:

- Enrollment questions
- Referral questions
- Application status updates

Compliance Hotline

- To report suspected fraud/abuse by another provider or member call
- ArchCare Advantage's Compliance Hotline at 1-800-443-0463, or the ArchCare Advantage Compliance E-mail at: ComplianceRport@archcare.org

Where to Get More Information:
The following information is available on our website at the link below:

- Provider Directory
- Provider Manual
- Member Handbook for members who live in the NYC or Westchester
- Notice of Privacy Practices
- ArchCare Code of Conduct

https://www.archcare.org/health-plans

REFERRAL FORM
For information about ArchCare or to make a referral, please contact:

archcare Advantage
HMO Special Needs Plan

Medical Management
Office: 646-289-7700 Fax: 646-289-7791
Website: www.archcare.org

REQUIRED INFORMATION:

Name of Patient:_____Phone: _____

Referrer:_____Referrer Phone: _____

Organization:_____Date of Referral: _____

REFERRAL INFORMATION:

Address: _____

Date of Birth:_____Gender:____Male____Female SSN#: _____

Current Location: __Home __Nursing Home__Hospital__Other: _____

Lives with: __Alone __Family____Other:_____

Medicaid Status:_____Eligible_____May be eligible Medicaid #:_____Medicare #: _____

Other Insurance: _____

FAMILY OR CAREGIVER INFORMATION

Name:_____Relationship_____

Address:_____

Phone: _____

REASON FOR REFERAL

- Chronic Conditions __ Yes __ No _____
- Disabilities _Yes_____No _____
- Requires Assistance __ Yes __ No _____
- Primary Diagnosis: _____

Patient requesting: _____

Receiving home care services:_____Yes_____No_____Don't know

If so, please specify service and provider contact info: _____

PRIMARY CARE PHYSICIAN

Name:_____Phone: _____

archcare

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 email to providerrelations@archcare.org.

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 NPI.
Check the appropriate box: □Participating Provider □Non-Participating
Check the appropriate box: □Changing information □Adding information
Line of Business: □ Archcare Advantage □ Archcare Senior Life (PACE) □Archcare ommunity Life(MLTC)

Date of Request	
Practice Name	
Provider Name	
Specialty	
Telephone	
Email address	
Tax ID	
NPI	
Billing Group NPI	
Type of change or addition Check the box that applies	Address type: □ Primary Address □ Secondary Address □ Billing Address □ Telephone □ Email □ Fax □Other
Enter the new information	
Requestor Contact Name:	

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

- A W9 Form is included a requirement for any business name or address change.
- All information entered is accurate and complete.
- 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.

DEFINITIONS

1. Enrollment Agreement is the document issued to a member by Archcare Advantage that describes the covered services the member is entitled to receive as a member of ArchCare Advantage; and its obligations to arrange for the delivery of those services to Archcare Advantage 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.
2. 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.
3. DOH is defined as the New York State Department of Health.
4. 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.
5. CMS is defined as the Centers for Medicare and Medicaid Services.
6. 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.

7. 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 Advantage.
8. 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.
9. Participating Agency is defined as an agency or health care Provider that has signed an Archcare Advantage Service Agreement.
10. 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.
11. 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 Advantage's credentialing criteria.
12. Quality Assurance Performance Improvement (QAPI): Archcare Advantage 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.

ARCHCARE ADVANTAGE QUICK REFERENCE GUIDE	
Member Eligibility	Telephone: 855-467-9351
Care Management	Telephone: 646-289-7700
Central Logistics Unit	Telephone: 855-720-9268
ED Visits & Hospitalization Reporting afterhours & Weekends	Telephone: 855-467-9351
Transportation	Telephone: 646-289-7701
Provider Relations	ProviderRelations@archcare.org
Claims Submission	**Submitting Claims Electronically:** Through the partnership with Peak TPA, claims may be submitted electronically through 4 clearinghouses: Smart Data Solutions, Change Healthcare, Ability, and Trizetto. Claims submitted electronically receive a status report indicating the claims are accepted, rejected and/or pending. Claims submitted electronically must include: 1. The ArchCare PayerID: 27034 2. Archcare Advantage Member ID Number 3. National Provider Identifier (NPI) **Submitting Paper Claims:** ArchCare Advantage PeakTPA P.O. Box 21631 Eagan, MN 55121 Note for Group Practices and Facilities: When submitting claims, please ensure separate billing NPI and Provider NPI numbers are entered in the appropriate fields.

www.archcare.org
Health Plans and Nursing Home Alternatives | Home Care |Skilled Nursing Care Rehabilitation |Assisted Living| Specialized Care| Palliative Care| Hospice