November 2023

State/Territory: ARKANSAS

Citation

Section 1902(a)(25)(E) **42 CFR 433.139(b)(3)(i)**	**(1)**	**The State will make payment for pediatric preventive services, including early and periodic screening, diagnosis, and treatment services, without regard to third party liability and seek reimbursement from any liable third party to the extent of such legal liability.**
Section 1902(a)(25)(F) **42 CFR 433.139(b)(3)(ii)**	**(2)**	**For services covered under the plan that are provided to an individual on whose behalf child support enforcement is being carried out by the State Title IV-D agency, the State will make payment for such services without regard to third party liability up to 100 days that is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by the State Title IV-D agency, and seek reimbursement from such liable third party to the extent of legal liability.** **Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.**
Section 1902(a)(25)(E) **42 CFR 433.139(b)(3)(i)**	**(3)**	**The State shall make payment without regard to third party liability for pediatric preventive services unless a Determination related to cost-effectiveness and access to care that warrants cost avoidance up to 90 days has been made.**
Section 1902(a)(25)(E)	**(4)**	**The State will use standard coordination of benefits cost avoidance when processing claims for prenatal services, labor and delivery, and postpartum care claims.**

Revised: **November 1, 2023**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

**Requirements for Third Party Liability –
Payment of Claims**

If the provider bills the Medicaid Program, he/she must certify either:

(1) that he/she has not billed the known third party due to medical support enforcement, or

(2) that he/she has billed the known third party but has not received payment or denial from the third party within 30 days from the date of service.

Claims submitted for payment with certification that the provider attempted to collect from the third party are extracted and written to a report produced monthly. The report is reviewed monthly using a random sampling of 10% based on the total number of claims reported. Follow-up activity is performed with the third party to ensure that payment has not been made within 30 days of the provider's date of service.

The Agency does not use threshold amounts for any cases other than Tort/Casualty cases to determine whether to seek reimbursement from a liable third party. Threshold amounts vary from $25.00 to $100.00 depending on the type of service. Total TPL program expense divided by the number of claims recovered (monthly figures are used) are utilized in this calculation. This limit is determined annually.

A timeframe of six months is allocated for the allowed amount on individual claims to be collected for comparison with the threshold level of each valid third party source's coverage areas. If the cumulative or individual allowed amount total exceeds the threshold level then each applicable third party source is pursued.

Medicare claims are reflected in Arkansas' MMIS as cost avoidance.

The State makes payment for pediatric preventive services, including early and periodic screening, diagnosis, and treatment services (EPSDT), without regard to third party liability and seeks reimbursement from any liable third party to the extent of such legal liability.

For services covered under the plan that are provided to an individual on whose behalf child support enforcement is being carried out by the State Title IV-D agency, the State makes payment for such services without regard to third party liability up to 100 days that is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by the State Title IV-D agency, and seeks reimbursement from such liable third party to the extent of legal liability.

Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

The State makes payment without regard to third party liability for pediatric preventive services unless a determination related to cost-effectiveness and access to care that warrants cost avoidance up to 90 days has been made.

The State will use standard coordination of benefits cost avoidance when processing claims for prenatal services, labor and delivery, and postpartum care claims.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Update to Third Party Liability attestation in Arkansas Medicaid State Plan

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ☐ No ☑

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
   Yes ☑ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☑ No ☐

   If no, please explain:

   (a) how the additional benefits of the more costly rule justify its additional cost;

   (b) the reason for adoption of the more costly rule;

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation? $0

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0.00	Total	$ 0.00

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0.00	Total	$ 0.00

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0.00	$ 0.00

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0.00	$ 0.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☑

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

RULES SUBMITTED FOR REPEAL

Rule #1: Division of Youth Services (DYS) and Division of Children and Family Services (DCFS) Targeted Case Management Manual

Rule #2: Episodes of Care Manual

SECTION II - DIVISION OF YOUTH SERVICES (DYS) AND DIVISION OF CHILDREN AND FAMILY SERVICES (DCFS) TARGETED CASE MANAGEMENT GENERAL INFORMATION

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200.000 DIVISION OF YOUTH SERVICES (DYS) AND DIVISION OF CHILDREN AND FAMILY SERVICES (DCFS) TARGETED CASE MANAGEMENT GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for DYS and DCFS Providers of Targeted Case Management Services

201.100 Participation Requirements for DYS Case Management Providers

201.110 Billing Providers of DYS Targeted Case Management Services 11-1-09

Billing providers of DYS targeted case management services must meet the criteria located in Section 141.000 in order to be eligible for participation in the Arkansas Medicaid Program.

201.120 Reserved 11-1-09

201.200 Participation Requirements for DCFS Targeted Case Management Providers 11-1-09

Providers of DCFS targeted case management services must meet the criteria located in Section 141.000 in order to be eligible for participation in the Arkansas Medicaid Program.

202.000 Qualifications of Providers

202.100 Qualifications of DYS Targeted Case Management Provider Agencies 4-1-05

DYS targeted case management services are provided only through qualified provider agencies. Qualified case management provider agencies must meet the following criteria:

A. The agency must have full access to all pertinent records concerning the child's needs for services including records of the Arkansas District Judicial Courts, the Division of Youth Services/Alexander Youth Services Center and its designated service providers and any Department of Human Services/DYS-funded county and state youth services agencies.

B. They must have established referral systems and demonstrated linkages and referral ability with community resources required by the target population.

C. They must have a minimum of one year's experience in providing all core elements of case management services to the target populations.

D. The agency must have an administrative capacity to ensure quality of services in accordance with state and federal requirements.

E. The provider agency must have a financial management capacity and system that provides documentation of services and costs in conformity with generally accepted accounting principles.

F. They must have a capacity to document and maintain individual case records in accordance with state and federal requirements.

REPEAL

G. The agency must have demonstrated the ability to meet all state and federal laws governing the participation of providers in the state Medicaid Program, including the ability to meet federal and state requirements for documentation billing and audits.

202.200 DCFS Targeted Case Management Provider Agencies 4-1-05

DCFS case management services will be provided only though qualified provider agencies. Qualified targeted case management service provider agencies must meet the following criteria:

A. They must have full access to all pertinent records concerning the child's needs for services including records of the Arkansas Family Courts and the State Child Welfare and Protection Agency.

B. They must ensure 24-hour availability of case management services and continuity of those services.

C. The provider agency must have established referral systems and demonstrated linkages and referral ability with community resources required by the target population.

D. They must have a minimum of five years of experience in providing all core elements of case management services to the target populations.

E. The agency must have an administrative capacity to ensure quality of services in accordance with state and federal requirements.

F. They must have a financial management capacity and system that provides documentation of services and costs in conformity with generally accepted accounting principles.

G. They must have a capacity to document and maintain individual case records in accordance with state and federal requirements.

H. The agency must have a demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid Program, including the ability to meet federal and state requirements for documentation, billing and audits.

202.210 Qualifications of Individual Case Managers within the DCFS Targeted Case Management Provider Agency 4-1-05

Individual case managers, denoted as Family Service Workers (FSW), who work for the provider agencies must meet the following two minimum qualifications:

A. The individual must have a minimum of a bachelor's degree in social work, sociology, psychology or a related field.

B. The individual is supervised by another person who, at a minimum, possesses the formal education equivalent of a bachelor's degree in social work, sociology, or a related field plus four years of experience in child welfare or human services.

203.000 Targeted Case Management Providers in Bordering and Non-Bordering States 4-1-05

The Arkansas Medicaid DYS and DCFS Targeted Case Management programs are limited to in-state providers only.

210.000 PROGRAM COVERAGE

REPEAL

211.000 Scope 4-1-05

Targeted case management is a service that assists individuals in gaining access to necessary medical, social, educational and other care and services appropriate to the needs of the individual. Medicaid-covered targeted case management services include client intake activities, assessment activities, case planning activities, service coordination and monitoring activities and case plan reassessments that assist beneficiaries in accessing needed medical, social, educational and other services appropriate to the beneficiaries' needs.

Targeted case management services are reimbursable when they are:

A. Medically necessary.

B. Provided to outpatients only.

C. Provided by a qualified provider enrolled to serve the target group in which the beneficiary belongs.

D. Provided at the option of the beneficiary and by the provider chosen by the beneficiary or designated custodial entity.

E. Provided to beneficiaries who have no reliable or available supports to assist them in gaining access to the necessary care and services they need.

F. Referrals for service that directly affect the beneficiary but may not require the beneficiary's active participation.

212.000 Target Populations

212.100 Target Population Covered by the DYS 4-1-05

DYS provider agencies enrolled as providers for this target population are restricted to serving beneficiaries under age twenty-one (21) who are at risk of delinquency as evidenced by their being in the care, supervision or custody of DYS or under the care of a designated provider, specified by DYS, for assessment, supervision or treatment.

212.200 Target Population Covered by the DCFS 4-1-05

DCFS provider agencies enrolled as providers for this target population are restricted to serving children who are Medicaid beneficiaries under the age of twenty-one (21) who are either at risk of abuse or neglect or are abused or neglected children and are in the care or custody of the Department of Human Services, DCFS.

213.000 Description of Service Activities 4-1-05

Case management assistance includes the following activities:

A. Client intake through identifying programs appropriate for the individual's needs and providing assistance to the individual in accessing those programs.

B. Assessment of the beneficiary's family/community circumstances and service needs and providing assistance to the individual in accessing those services.

C. Case planning with the beneficiary, care giver and other parties as appropriate to identify the care, services and resources required to meet the beneficiary's needs and how the services may be most appropriately delivered.

REPEAL

D. Service coordination and monitoring through linkage, referral, coordination, facilitation, documentation and beneficiary-specific advocacy to ensure the beneficiary's access to the care, services and resources identified in the case plan. This is accomplished by personal, written or electronic contacts with the beneficiary, his or her family or caregiver, service providers and other interested parties.

E. Periodically conducted case plan reassessment to determine and document whether medical, social, educational or other services continue to be adequate to meet the goals identified in the case plan. Activities include assisting beneficiaries to access different medical, social, educational or other needed care and services beyond those already identified and provided.

214.000 Exclusions 4-1-05

Services that are not appropriate for targeted case management services and are not reimbursable under the Arkansas Medicaid Program include but are not limited to:

A. Concurrent targeted case management services provided to beneficiaries who are receiving case management services. Payments for targeted case management services will be limited to one provider for each date of service. The fiscal agent will pay for the earliest billed targeted case management services from a provider for a specific date of service and will deny all later billed services by other providers for the same or overlapping date of service.

B. The actual provision of services or treatment, including but not limited to:

1. Training in daily living skills
2. Training in work skills, social skills and/or exercise
3. Grooming and other personal care services
4. Training in housekeeping, laundry, cooking
5. Transportation services
6. Counseling/crisis intervention services

C. Services that go beyond assisting individuals in gaining access to needed services. Examples include but are not limited to:

1. Supervisory activities.
2. Paying bills and/or balancing the beneficiary's checkbook.
3. Completing application forms, paper work, evaluations and reports.
4. Observing a beneficiary receiving a service, e.g., physical therapy, speech therapy, classroom instruction.
5. Escorting beneficiaries to scheduled medical appointments.
6. Attending meetings, conferences or court hearings to provide information regarding the beneficiary and/or the beneficiary's family.
7. Home visits to observe the beneficiary and family's interactions or the condition of the home for child protection purposes.
8. Travel and/or waiting time.

D. Case management services that duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

REPEAL

E. Case management services that duplicate integral and inseparable parts of other Medicaid or Medicare services.

F. Case management services provided to inpatients of Title XIX institutions.

G. Case management services provided while transporting a beneficiary.

215.000 Reserved 11-1-09

216.000 Documentation 11-1-09

Along with the required enrollment documentation which is located in Section 141.000, targeted case management, the following records must be included in the beneficiary's case file maintained by the provider.

216.100 Documentation in Beneficiary's Case Files 11-1-09

The targeted case management provider must develop and maintain sufficient written documentation to support each service for which billing is made. All entries in a beneficiary's file must be signed and dated by the targeted case manager or qualified provider agency staff that provided the service, along with the individual's title. The documentation must be kept in the beneficiary's case file.

This documentation must consist of, at a minimum, material that includes:

A. When applicable, a copy of the original and all updates of the beneficiary's case plan;

B. The specific services rendered;

C. The date and actual clock time for the service rendered;

D. The beneficiary's name;

E. The name of the provider agency, if applicable, and person providing the service;

F. The place of service;

G. The number of units billed; and

H. Updates describing the nature and extent of the case management services delivered.

216.200 Reserved 11-1-09

216.300 Reserved 11-1-09

217.000 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

240.000 PRIOR AUTHORIZATION 4-1-05

Prior authorization (PA) is not required for targeted case management services for the DYS or the DCFS beneficiaries.

REPEAL

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 4-1-05

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time the service is provided and upon accuracy and completeness of the claim filed for the service. The provider is responsible for verifying the beneficiary is eligible for Medicaid prior to rendering services.

251.100 Rate Appeal Process 4-1-05

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services (DMS). This request must be received within twenty (20) calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he/she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within twenty (20) calendar days of receipt of the request for review or the date of the Program/Provider conference.

When the provider disagrees with the decision made by the Assistant Director, DMS, the provider may appeal the question to a standing Rate Review Panel established by the Director of the DMS. The Rate Review Panel will include one member of the DMS, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairperson.

The request for review by the Rate Review Panel must be postmarked within fifteen (15) calendar days following the notification of the initial decision by the Assistant Director, DMS. The Rate Review Panel will meet to consider the question(s) within fifteen (15) calendar days after receipt of a request for such appeal. The panel will hear the question(s) and will submit a recommendation to the Director of the DMS.

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 7-1-20

DYS/DCFS targeted case management providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about options available for electronic claims submission.

262.000 CMS-1500 Billing Procedures

262.100 DYS/DCFS Targeted Case Management Procedure Codes 4-1-05

Section 262.200 describes the billing procedure and the procedure code payable for the DYS Targeted Case Management program.

Section 262.300 describes the billing procedure and the procedure code payable for the DCFS Targeted Case Management program.

REPEAL

262.200 DYS Procedure Codes 12-5-05

Procedure Code	Required Modifier	Required Modifier	Description
T1017	U1	UA	DYS targeted case management

262.300 DCFS Procedure Codes 12-5-05

Procedure Code	Required Modifier	Required Modifier	Description
T1017	U3	UA	DCFS targeted case management

263.000 Place of Service Codes 7-1-07

Below is a list of the place of service (POS) codes for the DYS and DCFS targeted case management procedures.

263.100 DYS National Place of Service (POS) Code 7-1-07

The national place of service (POS) code is used for both electronic and paper billing.

Place of Service	POS Code
Other Locations	99

263.200 DCFS National Place of Service (POS) Code 7-1-07

The national place of service (POS) code is used for both electronic and paper billing.

Place of Service	POS Code
Other Locations	99

264.000 Billing Instructions – Paper Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

REPEAL

264.100 Completion of CMS-1500 Claim Form 9-1-14

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.

REPEAL

Field Name and Number	Instructions for Completion
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

REVISED

Field Name and Number	Instructions for Completion
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB? $ CHARGES	Not required. Not required.

REPEAL

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Some providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code.
C. EMG	Enter "Y" for Yes or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) if applicable.

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Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F – the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.

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Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

264.200 Special Billing Procedures **4-1-05**

Not applicable to this program.

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SECTION II - EPISODES OF CARE

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200.000 EPISODES OF CARE GENERAL INFORMATION 10-1-20

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021, the final reconciliation report will be generated. The reconciliation report period allows Principal Accountable Providers the opportunity to improve their gain share/risk share or incentive position. (See the Reporting Timeframe table below.)

EOC	Final Reconciliation Report Date

CORONARY ARTERIAL BYPASS GRAFT (CABG)	7/31/2020
ASTHMA	10/31/2020
UPPER RESPIRATORY INFECTION NON-SPECIFIC, SINUSITIS, PHARYNGITIS (URI)	1/31/2021
CHOLECYSTECTOMY (CHOLE)	1/31/2021
PERINATAL	1/31/2021
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	4/30/2021
CONGESTIVE HEART FAILURE (CHF)	4/30/2021
COLONOSCOPY (COLON)	4/30/2021
TONSILLECTOMY (TONSIL)	4/30/2021
TOTAL JOINT REPLACEMENT (TJR)	4/30/2021

200.100 Episode Definition/Scope of Services 7-1-16

This section describes, for each episode type, the rules for determining the specific services as derived from paid claims included in a particular episode.

A. *Episode subtypes:* Episode types may be divided into two or more subtypes distinguished by more specific diagnostic criteria or other clinical information.

B. *Episode triggers:* Services, diagnoses or procedures that may initiate an episode as defined for each episode type.

C. *Episode duration:* The time before and after an episode trigger during which medical claims may be included in an episode.

D. *Episode services:* Criteria used to determine which medical claims are included or excluded in an episode when delivered within the episode duration. Services excluded across all episode types are nursing home claims, EPSDT claims and managed care claims and fees.

200.200 Principal Accountable Provider 10-1-12

This section specifies, for each episode type, the types of providers eligible to be Principal Accountable Providers (PAPs) for an episode type and the algorithm used to determine the PAP(s) for an individual episode. For each episode of care, providers designated as PAPs hold the main responsibility for ensuring that the episode is delivered with appropriate quality and efficiency.

200.300 Exclusions 7-1-16

There are two types of exclusions. Global Exclusions are either policy related or clinically pertinent medical conditions that will exclude a beneficiary from all Episodes of Care.

Global Exclusions (applied to all Episodes of Care):

A. Medicaid and Medicare dual eligibility

B. Beneficiaries with non-continuous Medicaid enrollment for the duration of the episode

C. Beneficiaries with Third Party Liability

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D. Beneficiaries with one or more of the following:

1. End-Stage Renal Disease
2. Clinically pertinent metabolic, nutritional, immunity disorders
3. Clinically pertinent disorders of blood and blood forming organs
4. Clinically pertinent cancers
5. Active chemotherapy treatments
6. Clinically pertinent organ transplants
7. Acute Leukemia
8. Cystic Fibrosis

E. Beneficiaries leaving against medical advice

F. Beneficiaries expiring during the episode duration

G. Beneficiaries admitted to hospice care

H. Episodes that are a result from trauma

The second type of exclusions, referred to as Episode-Specific Exclusions, are at the episode type level. These exclusions are determined through consultation with providers and are identified as a significant impact on a particular episode. Episode-Specific Exclusions are identified for each episode of care.

200.400 Adjustments 7-1-16

This section describes, for each episode type, adjustments to the reimbursement amount attributable to a PAP for the purpose of calculating performance and determining incentives.

Across all episode types, the reimbursement amount attributable to a PAP for facility claims for acute inpatient hospitalizations is adjusted to a per diem rate of $850.

200.500 Quality Measures 7-1-16

This section describes, for each episode type, the specified data and measures which Medicaid will track and evaluate to ensure provision of high-quality care for each episode type. Quality measures may be determined from paid claims data or provider portal entry.

A. *Quality measures "to pass":* Measures for which a PAP must meet or exceed a minimum threshold in order to qualify for a positive (gain-share) incentive for that episode type.

B. *Quality measures "to track":* Measures for which a PAP's performance is not linked to receive incentives. Performance on these measures may result in an Office of Medicaid Inspector General review.

200.600 Reimbursement Thresholds 7-1-16

This section describes, for each episode type, the specific values used to calculate positive (gain-share) or negative (risk-share) incentives. This includes an acceptable threshold, a commendable threshold, a gain-sharing limit and a risk-sharing percentage.

200.700 Minimum Case Volume 7-1-16

This section describes, for each episode type, the minimum case volume required for a PAP to qualify for positive (gain-share) or negative (risk-share) incentives. PAPs who do not meet the

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minimum case volume for an episode type will not be eligible for positive (gain-share) or negative (risk-share) incentives for that episode type.

210.000 ACUTE AMBULATORY UPPER RESPIRATORY INFECTION (URI) EPISODES 10-1-20

The transition process to sunset Episodes of Care will result in a final payment report for Acute Ambulatory Upper Respiratory Infection (URI) Episode to be produced on January 31, 2020 and a final reconciliation report to be produced on January 31, 2021.

210.100 Episode Definition/Scope of Services 10-1-12

A. *Episode subtypes:*

1. Acute Nonspecific URI
2. Acute Pharyngitis and similar conditions
3. Acute Sinusitis

B. *Episode trigger:*

Office visits, clinic visits or emergency department visits with a primary diagnosis of an Acute Ambulatory URI ("URI") that do not fall within the time window of a previous URI episode.

C. *Episode duration:*

Episodes begin on the day of the triggering visit and conclude after 21 days.

D. *Episode services:*

All services relating to the treatment of a URI within the duration of the episode are included. The following services are excluded:

1. Surgical procedures
2. Transport
3. Immunizations commonly administered for preventative care
4. Non-prescription medications

210.200 Principal Accountable Provider 10-1-12

The Principal Accountable Provider (PAP) for an episode is the first Arkansas Medicaid enrolled and qualified provider to diagnose a beneficiary with an Acute Ambulatory URI during an in-person visit within the time window for the episode.

210.300 Exclusions 10-1-12

Episodes meeting one or more of the following criteria will be excluded:

A. Children younger than 1 year of age

B. Beneficiaries with inpatient stays or hospital monitoring during the episode duration

C. Beneficiaries with surgical procedures related to the URI (tonsillectomy, adenoidectomy)

D. Beneficiaries with the following comorbidities diagnosed at least twice in the one year period before the episode end date: 1) asthma; 2) cancer; 3) chronic URI; 4) end-stage

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renal disease; 5) HIV and other immunocompromised conditions; 6) post procedural state for transplants, pulmonary disorders, rare genetic diseases, and sickle cell anemia

E. Beneficiaries with the following comorbid diagnoses during the episode: 1) croup, 2) epiglottitis, 3) URI with obstruction, 4) pneumonia, 5) influenza, 6) otitis media

F. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

210.400 Adjustments 10-1-12

The reimbursement for the initial visit that is attributable to the PAP is normalized across different places of service (e.g., "Level 2" visits will count equally toward average reimbursement regardless of place of service). Reimbursements for the facility claim associated with the initial visit are not counted in the total reimbursements attributed to a PAP for calculation of performance.

Reimbursement attributed to the calculation of a PAP's performance for beneficiaries 10 and under is adjusted to reflect age-related variations in treatment using a multiplier determined by regression.

210.500 Quality Measures 10-1-12

A. *Quality measures "to pass":*

1. Frequency of strep testing for beneficiaries who receive antibiotics (for Acute Pharyngitis episode only) – must meet minimum threshold of 47%

B. *Quality measures "to track":*

1. Frequency of antibiotic usage
2. Frequency of multiple courses of antibiotics during one episode
3. Average number of visits per episode

210.600 Thresholds for Incentive Payments 10-1-12

A. *Acute Nonspecific URI*

1. The acceptable threshold is $67.00.
2. The commendable threshold is $46.00.
3. The gain sharing limit is $14.70.
4. The gain sharing percentage is 50%.
5. The risk sharing percentage is 50%.

B. *Acute Pharyngitis and similar conditions*

1. The acceptable threshold is $80.00.
2. The commendable threshold is $60.00.
3. The gain sharing limit is $14.70.
4. The gain sharing percentage is 50%
5. The risk sharing percentage is 50%.

C. *Acute Sinusitis*

1. The acceptable threshold is $87.00.

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2. The commendable threshold is $68.00.

3. The gain sharing limit is $14.70.

4. The gain sharing percentage is 50%.

5. The risk sharing percentage is 50%.

210.700 Minimum Case Volume 10-1-12

The minimum case volume is 5 total cases for each episode subtype per 12-month period.

211.000 PERINATAL CARE EPISODES 10-1-20

The transition process to sunset Episodes of Care will result in a final payment report for Perinatal Episode to be produced on January 31, 2020 and a final reconciliation report to be produced on January 31, 2021.

211.100 Episode Definition/Scope of Services 9-1-14

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

A live birth on a facility claim

C. *Episode duration:*

Episode begins 40 weeks prior to delivery and ends 60 days after delivery

D. *Episode services:*

All medical assistance with a pregnancy-related ICD diagnosis code is included. Medical assistance related to neonatal care is not included.

211.200 Principal Accountable Provider 10-1-12

For each episode, the Principal Accountable Provider (PAP) is the provider or provider group that performs the delivery.

211.300 Exclusions 10-1-13

Episodes meeting one or more of the following criteria will be excluded:

A. Limited prenatal care (i.e., pregnancy-related claims) provided between start of episode and 60 days prior to delivery

B. Delivering provider did not provide any prenatal services

C. Episode has no professional claim for delivery

D. Pregnancy-related conditions: amniotic fluid embolism, obstetric blood clot embolism, placenta previa, severe preeclampsia, multiple gestation ≥3, late effect complications of pregnancy/childbirth, puerperal sepsis, suspected damage to fetus from viral disease in mother, cerebrovascular disorders

E. Comorbidities: cancer, cystic fibrosis, congenital cardiovascular disorders, DVT/pulmonary embolism, other phlebitis and thrombosis, end-stage renal disease, sickle cell, Type I diabetes

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211.400 Adjustments 10-1-12

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted to reflect risk and/or severity factors captured in the claims data for each episode in order to be fair to providers with high-risk patients, to avoid any incentive for adverse selection of patients and to encourage high-quality, efficient care. Medicaid, with clinical input from Arkansas providers, will identify risk factors via literature, Arkansas experience and clinical expertise. Using standard statistical techniques and clinical review, risk factors will be tested for statistical and clinical significance to identify a reasonable number of factors that have meaningful explanatory power ($p < 0.01$) for predicting total reimbursement per episode. Some factors which have meaningful explanatory power may be excluded from the set of selected risk factors where necessary to avoid potential for manipulation through coding practices. Episode reimbursement attributable to a PAP for calculating average adjusted episode reimbursement are adjusted based on selected risk factors. Over time, Medicaid may add or subtract risk factors in line with new research and/or empirical evidence.

211.500 Quality Measures 10-1-12

A. *Quality measures "to pass":*

1. HIV screening – must meet minimum threshold of 80% of episodes
2. Group B streptococcus screening (GBS) – must meet minimum threshold of 80% of episodes
3. Chlamydia screening – must meet minimum threshold of 80% of episodes

B. *Quality measures "to track":*

1. Ultrasound screening
2. Screening for Gestational Diabetes
3. Screening for Asymptomatic Bacteriuria
4. Hepatitis B specific antigen screening
5. C-Section Rate

211.600 Thresholds for Incentive Payments 10-1-14

A. The acceptable threshold is $3,852.00.

B. The commendable threshold is $3,245.00.

C. The gain sharing limit is $2,000.00.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

211.700 Minimum Case Volume 10-1-12

The minimum case volume is 5 total cases per 12-month period.

213.000 CONGESTIVE HEART FAILURE (chf) EpisodeS 10-1-20

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The transition process to sunset Episodes of Care will result in a final payment report for Congestive Heart Failure (CHF) Episode to be produced on April 30, 2020 and a final reconciliation report to be produced on April 30, 2021.

213.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

Inpatient admission with a primary diagnosis code for heart failure

C. *Episode duration:*

Episodes begin at inpatient admission for heart failure. Episodes end at the latter of 30 days after the date of discharge for the triggering admission or the date of discharge for any inpatient readmission initiated within 30 days of the initial discharge. Episodes shall not exceed 45 days post-discharge from the triggering admission.

D. *Episode services:*

The episode will include all of the following services rendered within the episode's duration:

1. Inpatient facility and professional fees for the initial hospitalization and for all cause readmissions (excluding those defined by Bundled Payments for Care Improvement (BPCI))

2. Emergency or observation care

3. Home health services

4. Skilled nursing facility care due to acute exacerbation of CHF (services not included in episode for patients with SNF care in 30 days prior to episode start)

5. Durable medical equipment

E. *Continuous Medicaid Enrollment*

For the purpose of the CHF episode, the beneficiary must be enrolled in Medicaid beginning at least 30 days before the start of the episode and maintain continuous enrollment in Medicaid for the duration of the episode.

213.200 Principal Accountable Provider 2-1-13

The Principal Accountable Provider (PAP) for an episode is the admitting hospital for the trigger hospitalization.

213.300 Exclusions 2-1-13

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries do not have continuous Medicaid enrollment for the duration of the episode

B. Beneficiaries under the age of 18 at the time of admission

C. Beneficiaries with any cause inpatient stay in the 30 days prior to the triggering admission

D. Beneficiaries with any of the following comorbidities diagnosed in the period beginning 365 days before the episode start date and concluding on the episode end date: 1) End-Stage Renal

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Disease; 2) organ transplants; 3) pregnancy; 4) mechanical or left ventricular assist device (LVAD); 5) intra-aortic balloon pump (IABP)

E. Beneficiaries with diagnoses for malignant cancers in the period beginning 365 days before the episode start date and concluding on the episode end date. The following types of cancers will not be criteria for episode exclusion: colon, rectum, skin, female breast, cervix uteri, body of uterus, prostate, testes, bladder, lymph nodes, lymphoid leukemia, monocytic leukemia.

F. Beneficiaries who received a pacemaker or cardiac defibrillator in 6 months prior to the start of the episode or during the episode

G. Beneficiaries with any of the following statuses upon discharge: 1) transferred to acute care or inpatient psych facility; 2) left against medical advice; 3) expired

213.400 Adjustments 2-1-13

No adjustments are included in this episode type.

213.500 Quality Measures 2-1-13

A. *Quality measures "to pass":*

1. Percent of patients with LVSD who are prescribed an ACEI or ARB at hospital discharge – must meet minimum threshold of 85%.

B. *Quality measures "to track":*

1. Frequency of outpatient follow-ups within 7 and 14 days after discharge
2. For qualitative assessments of left ventricular ejection fraction (LVEF), proportion of patients matching: hyperdynamic, normal, mild dysfunction, moderate dysfunction, severe dysfunction
3. Average quantitative ejection fraction value
4. 30-day all cause readmission rate
5. 30-day heart failure readmission rate
6. 30-day outpatient observation care rate – utilization metric

The following quality measures require providers to submit data through the provider portal: qualitative assessment of LVEF, average quantitative ejection fraction value.

213.600 Thresholds for Incentive Payments 2-1-13

A. The acceptable threshold is $6,644.

B. The commendable threshold is $4,722.

C. The gain sharing limit is $3,263.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

213.700 Minimum Case Volume 2-1-13

The minimum case volume is 5 total cases per 12-month period.

214.000 TOTAL JOINT REPLACEMENT EPISODES 10-1-20

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The transition process to sunset Episodes of Care will result in a final payment report for Total Joint Replacement (TJR) Episode to be produced on April 30, 2020 and a final reconciliation report to be produced on April 30, 2021.

214.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

A surgical procedure for total hip replacement or total knee replacement

C. *Episode duration:*

Episodes begin 30 days prior to the date of admission for the inpatient hospitalization for the total joint replacement surgery and end 90 days after the date of discharge.

D. *Episode services:*

The following services are included in the episode:

1. From 30 days prior to the date of admission to the date of the surgery: All evaluation and management, hip- or knee-related radiology and all labs/imaging/other outpatient services
2. During the triggering procedure: all medical, inpatient and outpatient services
3. From the date of the surgery to 30 days after the date of discharge: All cause readmissions (excluding those defined by Bundled Payments for Care Improvement (BPCI)), non-traumatic revisions, complications, all follow-up evaluation & management, all emergency services, all home health and therapy, hip/knee radiology and all labs/imaging/other outpatient procedures
4. From 31 days to 90 days after the date of discharge: Readmissions (excluding those defined by BPCI) due to infections and complications as well as hip or knee-related follow-up evaluation and management, home health and therapy and labs/imaging/other outpatient procedures

214.200 Principal Accountable Provider 2-1-13

For each episode, the Principal Accountable Provider (PAP) is the orthopedic surgeon performing the total joint replacement procedure.

214.300 Exclusions 2-1-13

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries who are under the age of 18 at the time of admission

B. Beneficiaries with the following comorbidities diagnosed in the period beginning 365 days before the episode start date and concluding on the date of admission for the joint replacement surgery: 1) select autoimmune diseases; 2) HIV; 3) End-Stage Renal Disease; 4) liver, kidney, heart, or lung transplants; 5) pregnancy; 6) sickle cell disease; 7) fractures, dislocations, open wounds, and/or trauma

C. Beneficiaries with any of the following statuses upon discharge: 1) left against medical advice; 2) expired during hospital stay

D. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

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214.400 Adjustments 2-1-13

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted for total joint replacement episodes involving a knee replacement to reflect that knee replacements have higher average costs than hip replacements. Over time, Medicaid may add or subtract risk or severity factors in line with new research and/or empirical evidence.

214.500 Quality Measures 2-1-13

A. *Quality measures "to track":*

1. 30-day, all cause readmission rate
2. Frequency of use of prophylaxis against post-op Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE) (pharmacologic or mechanical compression)
2. Frequency of post-op DVT/PE
3. 30-day wound infection rate

The following quality measures require providers to submit data through the provider portal: use of prophylaxis against post-op Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE), occurrence of post-op Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE)

214.600 Thresholds for Incentive Payments 2-1-13

A. The acceptable threshold is $12,469.

B. The commendable threshold is $8,098.

C. The gain sharing limit is $5,249.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

214.700 Minimum Case Volume 2-1-13

The minimum case volume is 5 total cases per 12-month period.

216.000 COLONOSCOPY EPISODES 10-1-20

The transition process to sunset Episodes of Care will result in a final payment report for Colonoscopy (COLON) Episode to be produced on April 30, 2020 and a final reconciliation report to be produced on April 30, 2021.

216.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

Outpatient colonoscopy procedure (including balloon, biopsy, polypectomy, etc.) and primary or secondary diagnosis indicating conditions that require a colonoscopy (e.g., colorectal bleeding, hemorrhoids, anal fistula, neoplasm of unspecified nature). For a complete list of diagnoses, please see the code sheet associated with the episode.

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C. *Episode duration:*

Episodes begin with the initial consult with the performing provider (within 30 days prior to procedure) and end 30 days after the procedure.

D. *Episode services:*

The episode will include all of the following services rendered within the episode's duration:

1. Within 30-day pre-procedure window: related services beginning on the day of the first consult with the performing provider, including inpatient and outpatient facility services, professional services, related medications, and excluding ER visits on the day of the first visit

2. Within procedure window: colonoscopies with and without additional procedures, including inpatient and outpatient facility services, professional services, and related medications, beginning day of procedure

3. Within 30-day post-procedure window; related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, inpatient post-procedure admission (excluding those defined by Bundled Payments for Care Improvement (BPCI))

216.200 Principal Accountable Provider 10-1-13

The Principal Accountable Provider (PAP) for an episode is the primary provider performing the colonoscopy.

216.300 Exclusions 10-1-13

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries with select comorbid conditions within 365 days prior to procedure or during episode (e.g., inflammatory bowel disease, select cancers, select transplants, etc.). For a complete list of comorbidities, please see the code sheet associated with the episode.

B. Beneficiaries under the age of 18 or over the age of 64 at the time of the procedure

C. Beneficiaries who are pregnant during the episode

D. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

E. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

F. Beneficiaries who die in the hospital during the episode

G. Beneficiaries with patient status "left against medical advice" during the episode

216.400 Adjustments 10-1-13

The cost of this episode is based on a) risk factors (e.g., renal failure, diabetes) and b) episode types. Episode types include 1) colonoscopies with additional procedures, 2) colonoscopies without additional procedures.

216.500 Quality Measures 10-1-13

A. *Quality measures "to pass":*

REPEAL

1. Cecal intubation rate reported by provider on an aggregated quarterly basis – must meet minimum threshold of 75%.

2. In at least 80% of valid episodes, the withdrawal time must be greater than 6 minutes.

B. *Quality measures "to track":*

1. Perforation rate

2. Post polypectomy/biopsy bleed rate

All of the above quality measures "to pass" require providers to submit data through the provider portal.

216.600 Thresholds for Incentive Payments 10-1-13

A. The acceptable threshold is $886.

B. The commendable threshold is $796.

C. The gain sharing limit is $717.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

216.700 Minimum Case Volume 10-1-13

The minimum case volume is 5 total cases per 12-month period.

217.000 Tonsillectomy episodes 10-1-20

The transition process to sunset Episodes of Care will result in a final payment report for Tonsillectomy (TONSIL) Episode to be produced on April 30, 2020 and a final reconciliation report to be produced on April 30, 2021.

217.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

Episode is triggered by an outpatient tonsillectomy, adenoidectomy, or adeno-tonsillectomy procedure, and a primary or secondary diagnosis (Dx1 or Dx2) indicating conditions that require tonsillectomy/adenoidectomy (e.g., chronic tonsillitis, chronic adenoiditis, chronic pharyngitis, hypertrophy of tonsils and adenoids, obstructive sleep apnea, insomnia, peritonsillar abscess). For a complete list of diagnoses, please see the code sheet associated with the episode.

C. *Episode duration:*

Episodes begin with the initial consult with the performing provider (within 90 days prior to procedure) and end 30 days after the procedure.

D. *Episode services:*

REPEAL

The following services are included in the episode:

1. Within 90 days prior to procedure: initial consult with performing provider, and any related services including sleep studies, head and neck X-rays, and laryngoscopy
2. The tonsillectomy/adenoidectomy procedure
3. Within 30 days after procedure: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, and post-procedure admissions (excluding those defined by Bundled Payments for Care Improvement (BPCI))

217.200 Principal Accountable Provider 10-1-13

For each episode, the Principal Accountable Provider (PAP) is the primary provider performing the tonsillectomy/adenoidectomy.

217.300 Exclusions 10-1-13

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries who are under the age of 3 or above the age of 21 at the time of the procedure

B. Beneficiaries with select comorbid conditions (e.g., Down syndrome, cancer, severe asthma, cerebral palsy, muscular dystrophy, myopathies). For a complete list of comorbidities, please see the code sheet associated with the episode.

C. Beneficiaries with an Uvulopalatopharngoplasty (UPPP) on date of procedure

D. Beneficiaries with a BMI>50

E. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

F. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

G. Beneficiaries who die in the hospital during the episode

H. Beneficiaries with a patient status of "left against medical advice" during the episode

217.400 Adjustments 10-1-13

For the purpose of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted for tonsillectomy episodes within certain risk factors (e.g., COPD, asthma), and depending on type. There are two episode types: 1) adenoidectomy and 2) tonsillectomy/adeno-tonsillectomy.

217.500 Quality Measures 10-1-13

A. *Quality measures "to pass":*

1. Percent of episode with administration of intra-operative steroids – must meet minimum threshold of 85%

B. *Quality measures "to track":*

1. Post-operative primary bleed rate (i.e., post-procedure admissions or unplanned return to OR due to bleeding within 24 hours of surgery)
2. Post-operative secondary bleed rate

REPEAL

3. Rate of antibiotic prescription post-surgery

All of the above quality measures "to pass" require providers to submit data through the provider portal.

217.600 Thresholds for Incentive Payments 10-1-13

A. The acceptable threshold is $1,069.

B. The commendable threshold is $1,019.

C. The gain sharing limit is $824.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

217.700 Minimum Case Volume 10-1-13

The minimum case volume is 5 total cases per 12-month period.

218.000 CHOLECYSTECTOMY EPISODES 10-1-20

The transition process to sunset Episodes of Care will result in a final payment report for Cholecystectomy (CHOLE) Episode to be produced on January 31, 2020 and a final reconciliation report to be produced on January 31, 2021.

218.100 Episode Definition/Scope of Services 10-1-13

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

Episode is triggered by open or laparoscopic cholecystectomy procedure, and a primary or secondary diagnosis (Dx1 or Dx2) indicating conditions related to cholecystectomy (e.g., cholelithiasis, cholecystitis). For a complete list of diagnoses, please see the code sheet associated with the episode.

C. *Episode duration:*

Episodes begin with the cholecystectomy procedure and end 90 days post-procedure

D. *Episode services:*

The following services are included in the episode:

1. During procedure: Cholecystectomy surgery and related services (i.e., inpatient and outpatient facility services, professional services, related medications, treatment for complications)

2. Within 90 days post-procedure: related services (i.e., inpatient and outpatient facility services, professional services, related medications, treatment for complications)

3. Within 30-day post-procedure window: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, inpatient post-procedure admission (excluding those defined by Bundled Payments for Care Improvement (BPCI))

REPEAL

218.200 Principal Accountable Provider 10-1-13

For each episode, the Principal Accountable Provider (PAP) is the primary surgeon performing the cholecystectomy.

218.300 Exclusions 10-1-13

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries who are less than or equal to the age of 1 or greater than or equal to the age of 65 at the time of the procedure

B. Beneficiaries with select comorbid conditions or past procedures within 365 days or 90 days after cholecystectomy (e.g., HIV, cancer, sickle cell anemia, transplants). For a complete list of comorbidities, please see the code sheet associated with the episode.

C. Beneficiaries with a pregnancy 30 days prior to a cholecystectomy procedure to 90 days after said cholecystectomy procedure

D. Beneficiaries with ICU care within 30 days prior to the cholecystectomy procedure

E. Beneficiaries with acute pancreatitis, cirrhosis, or cholangitis concurrent with procedure

F. Beneficiaries with open cholecystectomy procedure (includes laparoscopic converted to open and surgeries initiated open)

G. Beneficiaries who die in the hospital during the episode

H. Beneficiaries with a patient status of "left against medical advice" during the episode

I. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

J. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

218.400 Adjustments 10-1-13

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted for: cholecystectomy episodes in which patients have comorbidities, including indirectly related health conditions (e.g., acute cholecystitis, common bile duct stones), and episodes in which patients have an ED admittance prior to procedure.

REPEAL

218.500 Quality Measures 10-1-13

A. *Quality measures "to pass":*

1. Percent of episodes with CT scan prior to cholecystectomy – must be below threshold of 44%

B. *Quality measures "to track":*

1. Rate of major complications that occur in episode, either during procedure or in post-procedure window: common bile duct injury, abdominal blood vessel injury, bowel injury

2. Number of laparoscopic cholecystectomies converted to open surgeries

3. Number of cholecystectomies initiated via open surgery

218.600 Thresholds for Incentive Payments 10-1-13

A. The acceptable threshold is $2,048.

B. The commendable threshold is $1,614.

C. The gain sharing limit is $1,190.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

218.700 Minimum Case Volume 10-1-13

The minimum case volume is 5 total cases per 12-month period.

220.000 acute exacerbation of Asthma episodes 10-1-20

The transition process to sunset Episodes of Care will result in a final payment report for Asthma Episode to be produced on October 31, 2019 and a final reconciliation report to be produced on October 31, 2020.

REPEAL

220.100 Episode Definition/Scope of Services 4-1-14

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

Asthma episodes are triggered by medical claims with a primary diagnosis related to an asthma acute exacerbation on an emergency department or inpatient claim. Trigger must be preceded by 30-day clean period with no triggers or repeat exacerbations.

C. *Episode duration:*

Episodes begin with a trigger diagnosis in a hospital setting and end 30 days after discharge or until the end of a readmission where the patient had entered the hospital within the 30-day post-discharge period.

D. *Episode services:*

The following services are included in the episode:

1. During the trigger window (i.e., date of emergency room visit or entire inpatient stay): all services and claims received by the beneficiary

2. Within 30-day post-trigger window: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, and readmissions or repeat visits to the Emergency Department

220.200 Principal Accountable Provider 4-1-14

The PAP is the facility (i.e., hospital) where the initial trigger event occurred.

220.300 Exclusions 4-1-14

Episodes with one or more of the following criteria will be excluded:

A. Beneficiaries with select comorbid conditions

B. Beneficiaries who are intubated or have home oxygen usage at any point during the episode

C. Beneficiaries with ICU admissions greater than 72 hours

D. Beneficiaries who die in the hospital during episode

E. Beneficiaries with status of "left against medical advice" during episode

F. Beneficiaries under the age of 5 on the trigger date

G. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

H. Beneficiaries with third party liabilities in the episode

REPEAL

I. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

220.400 Adjustments 4-1-14

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP for an acute exacerbation episode is adjusted based on:

A. Patient comorbidities which may be risk factors that influence episode cost

B. Age

C. High cost or low cost outliers, applied after other cost adjustments

220.500 Quality Measures 4-1-14

A. *Quality measures "to pass":*

1. Rate of corticosteroid and/or inhaled corticosteroid usage determined by filled prescription rate for medication within +/- 30 days of trigger start date – must meet minimum threshold of 59%

2. Percent of episodes where patient visits outpatient physician within 30 days post initial discharge – must meet minimum threshold of 38%

B. *Quality measures "to track":*

1. Rate of repeat acute exacerbation within 30 days post initial discharge

220.600 Thresholds for Incentive Payments 4-1-14

A. The acceptable threshold is $575.

B. The commendable threshold is $427.

C. The gain sharing limit is $299.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

220.700 Minimum Case Volume 4-1-14

The minimum case volume is 5 valid cases per 12-month period.

REPEAL

221.000 ACUTE exacerbation of Chronic Obstructive pulmonary disease (COPD) Episodes 10-1-20

The transition process to sunset Episodes of Care will result in a final payment report for Chronic Obstructive Pulmonary Disease (COPD) Episode to be produced on April 30, 2020 and a final reconciliation report to be produced on April 30, 2021.

221.100 Episode Definition/Scope of Services 10-1-14

A. Episode subtypes:

There are no subtypes for this episode type.

B. Episode trigger:

COPD episodes are triggered by medical claims with a primary diagnosis related to a COPD acute exacerbation on an emergency department or inpatient claim. Trigger must be preceded by 30-day clean period with no triggers or repeat exacerbations.

C. Episode duration:

Episodes begin with a trigger diagnosis in a hospital setting and end 30 days after discharge or until the end of a readmission where the patient had entered the hospital within the 30 day post-discharge period.

D. Episode services:

The following services are included in the episode:

1. During the trigger window (i.e., date of emergency room visit or entire inpatient stay): all services and claims received by the beneficiary

2. Within 30-day post-trigger window: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, and readmissions or repeat visits to the Emergency Department.

221.200 Principal Accountable Provider 10-1-14

The PAP is the facility (i.e., hospital) where the initial trigger event occurred.

REPEAL

221.300 Exclusions 10-1-14

Episodes with one or more of the following criteria will be excluded:

A. Beneficiaries with select comorbid conditions

B. Beneficiaries who are intubated

C. Beneficiaries with ICU admissions greater than 72 hours

D. Beneficiaries who die in the hospital during episode

E. Beneficiary with status of "left against medical advice" during episode

F. Beneficiaries under the age of 35 on the trigger date

G. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

H. Beneficiaries with third party liabilities in the episode

I. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

221.400 Adjustments 10-1-14

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP for an acute exacerbation episode is adjusted based on:

A. Patient comorbidities, which may be risk factors that influence episode cost

B. Age

C. High cost or low cost outliers, applied after other cost adjustments

221.500 Quality Measures 10-1-14

A. Quality measures "to pass":

1. Percent of episodes where patient visits outpatient physician within 30 days post initial discharge – must meet minimum threshold of 36%

B. Quality measures "to track":

1. Rate of repeat acute exacerbation within 30 days post initial discharge

REPEAL

221.600 Thresholds for Incentive Payments 10-1-14

A. The acceptable threshold is $1,876.00.

B. The commendable threshold is $1,339.00.

C. The gain sharing limit is $859.00.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

221.700 Minimum Case Volume 10-1-14

The minimum case volume is 5 valid cases per 12 month period.

223.000 Coronary arterial bypass graft (CABG) episodes 10-1-20

The transition process to sunset Episodes of Care will result in a final payment report for Coronary arterial bypass graft (CABG) Episode to be produced on July 31, 2019 and a final reconciliation report to be produced on July 31, 2020.

223.100 Episode Definition/Scope of Services 1-1-14

A. *Episode subtypes:*

There are no subtypes for this episode type.

B. *Episode trigger:*

Episode is triggered by a coronary arterial bypass graft (CABG) procedure.

C. *Episode duration:*

The episode duration is the timeframe from the date of surgery through 30 days post discharge from the facility stay during which the procedure occurred.

D. *Episode services:*

The following services are included in the episode:

REAL

1. During procedure: All services (i.e., inpatient and outpatient facility services, professional services, medication, treatment for complications)

2. Within 30 days post discharge of the procedure: All related services including inpatient and outpatient facility services, professional services, medications, treatment for complications related to conditions affecting the coronary arterial system, and readmissions or repeat visits to the Emergency Department.

223.200 Principal Accountable Provider 1-1-14

For each episode, the Principal Accountable Provider (PAP) will be the physician performing the CABG.

223.300 Exclusions 1-1-14

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries with select comorbid conditions

B. Beneficiaries undergoing a salvage CABG (from failed or aborted PCI)

C. Beneficiaries who die in the hospital during episode

D. Beneficiaries with status of "left against medical advice" during episode

E. Beneficiaries under the age of 18 on the trigger date

F. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

G. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

H. Beneficiaries with CABG surgeries that include 2 or more valve procedures

I. Beneficiaries with procedure triggers that do not have a corresponding facility claim

J. Beneficiaries with third party liabilities in the episode

223.400 Adjustments 1-1-14

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted based on:

A. Patient comorbidities, including indirectly related health conditions and patient presentation prior to CABG episode

B. High cost or low cost outliers, applied after other cost adjustments

C. Presence of 1 valve procedure during CABG surgery

D. Changes to fee schedules and reimbursements originating from changes to provider procedure coding and billing practices

REPEAL

223.500 Quality Measures 1-1-14

A. *Quality measures "to pass":*

NOTE: For CABG quality measures, PAPs must satisfy thresholds for *two* of the three adverse outcome metrics in order to qualify for gain sharing

1. Percent of patients with stroke in 30 days post-procedure – must meet maximum threshold of 0%

2. Percent of patients with deep sternal wound infection in 30 days post-procedure – must meet maximum threshold of 0%

3. Percent of patients with post-operative renal failure in 30 days post-procedure – must meet maximum threshold of 0%

B. *Quality measures "to track":*

1. Percent of episodes during which at least 1 adverse outcome occurs (with adverse outcome defined as patients with either stroke, deep sternal wound infection or post-operative renal failure in 30 days post-procedure)

2. Percent of patients on a ventilator for longer than 24 hours after surgery

3. Average length of pre-operative inpatient stay

4. Percent of patients admitted on day of surgery

5. Percent of patients for whom an internal mammary artery is used

223.600 Thresholds for Incentive Payments 1-1-14

A. The acceptable threshold is $11,017.

B. The commendable threshold is $9,305.

C. The gain sharing limit is $7,550.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

223.700 Minimum Case Volume 1-1-14

The minimum case volume is 5 valid cases per 12-month period.

REPEAL