ADMINISTRATIVE POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
PASSE Provider Payment Exclusions-AR PASSE-AD-1238	12/01/2022-01/31/2024
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

PASSE Provider Responsibilities

B. Background

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The PASSE is responsible for the credentialing of HCBS providers, and all HCBS providers must be enrolled in Arkansas Medicaid and credentialed as such by the PASSE.

C. Definitions

- **Claims Payment** - A payment made in full or in part to a service provider for the provision of medically necessary treatment and services to an eligible beneficiary and can include hospital inpatient, outpatient, professional payments, clinic, ancillary, pharmacy, support service, and other institutional payments.
- **Direct Service Provider** - An organization or individual who delivers healthcare services to beneficiaries attributed to a PASSE.
- **Person Centered Service Plan (PCSP)** - A member's total plan of care made in accordance with 42 CFR 441.301(c)(1) that indicates services necessary for the member, specific member needs, member strengths and a crisis plan.

D. Policy

I. Provider services include care, supervision, and activities that directly relate to active treatment goals and objectives set forth in a member's PCSP that are medically necessary or nonmedical community supports or services.

II. Provider payments exclude the following (not an all-inclusive list):
   A. Member room and board expenses or monthly rental or mortgage expenses
   B. General maintenance, upkeep, or improvement to a member's home, including damage caused by provider staff
   C. Modifications or repairs to a member's home, including:
      1. General utility only and not for a specific medical or habilitative benefit
      2. Aesthetic value only
      3. Adding to the total square footage of the home
   D. Vehicle modification exclusions for members as indicated in Adaptive Equipment Manuals
   E. Regular food expenses or utility charges for members
   F. Items intended for member diversional or recreational purposes

III. If providers disagree with decisions regarding submitted claims or claims payments, additional information can be found within the CareSource Provider Portal, the Grievance and Appeals section of the CareSource PASSE Provider Manual, and through other guidance and communications submitted by CareSource at www.caresource.com.

E. Conditions of Coverage

NA

F. Related Policies/Rules

Medical Necessity Determinations
Nonmedical Community Supports and Services

G. Review/Revision History

	DATE	ACTION
Date Issued	09/14/2022	New policy.
Date Revised		
Date Effective	12/01/2022	
Date Archived	01/31/2024	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Arkansas Division of Medical Services. Provider-led Arkansas Shared Savings Entity Provider Manual, Section II. Retrieved September 7, 2022 from www.humanservices.arkansas.gov.
2. CareSource PASSE 2022 Provider Manual. Retrieved September 7, 2022 from www.caresource.com.