QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS
WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Andrew Allison, PhD
CONTACT PERSON Robbie Nix
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 320-86527 FAX NO. 682-2480 E-MAIL Robert.nix@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Marilyn Strickland
PRESENTER E-MAIL marilyn.strickland@arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after “Short Title of this Rule” below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

******************************************************************************

1. What is the short title of this rule?
   EPISODE-1-13 and State Plan Amendment #2013-003

2. What is the subject of the proposed rule?
   To add Tonsillectomy episodes, Cholecystectomy episodes, Colonoscopy episodes and Oppositional Defiant Disorder (ODD) episodes to both the Episodes of Care Medicaid manual and the Arkansas State Plan.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ____ No __X__. 
   If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ____ No __X__. 
   If yes, what is the effective date of the emergency rule? _____________________________
   When does the emergency rule expire? _____________________________
   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes _____ No ______
5. Is this a new rule? Yes ___ No ___ X ___ If yes, please provide a brief summary explaining the regulation.

Does this repeal an existing rule? Yes ____ No ___ X ___ If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

Is this an amendment to an existing rule? Yes ___ X ___ No ____ If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled “mark-up.”**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary?

The purpose of the proposed rule is to add Tonsillectomy episodes, Cholecystectomy episodes, Colonoscopy episodes and Oppositional Defiant Disorder (ODD) episodes to both the Episodes of Care Medicaid manual and the Arkansas State Plan. Medicaid has established a payment improvement initiative to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. This proposed rule also updates formatting of the Episodes of Care Provider Manual and provides clarification to previous language.

The proposed rule is necessary so that providers are aware of Arkansas Medicaid requirements for Tonsillectomy episodes, Cholecystectomy episodes, Colonoscopy episodes and Oppositional Defiant Disorder (ODD) episodes.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ___ X ___ No _____.

If yes, please complete the following:

Date: __ TBA _________________

Time: __ TBA _________________

Place: __ TBA _________________

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

   **March 14, 2013**

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

   **October 1, 2013**

12. Do you expect this rule to be controversial? Yes ___ X ___ No _____. If yes, please explain.

   While the episode based payment improvement initiative does not change current reimbursement, there is risk that providers could incur a negative incentive adjustment that would require them to remit money back to Medicaid

13. Please give the names of persons, groups, or organizations that you expect to comment on these
rules? Please provide their position (for or against) if known.

Medical associations, interested providers, and advocacy organizations. Their positions for or against is not known at this time.
To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

**SHORT TITLE OF THIS RULE** – EPISODE-1-13 and State Plan Amendment #2013-003

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes [X] No [ ].

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes [X] No [ ].
   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

<table>
<thead>
<tr>
<th>Current Fiscal Year</th>
<th>Next Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Revenue</td>
<td>General Revenue</td>
</tr>
<tr>
<td>Federal Funds</td>
<td>Federal Funds</td>
</tr>
<tr>
<td>Cash Funds</td>
<td>Cash Funds</td>
</tr>
<tr>
<td>Special Revenue</td>
<td>Special Revenue</td>
</tr>
<tr>
<td>Other (Identify)</td>
<td>Other (Identify)</td>
</tr>
<tr>
<td>Total</td>
<td>Total</td>
</tr>
</tbody>
</table>

5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

<table>
<thead>
<tr>
<th>Current Fiscal Year</th>
<th>Next Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Fiscal Year (2014)</td>
<td>Next Fiscal Year (2015)</td>
</tr>
<tr>
<td>$ 247,051 State</td>
<td>$ 322,015 State</td>
</tr>
<tr>
<td>$ 585,051 Federal</td>
<td>$ 762,576 Federal</td>
</tr>
<tr>
<td>$ 832,102 Total Savings</td>
<td>$1,084,591 Total Savings</td>
</tr>
</tbody>
</table>
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
AMENDING ADMINISTRATIVE REGULATIONS

NUMBER AND TITLE: EPISODE-1-13 and State Plan Amendment #2013-003

PROPOSED EFFECTIVE DATE: July 1, 2013

STATUTORY AUTHORITY:

NECESSITY AND FUNCTION: The purpose of the proposed rule is to add Tonsillectomy episodes, Cholecystectomy episodes, Colonoscopy episodes and Oppositional Defiant Disorder (ODD) episodes to both the Episodes of Care Medicaid manual and the Arkansas State Plan. Medicaid has established a payment improvement initiative to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. This proposed rule also updates formatting of the Episodes of Care Provider Manual and provides clarification to previous language.

The proposed rule is necessary so that providers are aware of Arkansas Medicaid requirements for Tonsillectomy episodes, Cholecystectomy episodes, Colonoscopy episodes and Oppositional Defiant Disorder (ODD) episodes.

PAGES FILED:

Andrew Allison, PhD, Director
Division of Medical Services

Promulgation date: October 1, 2013

Contact Person: Robert Nix
Program Development and Quality Assurance
P. O. Box 1437, Slot S295
Little Rock, AR  72203-1437
(501) 320-6427
MEMORANDUM

TO: Judy Besancon, Director, Risk Management
   Office of Chief Counsel
FROM: Becky Murphy, Policy Development Coordinator
       Program Development and Quality Assurance
DATE: February 13, 2013
SUBJ: APA Promulgation

Please review the attached APA packet on changes relating to the following:

EPISODE-1-13 and State Plan Amendment #2013-003

Please call me at 2-8096, if you need further information concerning this packet.

Thank you.

Attachment
NOTICE OF RULE MAKING

The Director of the Division of Medical Services hereby issues the following proposed medical assistance rule(s) under one or more of the following chapters or sections of the Arkansas Code: 20-10-211(a), 20-10-203(b), 20-76-433, 25-10-129, and Title 20, Chapter 77.

Effective October 1, 2013 Arkansas Medicaid proposes to add Tonsillectomy episodes, Cholecystectomy episodes, Colonoscopy episodes and Oppositional Defiant Disorder (ODD) episodes to the Episodes of Care Medicaid manual and Arkansas State Plan to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. This proposed rule also updates formatting of the Episodes of Care Provider Manual and provides clarification to previous language. The estimated annualized savings for FFY2014 is $780,069.

The proposed policy is available for review at the Division of Medical Services, Program Planning and Development, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access it on the Medicaid website (www.medicaid.state.ar.us), and download it from the “Proposed Rules For Public Comment” section of the website’s General menu. Policy accessed from this location will be watermarked with the word “Proposed”. All comments must be submitted in writing no later than March 14, 2013.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free); or to obtain access to these numbers through voice relay: 1-800-877-8973 (TTY Hearing Impaired).

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin.

Andrew Allison, PhD, Director
Division of Medical Services

Date: February 13, 2013 – February 15, 2013
MEMORANDUM

TO: Interested Persons and Providers

FROM: Andrew Allison, PhD, Director, Division of Medical Services

DATE: February 13, 2013

SUBJ: EPISODE-1-13 and State Plan Amendment #2013-003

As a part of the Administrative Procedures Act process, attached for your review and comment are proposed Medicaid policy revisions.

If you have any comments, please submit those comments in writing, to the following address, no later than March 14, 2013.

Division of Medical Services
Program Planning and Development
P. O. Box 1437, Slot S295
Little Rock, Arkansas  72203-1437

The Program Planning and Development Unit anticipates filing with the Arkansas Legislative Council on September 14, 2012, and the Secretary of State, the Arkansas State Library and the Bureau of Legislative Research on December 18, 2012.
February 13, 2012

Ms. Donna Davis  
Committee on Administrative Rules and Regulations  
Arkansas Legislative Council  
Room 315 State Capitol Building  
Little Rock, AR  72201

Dear Ms. Davis:

Enclosed are two copies of the Questionnaire with the proposed rule regarding the following: EPISODE-1-13 and State Plan Amendment #2013-003

If you have any questions or comments, please address them to Division of Medical Services, Program Planning and Development, P. O. Box 1437, Mail Slot S295, Little Rock, AR  72203-1437.

Sincerely,

Andrew Allison  
Director

AA/bam  
Enclosure
Effective October 1, 2013 Arkansas Medicaid proposes to add Tonsillectomy episodes, Cholecystectomy episodes, Colonoscopy episodes and Oppositional Defiant Disorder (ODD) episodes to the Episodes of Care Medicaid manual and Arkansas State Plan to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. This proposed rule also updates formatting of the Episodes of Care Provider Manual and provides clarification to previous language.
ECONOMIC IMPACT STATEMENT
(As Required under Arkansas Code § 25-15-301)

Department: Arkansas Department of Human Services
Division: Medical Services
Person Completing this Statement: Tom Show
Telephone Number: 501-682-2483 Fax Number: 501-682-3889
EMAIL: Tom.Show@Arkansas.gov

Short Title of this Rule: EPISODE-1-13 and State Plan Amendment #2013-003

(1) The type or types of small businesses that will be directly affected by the proposed rule, bear the cost of the proposed rule, or directly benefit from the proposed rule.
Health Care providers providing services for conditions covered under episodes included in the Arkansas Health Care Payment Improvement Initiative.

(2) A description of how small businesses will be adversely affected.
Some health care providers may benefit from the episode performance payment model, while those providing services that do not meet certain cost and quality standards will see reduced provider revenue. Impact to any individual provider will depend on the provider’s behavior and performance.

(3) A reasonable determination of the dollar amounts the proposed rule will cost small businesses in terms of fees, administrative penalties, reporting, recordkeeping, equipment, construction labor, professional services, revenue loss, or other costs associated with compliance.
No additional incremental costs to providers are expected. The net revenue impact to any individual provider will depend on their current standard of care and any improvement they make.

(4) A reasonable determination of the dollar amounts of the costs to the agency of implementing the proposed rule, as well as the financial benefit to the agency of implementing the rule.
The Department projects savings resulting from implementation of this initiative to be $1,084,591 in SFY 2015. 2015 is the first year that the full impact of this initiative would be realized.

(5) Whether and to what extent alternative means exist for accomplishing the objectives of the proposed rule that might be less burdensome to small businesses and why such alternatives are not being proposed.
Not Applicable

(6) A comparison of the proposed rule with federal and state counterparts.
Not Applicable
211.100  Episode Definition/Scope of Services  10-1-13

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-9 diagnosis code is included. Medical assistance related to neonatal care is not included.

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

212.300  Exclusions  10-1-13

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

A. Duration of less than 4 months

B. Small number of medical and/or pharmacy claims during the episode

C. Beneficiaries with any comorbid behavioral health condition or developmental disability

D. Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim

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.

214.100 Episode Definition/Scope of Services

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

215.000 OPPOSITIONAL DEFIA NT DISORDER (ODD) EPISODES

215.100 Episode Definition/Scope of Services

A. **Episode subtypes:**

There are no subtypes for this episode type.
B. **Episode trigger:**

ODD episodes are triggered by three medical claims with a primary diagnosis of ODD.

C. **Episode duration:**

The standard episode duration is a 90-day period beginning at the time of the first trigger claim. Claims for a beneficiary are tracked for 180 days following the closure of the 90-day standard episode to determine the episode remission rate quality metric.

D. **Episode services:**

All claims with a primary diagnosis of ODD. Behavioral health medications will be excluded from the episode, but utilization of medications will be tracked as a quality metric for providers “to pass.” Notwithstanding any other provisions in the provider manual, medical assistance included in an ODD episode shall not be subject to prior authorization requirements.

215.200 Principal Accountable Provider

Determination of the Principal Accountable Provider (PAP) is based upon which provider is responsible for the largest number of claims within the episode.

The provider responsible for the largest number of claims is designated the PAP. In instances in which two providers are responsible for an equal number of claims within the episode, the provider whose claims accounted for a greater proportion of total reimbursement will be designated PAP.

Providers eligible to be PAPs include primary care physicians, psychiatrists, clinical psychologists, and RSPMI provider organizations.

215.300 Exclusions

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

A. Beneficiaries not continuously enrolled in Medicaid during the 90-day episode

B. Beneficiaries with any comorbid behavioral health condition

C. Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim

215.400 Adjustments

An episode with fewer than 10 therapy visits over 30+ days will not be applied to reduce a PAP’s average episode cost but may count toward risk sharing. PAPs who in an entire performance period have no episodes with 10 or more therapy visits over 30+ days will not be eligible for gain sharing.

215.500 Quality Measures

A. **Quality measures “to pass”:**

1. Percentage of episodes with completion of either Continuing Care or Quality Assessment certification – must meet minimum threshold of 90% of episodes.

2. Percentage of new episodes (i.e., a PAP’s first ODD episode for this beneficiary) in which the beneficiary received behavioral health medications – must be under maximum threshold of 20%.

3. Percentage of repeat episodes (i.e., all episodes other than a PAP’s first ODD episode for this beneficiary) for which the beneficiary received behavioral health medications – must be equal to 0%.

4. Percentage of episodes resulting in beneficiary remission (no repeat ODD episode for this beneficiary within 180 days after the end of the episode) – must meet minimum threshold of
40%. If a PAP has <5 episodes used for the calculation in a performance period, the metric becomes a quality measure “to track” – not “to pass”.

B. **Quality measures “to track”:**
   1. Percentage of episodes with >9 visits over >30 days
   2. Percentage of episodes certified as non-guideline concordant care
   3. Average number of visits per episode
   4. Average number of behavioral therapy visits per episode
   5. Percentage of episodes with >9 therapy sessions over a period of 30+ days and of which >7 are family therapy sessions (CPT 90846 OR CPT 90847)

**215.600 Thresholds for Incentive Payments**

A. The acceptable threshold is $2,671.

B. The commendable threshold is $1,642.

C. The gain sharing limit is $984.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

**215.700 Minimum Case Volume**

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

**216.000 COLONOSCOPY EPISODES**

**216.100 Episode Definition/Scope of Services**

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.

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

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

216.300 Exclusions

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

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

A. Quality measures “to pass”:

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

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

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

217.000 TONSILLECTOMY EPISODES

217.100 Episode Definition/Scope of Services

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:

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

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

217.300 Exclusions

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 Uvulopalatopharnngoplasty (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

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

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
   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

A. The acceptable threshold is $1,003.
B. The commendable threshold is $974.
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

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

218.000 CHOLECYSTECTOMY EPISODES

218.100 Episode Definition/Scope of Services

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))

**218.200 Principal Accountable Provider**

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

**218.300 Exclusions**

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**

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.

**218.500 Quality Measures**

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 $1,919.
   B. The commendable threshold is $1,581.
   C. The gain sharing limit is $1,337.
   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.
TO: Arkansas Medicaid Health Care Providers – All Providers

DATE: October 1, 2013

SUBJECT: Provider Manual Update Transmittal EPISODE-1-13

<table>
<thead>
<tr>
<th>REMOVE</th>
<th>INSERT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section</td>
<td>Date</td>
</tr>
<tr>
<td>211.100</td>
<td>10-1-12</td>
</tr>
<tr>
<td>211.300</td>
<td>10-1-12</td>
</tr>
<tr>
<td>212.300</td>
<td>10-1-12</td>
</tr>
<tr>
<td>213.100</td>
<td>2-1-13</td>
</tr>
<tr>
<td>214.100</td>
<td>2-1-13</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Explanation of Updates

Section 211.100 is updated to clarify that there are no subtypes for the Perinatal episode of care.

Section 211.300 is updated to clarify the exclusions for the Perinatal Care episode of care.

Section 212.300 is updated to clarify the exclusions for the Attention Deficit Hyperactivity Disorder (ADHD) episode of care.

Section 213.100 is updated to clarify the episode services and to add continuous Medicaid enrollment information for the Congestive Heart Failure (CHF) episode of care. It is also reformatted to match the established manual style.

Section 214.100 is updated to clarify the episode services for the Total Joint Replacement episode of care. It is also reformatted to match the established manual style.


Sections 216.000, 216.100, 216.200, 216.300, 216.400, 216.500, 216.600, and 216.700 are added to provide information pertaining to the Colonoscopy episode of care.

Sections 217.000, 217.100, 217.200, 217.300, 217.400, 217.500, 217.600, and 217.700 are added to provide information pertaining to the Tonsillectomy episode of care.

Sections 218.000, 218.100, 218.200, 218.300, 218.400, 218.500, 218.600, and 218.700 are added to provide information pertaining to the Cholecystectomy episode of care.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Arkansas Payment Improvement Initiative Center at 1-866-322-4696 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 301-8311.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director
Section 215.300, B.

- New Language: “Beneficiaries with any comorbid behavioral health condition”
- Previous Language: “Beneficiaries with any behavioral health comorbid condition”
- Rationale for Change: To match exclusion language in the ADHD episode.

Section 215.400

- New Language: “An episode with fewer than 10 therapy visits over 30+ days will not be applied to reduce a PAP’s average episode cost but may count toward risk sharing. PAPs who in an entire performance period have no episodes with 10 or more visits over 30+ days will not be eligible for gain sharing.”
- Previous Language: “Only episodes with 10 or more visits over >30 days AND at least 8 of those visits taking place with the family (CPT code 90846 or 90847) will be able to reduce a PAP’s average episode cost. PAPs with no episodes with 10 or more visits over >30 days AND <8 family visits (CPT code 90846 or 90847) in a performance period will not be eligible for gain sharing.”
- Rationale for Change: Based upon feedback from the clinical advisory group and stakeholders, this language was amended to reflect that an episode with fewer than 10 therapy visits (individual or family) cannot be applied to reduce the PAP’s average episode cost, but can be included toward risk sharing. A PAP cannot qualify for gain sharing for ODD episodes if they have no episodes with 10 or more therapy visits over 30 days.

Section 215.500, B., 5.

- New Language: “Percentage of episodes with >9 therapy sessions over a period of 30+ days and of which >7 are family therapy sessions (CPT 90846 OR CPT 90847)”
- Previous Language: Not Applicable
- Rationale for Change: The Division of Medical services wants to be able to track the percentage of episodes which have more than 9 therapy sessions and of those, more than 7 are family therapy sessions.

Section 215.600, C.

- New Language: “The gain sharing limit is $984.”
- Previous Language: “The gain sharing limit is $552.”
- Rationale for Change: The goal of the ODD episode is to incentivize high quality care that is most beneficial to the beneficiary. The original gain sharing limit was calculated based on delivery of group therapy only to treat beneficiaries with ODD. The new threshold is based on a mix of family and group therapy. Delivery of family therapy is reflected in the evidence base and by our clinical work group as essential to delivery of high quality care and treatment.

Section 218.300, C.

- New Language: “Beneficiaries with a pregnancy 30 days prior to a cholecystectomy procedure to 90 days after said cholecystectomy procedure”
- Previous Language: “Beneficiaries with a pregnancy 30 days prior to 90 days after a cholecystectomy procedure”
- Rationale for Change: To clarify that a beneficiary who is pregnant (30 days prior to the cholecystectomy to 90 days after the cholecystectomy) will be excluded from the episode. The previous language “30 days prior to 90 days” created confusion.
Section 218.500, B. 1.

- New Language: “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”
- Previous Language: “Rate of major complications that occur in episode, either during procedure or in post-procedure window: common bile duct injury, abdominal blood vessel injure, bowel injury”
- Rationale for Change: Injure was inadvertently used rather than injury