SECTION I - GENERAL POLICY

CONTENTS

100.000 GENERAL INFORMATION — 10-13-03

100.100 Introduction — 10-13-03

Section I imparts general program information about the Arkansas Medicaid Program. It includes information about recipient eligibility and explains the provider's role and responsibilities in utilizing the program. The Primary Care Case Management (PCCM) Program is explained in detail. The information conveyed will provide users with an understanding of Medicaid Program policy. It also contains information the provider may need to answer questions often asked about the Medicaid Program.

Four major areas are covered in Section I.

A. General information about the program - This area contains information regarding the background, history and scope of the Medicaid Program, including information about Medicaid waivers and/or programs covered by the Division of Medical Services.

B. Recipient eligibility - This area contains information about Medicaid recipient aid categories, recipients' eligibility for benefits, an explanation of the Medicaid identification card, the recipients' responsibilities and other recipient information.

C. Provider participation - This area specifies the provider enrollment procedures, the general conditions that must be met by providers to begin and to maintain program participation and remedies and sanctions that the Division of Medical Services may employ in the administration and regulation of the Arkansas Medicaid Program.

D. Primary Care Case Management Program (PCCM) - This area defines the scope of the Primary Care Case Management program and provider and enrollee participation. It lists the categories of eligibility that are exempt from primary care physician (PCP) referral requirements and itemizes the services that do not require PCP referral. PCP enrollment and enrollment transfer procedures are explained, as are PCP referral requirements and procedures.

101.000 Provider Manuals 10-13-03

Provider manuals contain the policies and procedures of the Arkansas Medicaid Program. These policies and procedures are generally based on federal and state laws and federal regulations. Medicaid provider manual policy and procedures, and changes thereto, will be promulgated as required by the state's Administrative Procedures Act.

When fully utilized, each program manual is an effective tool for the provider. It provides information about the Medicaid Program, covered and non-covered services, billing procedures and detailed instructions for accurate completion of claims.

Provider manuals are available at the Arkansas Medicaid Web site (**http://www.medicaid.state.ar.us**), on the Arkansas Medicaid Provider Reference compact disc (CD) and on paper. As new providers are enrolled, they will be asked if they have Internet access to the provider manuals. Those who do not have Internet access will be asked to specify the medium they will use. Providers are encouraged, however, to use an electronic medium.

101.100 Provider Manual Organization 10-13-03

The manuals are organized as follows:

A. Section I – general information

B. Section II – program policy and program-specific billing information, including special billing

C. Section III – generic billing information

D. Section IV – glossary

E. Section V – forms and contact information

F. Appendix A – update log followed by transmittal letters

G. Official Notices

H. Remittance Advice messages (RAs)

Sections I, III, IV and V are the same in each manual; only Section II is program and provider specific.

The manuals are divided into numbered sections with a heading and a revision date such as "101.000 Provider Manuals 10-13-03". Text that appears underlined and in blue to Web site and CD users is "linked" to the information being referenced so that it may be viewed or printed. The paper version contains the same underlined text, though not in blue, so paper users must locate the "linked" information in Section V.

101.200 Updates 10-13-03

Provider manuals are updated when necessitated by changes in federal or state laws, changes in interpretations of the law, changes in federal regulations, changes in DMS policy and procedures and when clarifications are warranted. These changes are released to the provider in the form of a manual update, an official notice or a remittance advice (RA) message.

As changes are made, the changed sections are dated with the revision date of the change. The provider manuals on the Arkansas Medicaid Provider Reference CD, issued quarterly, display the quarterly issuance date in the footer on the left. This will enable the user to ensure that the latest version is being used. Since paper copies may be printed from the CD, the date will appear in the footer of printed copies.

Provider manual changes are made automatically on the Arkansas Medicaid Web site; providers are notified via e-mail or paper when an applicable manual update, official notice or RA is issued. Providers must supply an e-mail address to receive e-mail notification of any supplementary material.

Providers who receive paper copies of manual updates, official notices and RAs must maintain the paper supplements as they are received. Only the revised section(s) are issued in manual updates.

The Arkansas Medicaid Provider Reference CD is updated and issued quarterly; manual updates, official notices and RAs issued during the previous quarter will be incorporated into the CD.

Policy and procedure changes are highlighted in the electronic media (Web site and CD) and are shaded in the paper manuals to aid the provider in quickly reviewing changes; minor wording changes are not highlighted. The highlighting feature is provided as a convenience to providers.

An update transmittal letter accompanies each manual update. Manual updates have sequential identification numbers assigned, e.g., Update Transmittal #1. The transmittal letter identifies the new sections being added and/or the sections being replaced or deleted, explains what is being changed and provides any other information about the update. Manual updates are recorded on the update log located in Appendix A of the manual.

For persons maintaining a printed copy of a manual, the updated manual sections should be manually filed in the provider manual, and the outdated sections should be crossed out or removed, as appropriate. The effective date should be entered on the update log opposite the appropriate update number. Transmittal letters should be filed immediately following the update log in descending numerical order by update number. Immediately following the transmittal letters should be the official notices, which are numbered sequentially and should be filed with the most recent first. The RAs will follow the official notices, with the most recent filed first.

The fiscal agent, EDS, will issue changes as directed by the Division of Medical Services (DMS).

101.300 Obtaining Provider Manuals 10-13-03

All provider manuals, manual updates, official notices and RAs are available for downloading, without charge, from the Arkansas Medicaid Web site (**http://www.medicaid.state.ar.us/**).

Prior to enrollment, providers will be asked if they have Internet access. Those who do not have Internet access will choose if they want to receive their manual by CD or on paper.

At that time, providers choosing to use the CD will receive a copy of the Arkansas Medicaid Provider Reference CD and will receive the quarterly issues of the CD without charge. The providers using the CD will be asked if they want to receive manual updates, official notices and RAs pertaining to their program through e-mail notification or mailed paper copies. E-mail notifications contain a link to the Arkansas Medicaid Web site; therefore, Internet access is required for e-mail notifications.

Providers choosing a paper copy of their provider manual will be issued a paper copy without charge. These providers will receive paper copies of all manual updates, official notices and RAs that pertain to their program through the mail.

Persons, entities and organizations that are not enrolled providers may purchase a copy of the Arkansas Medicaid Provider Reference CD or a paper copy of a provider manual through EDS.

Enrolled providers may purchase extra copies of the Arkansas Medicaid Provider Reference CD or extra paper copies of a manual through EDS. See information below regarding purchasing copies.

A. Arkansas Medicaid Provider Reference CD

The cost for a copy of the most recent Arkansas Medicaid Provider Reference CD is $10.00.

B. Paper Manuals

The cost for a printed copy of an Arkansas Medicaid provider manual is $125.00.

Orders for CDs and printed manuals should be sent to EDS, Technical Publications. A check for the appropriate amount should be included with the order and be written to "EDS". **View or print the EDS manual order contact information.**

102.000 Legal Basis of the Medicaid Program 10-13-03

Titles XIX and XXI of the Social Security Act created a joint federal-state medical assistance program commonly referred to as Medicaid. Chapter 77 of the Arkansas Code and Arkansas Code 20-76-201 authorize the Department of Human Services to establish a Medicaid Program.

Title XIX of the Social Security Act provides for federal grants to states for medical assistance programs. The stated purpose of Title XIX is to enable the states to furnish the following:

A. Medical assistance to families with dependent children, the aged, the blind, the permanently and totally disabled, the medically needy and children under 18 whose income and resources are insufficient to meet the costs of necessary medical services.

B. Rehabilitation and other services to help these families and individuals attain or retain the capability for independence or self-care.

The Medicaid Program is a joint federal-state program that provides necessary medical services to eligible persons who would not be able to pay for such services.

In Arkansas, the Division of Medical Services administers the program. Within the Division, the Office of Long Term Care is responsible for nursing home policy and procedures.

103.000 Scope of Program 10-13-03

The Arkansas Medicaid Program provides, with limitations, the services listed in Sections 103.100 and 103.200.

103.100 Federally Mandated Services 10-13-03

Program	Coverage
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Child Health Services)	Under Age 21
Family Planning	All Ages
Federally Qualified Health Center (FQHC)	All Ages
Home Health	All Ages
Inpatient Hospital	All Ages
Laboratory and X-Ray	All Ages
Certified Nurse-Midwife	All Ages

Nurse Practitioner	All Ages
Nursing Facility	Age 21 or Older
Outpatient Hospital	All Ages
Physician	All Ages
Rural Health Clinic	All Ages

103.200 Optional Services 10-13-03

Program	Coverage
Ambulatory Surgical Center	All Ages
Audiological	Under Age 21
Certified Registered Nurse Anesthetist (CRNA)	All Ages
Child Health Management Services (CHMS)	Under Age 21
Chiropractic Services	All Ages
Dental Services	Under Age 21
Developmental Day Treatment Clinic Services (DDTCS)	Pre-School and Ages 18 and Over
Developmental Rehabilitation Services	Under Age 3
Domiciliary Care	All Ages
Durable Medical Equipment	All Ages
End-Stage Renal Disease (ESRD) Facility Services	All Ages
Hearing Aid Services	Under Age 21
Hospice	All Ages
Hyperalimentation	All Ages
Inpatient Psychiatric Services	Under Age 21
Intermediate Care Facility Services for Mentally Retarded	All Ages
Medical Supplies	All Ages
Nursing Facility	Under Age 21
Occupational, Physical and Speech Therapy	Under Age 21
Outpatient Mental Health Services	All Ages
Orthotic Appliances	All Ages
Personal Care	All Ages
Podiatrist	All Ages
Portable X-Ray	All Ages
Prescription Drugs	All Ages
Private Duty Nursing Services (High Technology, Non-Ventilator Dependant, EPSDT Program)	Under Age 21

Private Duty Nursing Services (Ventilator-Dependent)	All Ages
Prosthetic Devices	All Ages

Rehabilitative Hospital and Extended Rehabilitative Hospital Services	All Ages
Rehabilitative Services for Persons with Mental Illness (RSPMI)	All Ages
Rehabilitative Services for Persons with Physical Disabilities (RSPD)	Under Age 21
Respiratory Care	Under Age 21
Respite Care	Under Age 19
Targeted Case Management for Recipients of Children's Medical Services (CMS)	Under Age 21
Targeted Case Management for Pregnant Women	Women Ages 14 to 44
Targeted Case Management for Recipients Age 22 and Older with a Developmental Disability	Age 22 or Older
Targeted Case Management for Recipients Age 60 and Older	Age 60 or Older
Targeted Case Management for Recipients in the Division of Children and Family Services	Under Age 21
Targeted Case Management for Recipients in the Division of Youth Services	Under Age 21
Targeted Case Management for Recipients in the Child Health Services (EPSDT) Program	Under Age 21
Targeted Case Management for Recipients under Age 21 with a Developmental Disability	Under Age 21
Targeted Case Management for SSI Recipients and TEFRA Waiver Recipients	Under Age 17
Transportation Services (Ambulance, Non-Emergency)	All Ages
Ventilator Equipment	All Ages
Visual Care	All Ages

104.000 Services Available through the Child Health Services (EPSDT) Program 10-13-03

Medicaid covers certain services only through the Child Health Services (EPSDT) Program for individuals under age 21. See the Child Health Services (EPSDT) manual and the appropriate provider program manual for more information.

105.000 Services Available through Demonstration Projects and Waivers 10-13-03

The services detailed in Sections 105.100 through 105.190 are available for eligible recipients through waivers of federal regulations.

105.100 Alternatives for Adults with Physical Disabilities 10-13-03

The Alternatives for Adults with Physical Disabilities (APD) waiver has been designed for disabled individuals age 21 through 64 who receive Supplemental Security Income (SSI) or are

Medicaid eligible by virtue of their disability and who, without the provision of the services, would require a nursing facility level of care.

APD eligibility requires a determination of categorical eligibility, a level of care determination, the development of a plan of care, a cost comparison to determine the cost-effectiveness of the plan of care and notification of a choice between home and community-based services and institutional services.

The services offered through the waiver are:

A. Environmental Accessibility/Adaptations/Adaptive Equipment

B. Attendant Care

These services are available only to individuals who are eligible under the waiver's conditions. More detailed information is found in the APD provider manual.

105.110 ARKids First-B 10-13-03

ARKids First-B was designed to integrate uninsured children age 18 and under into the health care system. ARKids First-B benefits are comparable to those of the state employees/teachers insurance program. Most services require cost sharing.

The following is a summary of the eligibility criteria for ARKids First-B:

A. Family income must be at or below 200% of the Federal Poverty Level (FPL).

B. Applicants must be age 18 and under.

C. Applicants must have had no health insurance that covers comprehensive medical services, other than Medicaid, within the preceding six months (unless insurance coverage was lost through no fault of the applicant).

D. Applicants whose health insurance is inaccessible are considered to be uninsured. An example of "inaccessible" is when an out of state, non-custodial parent, has HMO insurance for his or her children but the HMO network does not contain medical providers where the children reside, etc.

E. Children who do not have primary comprehensive health insurance or have non-group or non-employer sponsored insurance are considered to be uninsured. Primary comprehensive health insurance is defined as insurance that covers both physician and hospital charges.

For more information, refer to the ARKids First-B provider manual and to the Arkansas Medicaid Web site at **www.medicaid.state.ar.us**.

105.120 ConnectCare: Primary Care Case Management (PCCM) 10-13-03

In ConnectCare, a Medicaid beneficiary selects and enrolls with a primary care physician (PCP) that has contracted with Medicaid to be responsible for managing the health care of a limited number (a number chosen by the PCP, between 10 and 1000) of Medicaid beneficiaries.

PCPs contract with Medicaid to provide primary care, health education and case management for a self-limited number of Medicaid enrollees, in consideration of a monthly per-enrollee case management fee that Medicaid pays him or her in addition to the PCP's regular Medicaid fee-for-service reimbursement.

The PCP is responsible for referring enrollees to specialists and other providers, which includes the responsibility for deciding whether a particular referral is medically necessary. A PCP may make such decisions in consultation with physicians or other professionals as needed and in

accordance with his or her medical training and experience; however, PCPs are not required to make any referral simply because it is requested.

A PCP coordinates his or her enrollees' medical and rehabilitative services with the providers of those services. Medical and rehabilitative professionals to whom a PCP refers a patient are required to report to or consult with the PCP, even when the PCP does not so request or protocol does not require a report in order to assist the PCP in coordinating care and in monitoring enrollee's status, progress and outcomes.

Most Medicaid-eligible individuals, as well as children participating in ARKids First-B, must enroll with PCPs in order to receive Medicaid-covered or ARKids First-B services. Some individuals are not required to enroll with a PCP. A few services are covered for all Medicaid and ARKids First-B eligibles without PCP referral. See Sections 170.000 through 183.000 for details regarding ConnectCare.

105.130 DDS Alternative Community Services (ACS) 10-13-03

The Developmental Disability Services Alternative Community Services (DDS ACS) Waiver is designed for individuals who, without the services, would require institutionalization and could not otherwise reside in the community. Participants must not be residents of a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF/MR).

DDS ACS eligibility requires a determination of categorical eligibility, a level of care determination, the development of a plan of care, a cost comparison to determine the cost-effectiveness of the plan of care and notification of a choice between home and community-based services and institutional services.

Services supplied through this program are:

A. Case management

B. Respite care

C. Supportive living

D. Community experiences

E. Consultation services

F. Waiver coordination

G. Non-Medical Transportation

H. Supported employment services

I. Adaptive equipment

J. Environment modifications

K. Supplemental support services

L. Crisis intervention services

M. Crisis center

More detailed information may be found in the DDS ACS Waiver provider manual.

105.140 ElderChoices 10-13-03

ElderChoices is designed for individuals age 65 and over, who, without the services, would require an intermediate level of care in a nursing home. The services listed below are designed

to maintain Medicaid-eligible individuals at home in order to preclude or postpone institutionalization.

A. Adult foster care

B. Homemaker services

C. Chore services

D. Home delivered meals

E. Personal emergency response system

F. Adult day care

G. Adult day health care

H. Respite care

ElderChoices eligibility requires a determination of categorical eligibility, a level of care determination, the development of a plan of care, a cost comparison to determine the cost-effectiveness of the plan of care and notification of a choice between home and community-based waiver services and institutional services.

More detailed information may be found in the ElderChoices provider manual.

105.150 Independent Choices 10-13-03

The Division of Aging and Adult Services (DAAS) and the Division of Medical Services (DMS) jointly administer Independent Choices, a Section 1115 demonstration project. Participants in this project choose to forego traditional personal care services furnished by a Medicaid-enrolled agency in exchange for the right to direct their own care (consumer-direction). Individuals that choose Independent Choices accept the risks, rights and responsibilities that consumer direction involves.

A participant may hire one or more assistants, employing whomever he or she wishes except his or her spouse or a person to whom a court of law has granted legal responsibility for the participant ("a guardian of the person"). Medicaid provides each participant with a cash allowance that the participant uses to meet his or her personal care needs. Participants pay their assistants from their cash allowance. Additionally, the participants may use cash allowance funds for certain other purchases when those purchases are included in their individualized cash expenditure plan.

Independent Choices includes individualized counseling and fiscal agent services provided by counseling fiscal agencies (CFA) that contract with Medicaid for those purposes. Each participant has a designated CFA. A CFA is responsible for educating each of its assigned Independent Choices participants in consumer direction. CFAs are also required to help participants develop and maintain an individualized cash expenditure plan and to provide participants with bookkeeping services related to cash allowance receipts and disbursements.

More detailed information may be found in the Independent Choices Manual.

105.160 Living Choices Assisted Living 10-13-03

Living Choices Assisted Living is a home and community-based services waiver that is administered jointly by the Division of Aging and Adult Services (DAAS) and the Division of Medical Services (DMS). Qualifying individuals are persons aged 21 and older who are blind, elderly or disabled and who have been determined by Medicaid to be eligible for an intermediate level of care in a nursing facility.

Participants in Living Choices must reside in Level II assisted living facilities (ALFs), in apartment-style living units. The assisted living environment encourages and protects individuality, privacy, dignity and independence. Each Living Choices participant receives personal, health and social services in accordance with an individualized plan of care developed and maintained in cooperation with a DAAS-employed registered nurse. A participant's individualized plan of care is designed to promote and nurture his or her optimal health and well being.

Living Choices providers furnish "bundled services" in the amount, frequency and duration required by the Living Choices plans of care. They facilitate participants' access to medically necessary services that are not components of Living Choices bundled services, but which are ordered by participants' plans of care. Living Choices providers receive per diem Medicaid reimbursement for each day a participant is in residence and receives services. The per diem amount is based on a participant's "tier of need", which DAAS-employed RNs determine and periodically re-determine by means of comprehensive assessments performed in accordance with established medical criteria. There are four tiers of need.

Living Choices participants are eligible to receive up to nine Medicaid-covered prescriptions per month. More detailed information may be found in the Living Choices Assisted Living provider manual.

105.170 Non-Emergency Transportation Services (NET) 10-13-03

Medicaid non-emergency transportation (NET) services for Medicaid recipients are furnished, under the authority of a capitated selective contract waiver, by twelve regional brokers. Medicaid recipients contact their local transportation broker for non-emergency transportation to appointments with Medicaid providers.

Providers transporting Medicaid beneficiaries to Developmental Day Treatment Clinic Service (DDTCS) providers for DDTCS services have been allowed to remain enrolled as fee for service providers for that purpose only, if they so choose. All other Medicaid non-emergency transportation for DDTCS clients must be obtained through the regional broker.

The Arkansas Medicaid non-emergency transportation waiver program does not include transportation services for:

A. Nursing facility residents

B. Residents of intermediate care facilities for the mentally retarded (ICF-MR)

C. Qualified Medicare Beneficiaries (QMB)

D. Special Low Income Qualified Medicare Beneficiaries (SMB)

E. Qualifying Individual-1 (QI-1 eligibles)

F. ARKids First-B participants

G. Women's Health (Family Planning) FP-W category eligibles

H. Tuberculosis (TB) category eligibles

More detailed information may be found in the Transportation provider manual and on the Arkansas Medicaid Web site at **www.medicaid.state.ar.us**.

105.180 Respite Care 10-13-03

Respite Care for Children with Physical Disabilities and Respite Care for Children with Mental Retardation or Developmental Disabilities cover respite care for children from birth to 19 years of age.

The purpose of respite care is to decrease the likelihood of an individual's institutionalization by directly assisting the individual. Services provide temporary physical and emotional relief to families who are caring for children with disabilities.

To qualify for respite care, children must be Medicaid eligible as Supplemental Security Income (SSI) beneficiaries or through the Tax Equity and Fiscal Responsibility Act (TEFRA) demonstration project.

Eligibility criteria include a determination of categorical eligibility and a nursing facility or institutional level of care, the development of a plan of care and notification of a choice between home and community-based services or institutional services.

More detailed information may be found in the CMS Respite Care provider manual.

105.190 Women's Health (Family Planning) 10-13-03

The Arkansas Department of Human Services, in collaboration with the Arkansas Department of Health, established the Family Planning Demonstration Waiver Program, renamed the Women's Health Demonstration Waiver Program. Eligibility for the program is limited to women of childbearing age who are not currently certified in any other Medicaid category. The target population contains women age 14 to age 44, but all women at risk of unintended pregnancy are allowed to apply for the program. The family income must be at or below 200% of the Federal Poverty Level.

Participants are not required to have a photo Medicaid identification card. Their Medicaid coverage entitles them to receive only Medicaid covered family planning services. Recipients may use the participating and willing provider of their choice.

106.000 Utilization Review (UR) 10-13-03

The Utilization Review (UR) Section of the Arkansas Medicaid Program has the responsibility for assuring quality medical care for Medicaid eligibles along with protecting the integrity of both state and federal funds supporting the Medical Assistance Program.

The tasks of the Utilization Review Section are mandated by federal regulations. To realize completion of the tasks assigned, a system has been developed which retrospectively evaluates medical practice patterns by comparing each provider's pattern to norms and limits set by all providers of the same specialty. This system utilizes the information that appears on the Medicaid claim.

Utilization Review reports are then printed for all providers who exceed the norms or limits established by their peers. The staff evaluating these computerized reports are experienced medical review analysts who work under the direction of the Medicaid Program's Medical Director, and who have access to the expertise of a peer review committee plus a full complement of specialty consultants on an as-needed basis.

Review analysts may, from time to time, contact a provider to supply the provider with information from these reports as well as to request additional information regarding their medical practice. The provider's cooperation in responding to these contacts will allow for greater accuracy in evaluation.

The Utilization Review Section is also responsible for conducting on-site medical audits for the purpose of verifying the nature and extent of services paid for by the Medicaid Program. Providers to be reviewed on-site are selected based on Surveillance and Utilization Review Subsystem (SURS) exceptions (the peer weighted computerized program), random sample selection and community referrals. Providers selected for an on-site audit will not be notified in advance.

All Medicaid providers are required to keep and maintain records that fully disclose the type and extent of services provided to an Arkansas Medicaid recipient. Providers are reminded that

pertinent records concerning the provision of Medicaid covered health care services are to be made available during regular business hours to all Division of Medical Services staff acting within the scope and course of their employment.

Pertinent records are also to be made available to the Division's contractual review organization, which is Arkansas Foundation for Medical Care, Inc./Quality Improvement Organization (AFMC/QIO).

The nature of the reviews will be to primarily review documentation for services provided, but will, at certain times, be used to evaluate the medical necessity of the delivered services in the view of the professional staff and consultants of the Medicaid Program.

When records are stored off-premise or are in active use, the audited provider may certify, in writing, that the records in question are in active use or off-premise storage and set a date and hour within three (3) working days, at which time the records will be available. However, the audited provider will not be allowed to delay the audit for matters of convenience, including availability of personnel.

This section is responsible for researching all inquiries from recipients in response to the Explanation of Medicaid Benefits (EOMB) and for approving requests for procedures requiring prior authorization.

106.100 Utilization Review Recoupment Process 10-13-03

The Utilization Review Section is responsible for recovering Medicaid funds from providers when necessary. Situations resulting in recoupment include, but are not limited to, the following:

A. When duplicate payments are made.

B. When the Quality Improvement Organization (QIO) denies all or part of a hospital admission.

C. When medical consultants to the Medicaid Program determine lack of medical necessity.

D. When Medicaid, Medicare or the Attorney General's Medicaid Fraud Unit discovers evidence of overpayment.

E. When documentation of a billed service is inadequate or non-existent.

When a recoupment decision is made, Utilization Review forwards an Explanation of Recoupment notice to the provider. This explanation includes the name(s) of the patient(s), date(s) of service, date(s) of payment and the reason for the repayment request.

Upon receipt of this notice, the provider has thirty days to forward a check for the refund amount or appeal the recoupment action. Failure to respond to the recoupment notice will result in the recoupment amount being deducted from future Medicaid reimbursement.

106.200 Recoupment Appeal Process 10-13-03

Upon receipt of an Explanation of Recoupment, the provider has thirty (30) days in which to supply written notice of appeal. The appeal process is fully explained in the letter that accompanies the Explanation of Recoupment. In brief, the process is as follows:

A. QIO Denials

1. In situations where the QIO agent, Arkansas Foundation for Medical Care, Inc. (AFMC), denies all or part of a hospital admission, the Utilization Review Section recoups any Medicaid funds expended in connection with the denied services. In these situations, all appeals must be directed to AFMC, in writing, within thirty days of receiving the denial from AFMC.

B. Utilization Review Denials

1. Denials issued by Utilization Review result from two instances:
   a. The provider's failure to comply with administrative policy
   b. Lack of documented medical necessity or adequate justification
2. There are two types of Utilization Review denials.
   a. Administrative policy denials: Denials resulting from failure to comply with administrative policy are not subject to appeal by the provider
   b. Lack of medical necessity or adequate justification denials: Denials resulting from a lack of medical necessity or adequate justification are determined by the appropriate Medicaid Program consultants.
3. Documentation
   a. The provider is entitled to submit any documentation to the Utilization Review Section refuting the stated reason for recoupment.
4. Utilization Review Appeal Process
   a. The appeal and related documentation will be reviewed by the medical director and/or the appropriate Medicaid Program consultant(s).
   b. In the event the original decision is upheld, the provider will be notified in writing.
   c. If a further appeal is desired, the Utilization Review Section must receive the written request within thirty days of the date of the provider's notification of the review decision.
   d. If desired, the provider may request an appeal of the action before the appropriate peer review committee's next scheduled meeting. These committees are composed of the executive officers of the appropriate professional organization, e.g., the Arkansas Medical Society, the Arkansas Dental Association, the Arkansas Optometric Association, etc.
   e. The committee will review all submitted documentation and make a recommendation to the Medicaid Program regarding the service in question.
   f. The Medicaid Program will advise the provider of its decision once the recommendation has been received and considered.

110.000 SOURCES OF INFORMATION 10-13-03

110.100 Provider Enrollment Unit 10-13-03

Any questions regarding provider enrollment, participation requirements and/or contracts should be directed to the Provider Enrollment unit. **View or print the Provider Enrollment contact information.**

110.200 Provider Relations and Claims Processing Contractor 10-13-03

EDS, a contractor, performs provider relations and the processing of Medicaid claims. EDS Provider Representatives are available to assist providers with detailed billing or policy questions and to schedule on-site technical assistance. To contact a representative, providers may call the Provider Assistance Center. **View or print the EDS Provider Assistance Center contact information.**

110.300 Utilization Review Section 10-13-03

The Utilization Review Section of the Division of Medical Services is available to assist providers with questions regarding extension of benefits and prior authorization of services for individuals

age 21 and over, and for specified services for individuals under age 21, with the exception of prescription drug prior authorizations. **View or print the Utilization Review contact information.** The Personal Care, Inpatient Psychiatric and Home Health Units are located within the Utilization Review Section.

110.400 Arkansas Foundation for Medical Care, Inc. (AFMC) 10-13-03

Arkansas Foundation for Medical Care, Inc., (AFMC) performs medical and/or surgical prior authorizations. **View or print the AFMC contact information.**

110.500 Customer Assistance 10-13-03

Customer Assistance, a section of the Division of County Operations, handles recipient inquiries regarding Medicaid eligibility and their Medicaid identification card. **View or print the Division of County Operations Customer Assistance Section contact information.**

110.600 Americans with Disabilities Act 10-13-03

Any materials needed in an alternate format, such as large print, can be obtained by contacting the Americans with Disabilities Act Coordinator. **View or print the Americans with Disabilities Act Coordinator contact information.**

110.700 Program Communications Unit 10-13-03

This unit responds to Medicaid recipient inquiries regarding Medicaid coverage and benefits, assists out-of-state providers with claim filing procedures, verifies recipient eligibility and maintains recipient correspondence files. **View or print the Program Communications Unit contact information.**

110.800 Dental Care Unit 10-13-03

The dental coordinator assists providers with questions regarding dental services. **View or print the Dental Coordinator contact information.**

110.900 Visual Care Unit 10-13-03

The visual care coordinator assists providers with questions regarding visual care services. **View or print the Visual Care Coordinator contact information.**

111.000 DMS and Fiscal Agent (EDS) Office Hours 10-13-03

EDS, the fiscal agent, has a Provider Assistance Center that is available for billing questions. **View or print the EDS Provider Assistance Center contact information.**

The state's Program Communications Unit is available to answer providers' questions and direct their telephone calls. **View or print the Program Communications Unit contact information.**

120.000 RECIPIENT ELIGIBILITY 10-13-03

121.000 Introduction 10-13-03

Recipient eligibility is based on many factors that vary depending on the recipient's aid category. Eligibility factors often include income, resources, age or disability, current residency in Arkansas and other factors.

122.000 Agencies Responsible for Determining Eligibility 10-13-03

The Department of Human Services (DHS) local county offices or district Social Security offices determine recipient eligibility certification. The category of aid each office is responsible for is described below. The Department of Health determines presumptive eligibility for certain Medicaid categories.

122.100 Department of Human Services County Offices 10-13-03

Family Support Specialists in the DHS county offices are responsible for evaluating the circumstances of an individual or family to determine eligibility, and if eligible, the proper aid category through which Medicaid should be received.

After evaluation, the DHS county office establishes Medicaid eligibility dates in accordance with state and federal policy and regulations. See Sections 123.000 and 124.000 of this manual for further explanation.

122.200 District Social Security Offices 10-13-03

Social Security representatives are responsible for evaluating an individual's circumstances to determine eligibility for the Supplementary Security Income (SSI) program administered by the Social Security Administration. SSI includes aged, blind and disabled categories. The SSI aid categories are listed in Section 124.000.

To be eligible for SSI, an aged, blind or disabled person must also meet income, resource and other eligibility criteria.

Individuals entitled to SSI automatically receive Medicaid.

122.300 Department of Health 10-13-03

The Arkansas Department of Health (ADH) determines presumptive eligibility for category 62, titled Pregnant Women-Presumptive Eligibility. ADH is the designated application point for Breast and Cervical Cancer Prevention and Treatment and for Tuberculosis aid categories; however, the Division of County Operations, located within the Department of Human Services, makes the final eligibility determination.

123.000 Medicaid Eligibility 10-13-03

Under its contract with the Division of Medical Services, EDS has deployed Provider Electronic Solutions Application (PES) technology. With PES, Medicaid providers are able to verify a patient's Medicaid eligibility for a specific date or range of dates, including retroactive eligibility for the past year. Providers may obtain other useful information, such as the status of benefits used during the current fiscal year, other insurance or Medicare coverage, etc. See Section III of this manual for further information on PES and other electronic solutions.

EDS and the Division of Medical Services (DMS) will verify Medicaid eligibility by telephone only for "Limited Services Providers" (see Section II) in non-bordering states and in the case of retroactive eligibility for dates of service that are more than a year prior to the eligibility authorization date.

123.100 Date Specific Medicaid Eligibility 10-13-03

Recipient eligibility in the Arkansas Medicaid Program is date specific. Medicaid eligibility may begin or end on any day of a month. A PES electronic response displays the current eligibility period through the date of the inquiry.

123.200 Retroactive Medicaid Eligibility 10-13-03

Medicaid recipients may be eligible for Medicaid benefits for the three-month period prior to the date of application provided eligibility requirements for that three-month period are met. The DHS county office establishes retroactive eligibility.

123.300 Recipient Notification of a Denied Medicaid Claim 10-13-03

By federal mandate, the Division of Medical Services must notify Medicaid recipients when a claim for Medicaid payment is denied. A letter is forwarded to recipients each time a medical claim for payment is denied by the Medicaid Program. The notice includes the recipient's name, provider's name, date of service, description of the service and the reason for denial. The notice indicates whether there is recipient responsibility for payment of the denied service.

If the letter indicates the recipient is not responsible for the unpaid amount, the provider may not request payment from the recipient. If the letter indicates the recipient is responsible for the unpaid amount, the provider may contact the recipient for payment. For program information regarding the recipient's responsibilities, refer to Section 132.000 of this manual. **View or print an example of the recipient notification of denied Medicaid claim.**

When a recipient disagrees with the Medicaid claim denial, he or she may file for a fair hearing with the Department of Human Services.

123.400 Recipient Lock-In 10-13-03

The purposes of the recipient lock-in rule are to better enable physicians and pharmacists to provide quality care and to assure that the Medicaid Program does not unintentionally facilitate recipient drug abuse or injury from overmedication or drug interaction. An eligible individual, when correctly identified by a computerized algorithm and clinical review to have utilized Medicaid pharmacy services at a frequency or amount not medically necessary, will be required to select one provider of pharmacy services and will be informed that Medicaid will deny claims for pharmacy services submitted by any provider other than the single provider selected.

At least 30 days before implementing a recipient lock-in, the Division of Medical Services (DMS) or its agents will mail a notice to the recipient at the address listed on the recipient's eligibility records stating the reasons for the intended action. This notice will inform the recipient of his or her right to request a reconsideration and provide the reconsideration process. If, after reconsideration by DMS or its agent, the recipient is not satisfied with the decision to be locked-in to one pharmacy provider, the recipient will be notified by the state of the process to appeal in accordance with the Department of Human Services appeal procedures.

Within 10 days of receiving the notice of the decision to be locked-in, the recipient must select one pharmacy provider.

In cases of provider restriction, the provider selected will be notified prior to the actual "lock-in," so that adequate time is allowed for selection of another provider should the first provider find he cannot provide the needed services. If a recipient fails or refuses to choose one provider, a list of providers used by the recipient will be reviewed and a provider will be chosen.

When a recipient has been restricted, eligibility verification transactions will reflect "lock-in to other provider." The restriction will be removed after demonstration by the recipient that the abusive situation has been corrected.

Application of this rule will not result in the denial, suspension, termination, reduction or delay of medical assistance to any recipient.

Any provider who believes that a particular recipient should be considered for recipient lock-in should notify the Division of Medical Services, Pharmacy Unit/Utilization Review Section. **View or print the Division of Medical Services, Pharmacy Unit/Utilization Review Section contact information.**

124.000 Recipient Aid Categories 10-13-03

The following is the full list of recipient aid categories. Some categories may provide a full range of benefits, may offer limited benefits or may be a category that requires cost sharing by a recipient. The following codes describe each level of coverage.

FR full range

LB limited benefits

AC additional cost sharing

MNLB medically needy limited benefits

Category	Description	Code
01 ARKIDS B	ARKids First Demonstration	LB, AC
07 BCC	Breast and Cervical Cancer Prevention and Treatment	FR
08 TB-Limited	Tuberculosis – Limited Benefits	LB
1N WD NewCo*	Working Disabled – New Cost Sharing (N)	FR, AC
1R WD RegCo*	Working Disabled – Regular Medicaid Cost Sharing (R)	FR, AC
11 AABD	AABD	FR
13 SSI	SSI	FR
14 SSI	SSI	FR
16 AA-EC	AA-EC	MNLB
17 AA-SD	Aid to the Aged Medically Needy Spend Down	MNLB
18 QMB-AA	Aid to the Aged-Qualified Medicare Beneficiary (QMB)	LB
8S AR Seniors*	ARSeniors	FR
20 AFDC-GRANT	Transitional Employment Assistance (TEA, formerly AFDC) Medicaid	FR
25 TM	Transitional Medicaid	FR
26 AFDC-EC	AFDC Medically Needy Exceptional Category	MNLB
27 AFDC-SD	AFDC Medically Needy Spend Down	MNLB
31 AAAB	Aid to the Blind	FR
33 SSI	SSI Blind Individual	FR
34 SSI	SSI Blind Spouse	FR
35 SSI	SSI Blind Child	FR
36 AB-EC	Aid to the Blind-Medically Needy Exceptional Category	MNLB
37 AB-SD	Aid to the Blind-Medically Needy Spend Down	MNLB
38 QMB-AB	Aid to the Blind-Qualified Medicare Beneficiary (QMB)	LB
41 AABD	Aid to the Disabled	FR
43 SSI	SSI Disabled Individual	FR
44 SSI	SSI Disabled Spouse	FR
45 SSI	SSI Disabled Child	FR

46 AD-EC	Aid to the Disabled-Medically Needy Exceptional Category	MNLB
47 AD-SD	Aid to the Disabled-Medically Needy Spend Down	MNLB
48 QMB- AD	Aid to the Disabled-Qualified Medicare Beneficiary (QMB)	LB
49 TEFRA	TEFRA Waiver for Disabled Child	AC
51 U-18	Under Age 18 No Grant	FR
52 ARKIDS A	Newborn	FR
56 U-18 EC	Under Age 18 Medically Needy Exceptional Category	MNLB
57 U-18 SD	Under Age 18 Medically Needy Spend Down	MNLB
58 QI-1	Qualifying Individual-1 (Medicaid pays only the Medicare premium.	LB
61 PW-PL	Pregnant Women, Infants & Children Poverty Level (SOBRA). A 100 series suffix (the last 3 digits of the ID number) is a pregnant woman; a 200 series suffix is an ARKids-First-A child.	LB (for the pregnant woman only) FR (for SOBRA children)
62 PW-PE	Pregnant Women Presumptive Eligibility	LB
63 ARKIDS A	SOBRA Newborn	FR
65 PW-NG	Pregnant Women No Grant	FR
66 PW-EC	Pregnant Women Medically Needy Exceptional Category	MNLB
67 PW-SD	Pregnant Women Medically Needy Spend Down	MNLB
69 FAM PLAN	Family Planning Waiver	LB
76 UP-EC	Unemployed Parent Medically Needy Exceptional Category	MNLB
77 UP-SD	Unemployed Parent Medically Needy Spend Down	MNLB
80 RRP-GR	Refugee Resettlement Grant	FR
81 RRP-NG	Refugee Resettlement No Grant	FR
86 RRP-EC	Refugee Resettlement Medically Needy Exceptional Category	MNLB
87 RRP-SD	Refugee Resettlement Medically Needy Spend Down	MNLB
88 SLI-QMB	Specified Low Income Qualified Medicare Beneficiary (SMB) (Medicaid pays only the Medicare premium.)	LB
8S AR Seniors*	ARSeniors	FR
91 FC	Foster Care	FR
92 IVE-FC	IV-E Foster Care	FR
96 FC-EC	Foster Care Medically Needy Exceptional Category	MNLB
97 FC-SD	Foster Care Medically Needy Spend Down	MNLB

***** In the system design, only 2 spaces have been allotted to the numerical designation for categories. Therefore, the Working Disabled category, which is category 10, is shown on the

system as 1, plus the alpha character that designates the individual's level of cost sharing, i.e., 1N or 1R. See list for explanation. Similarly QMB-AA is category 18, however those who are ARSeniors are coded with an alpha character (S). ARSeniors are actually shown on the system as 8S (rather than 18S).

124.100 Recipient Aid Categories with Limited Benefits 10-13-03

Most Medicaid categories provide the full range of Medicaid services as specified in the Arkansas Medicaid State Plan. However, certain categories offer a limited benefit package. These categories are discussed below.

124.110 ARKids First-B 10-13-03

Act 407 of 1997 established the ARKids First Program. The ARKids First-B Program integrates uninsured children into the health care system. ARKids First-B benefits are comparable to the Arkansas state employees/teachers insurance program.

Covered services provided to ARKids First-B participants are within the same scope of services provided to Arkansas Medicaid recipients, but may be subject to different benefit limits.

Refer to the ARKids First-B provider manual for the scope of each service covered under the ARKids First-B Program.

124.120 Medically Needy 10-13-03

The medically needy category was established to provide medical care for those individuals who are medically eligible for benefits, but whose income and/or resources exceed the limits for other types of assistance but are insufficient to provide for all or part of their medical care. A full range of benefits is available for those individuals with the exception of long term care (which includes ICF/MR) and personal care services.

For more information regarding the medically needy program, providers may access the Medicaid Web site at **www.medicaid.state.ar.us**.

124.130 Pregnant Women Infants & Children Poverty Level (SOBRA) 10-13-03

The infants and children in the SOBRA (Sixth Omnibus Budget Reconciliation Act of 1986) aid category receive the full range of Medicaid benefits; however, the pregnant women receive only services related to the pregnancy and services that if not provided could complicate the pregnancy.

124.140 Pregnant Women Presumptive Eligibility 10-13-03

Covered services are those that are related to the pregnancy and services that, if not provided, could complicate the pregnancy. Services are further limited to ambulatory prenatal care (hospitalization is not covered).

124.150 Qualified Medicare Beneficiaries (QMB) 10-13-03

The Qualified Medicare Beneficiary (QMB) aid category was created by the Medicare Catastrophic Coverage Act and uses Medicaid funds to assist low-income Medicare beneficiaries. If a person is eligible for QMB, Medicaid will pay the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance, less any Medicaid cost sharing, for other medical services. Medicaid will also pay the Medicare Part A premium, the Medicare Part A hospital deductible and the Medicare Part A coinsurance, less any Medicaid cost sharing. Certain QMBs are also eligible for Medicaid services.

To be eligible for QMB, individuals must be age 65 or older, blind or disabled and enrolled in Medicare Part A or conditionally eligible for Medicare Part A. Their countable income may equal but cannot exceed 100% of the Federal Poverty Level (FPL).

Countable resources may equal but cannot exceed twice the current Supplemental Security Income (SSI) resource limitations.

Generally, individuals may not be certified in a QMB category and in another Medicaid category for simultaneous periods. However, QMBs may simultaneously receive assistance in the medically needy spend down categories of SOBRA pregnant women (61 and 62), Family Planning (69) and TB (08).

QMBs do not receive the full range of Medicaid benefits. For example, QMBs do not receive prescription drug benefits.

For a QMB eligible, Medicaid pays only his or her Medicare cost sharing (less the individual's Medicaid cost-sharing) for **Medicare** covered services.

Individuals eligible for QMB receive a plastic Medicaid ID card. Providers must view the electronic eligibility display to verify the QMB category of service. The category of service for a QMB will reflect QMB-AA, QMB-AB or QMB-AD. The system will display the current eligibility.

Not all providers are mandated to accept Medicare assignment on QMB eligibles (See Section 142.100). However, if a non-physician desires Medicaid reimbursement for coinsurance or deductible on a Medicare claim, he or she must accept assignment on that claim and enter the information required by Medicare on assigned claims.

When treated by a provider who must accept Medicare assignment according to Section 142.000, Conditions of Participation, the recipient is not responsible for the difference between the billed charges and the Medicare allowed amount.

Interested individuals may apply for the QMB program at their local Department of Human Services (DHS) county office.

124.160 Qualifying Individuals-1 (QI-1) 10-13-03

The Balanced Budget Act of 1997, Section 4732, (Public law 105-33) created the Qualifying Individuals-1 (QI-1) aid category. Individuals eligible as QI-1 are not eligible for Medicaid benefits. They are eligible only for the payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered. Individuals eligible for QI-1 will not receive a Medicaid card, and, unlike QMBs and SMBs, may not be certified in another Medicaid category for simultaneous periods. Individuals who meet the eligibly requirements for both QI-1 and medically needy spend down will have to choose which coverage is wanted for a particular period of time.

Eligibility for the QI-1 program is similar to that of the QMB program. The individuals must be age 65 or older, blind or disabled and entitled to receive Medicare Part A hospital insurance and Medicare Part B medical insurance. Countable income must be at least 120% but less than 135% of the current Federal Poverty Level.

Countable resources may equal but cannot exceed twice the current SSI resource limitations.

124.170 Specified Low-Income Medicare Beneficiaries (SMB) 10-13-03

The Specified Low Income Medicare Beneficiaries Program (SMB) was mandated by Section 4501 of the Omnibus Budget Reconciliation Act of 1990.

Individuals eligible as specified low income Medicare beneficiaries (SMB) are not eligible for the full range of Medicaid benefits. They are eligible for only the payment of their Medicare Part B

premium. No other Medicare cost sharing charges will be covered. SMB individuals do not receive a Medicaid card.

Eligibility criteria for the SMB program are similar to that of the QMB program. The individuals must be age 65 or older, blind or disabled and entitled to receive Medicare Part A hospital insurance and Medicare Part B medical insurance. Their countable income must be greater than, but not equal to 100% of the current Federal Poverty Level, and less than, but not equal to 120% of the current Federal Poverty Level.

The resource limit may be equal to but cannot exceed twice the current SSI resource limitations.

Interested individuals may apply for services at their local Department of Human Services (DHS) county office.

124.180 Tuberculosis (TB) 10-13-03

The TB aid category is for low-income individuals of all ages who are infected or who are suspected to be infected with TB. Applications may be made through the Arkansas Department of Health by contacting the local health unit. Providers may refer potential eligibles to local health units.

Individuals eligible in the TB aid category are not required to select a Primary Care Physician (PCP) since this is a limited services category.

Eligible individuals will receive *only* TB related services and *only* from the following service categories:

A. Prescribed drugs

Only the following drugs are covered through the TB aid category:

Capreomycin/1 gm vial	Mycobutin/150 mg capsules
Ethambutol/400 mg tablets	Pyrazinamide/500 mg tablets
Isoniazid/100 mg tablets	Rifampin/150 mg capsules
Isoniazid/300 mg tablets	Rifampin/300 mg capsules
Levofloxacin/250 mg tablets	Isoniazid/Rifampin 150/300 mg capsules
Levofloxacin/500 mg tablets	Streptomycin Sulfate, USP Sterile 1 gm/vial

B. Physician services

C. Outpatient hospital services (inpatient hospital services are *not* covered)

D. Rural Health Clinic services

E. Federally Qualified Health Center services

F. Laboratory and X-ray services, including services to confirm the presence of infection

G. Clinic services

124.190 Women's Health (Family Planning) 10-13-03

Women in aid category 69 (FP-W) are eligible for all family planning services, subject to the benefit limits listed in the appropriate provider manual.

Women in the FP-W category who elect sterilization are covered for one post-sterilization visit per state fiscal year (July 1 through June 30).

124.200 Recipient Aid Categories with Additional Cost Sharing 10-13-03

Certain programs require recipients to share the cost for Medicaid services received. The programs are discussed below.

124.210 ARKids First-B 10-13-03

Covered services provided to ARKids First-B participants are within the same scope of services provided to Arkansas Medicaid recipients, but may be subject to cost sharing requirements. See Section II of the ARKids First-B provider manual for a list of services that require cost sharing and the amount of participant liability for each service.

124.220 TEFRA 10-13-03

Eligibility category 49 contains children under age 19 who are eligible for Medicaid services as authorized by Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and amended of the Omnibus Budget Reduction Act. Children in category 49 receive the full range of Medicaid services. However, there are cost sharing requirements. Some parents are required to pay monthly premiums according to the chart below.

TEFRA Cost Share Schedule

Family Income		Monthly Premiums		
From	**To**	**%**	**From**	**To**
$0	$25,000	0.00%	$0	$0
$25,001	$50,000	1.00%	$21	$42
$50,001	$75,000	1.25%	$52	$78
$75,001	$100,000	1.50%	$94	$125
$100,001	$125,000	1.75%	$146	$182
$125,001	$150,000	2.00%	$208	$250
$150,001	$175,000	2.25%	$281	$328
$175,001	$200,000	2.50%	$365	$417
$200,001	And above	2.75%	$458	$458

The maximum premium is $5,500 per year ($458 per month) for income levels of $200,001 and above.

The premiums listed above represent family responsibility. They will not increase if a family has more than one TEFRA eligible child.

124.230 Working Disabled 10-13-03

The Working Disabled category is an employment initiative designed to serve as a “bridge” to enable people with disabilities to gain employment without losing medical benefits. Eligibles in this category are individuals who are ages 16 through 64 and who are disabled according to Supplemental Security Income (SSI) criteria.

There are two levels of cost sharing in this aid category, depending on the individual’s income:

A. Regular Medicaid cost sharing.

B. New cost sharing requirements.

Eligibles with gross income below 100% of the Federal Poverty Level (FPL) are responsible for the regular Medicaid cost sharing (pharmacy and inpatient hospital). They are designated in the system as “WD RegCO”.

Eligibles with gross income equal to or greater than 100% FPL, have cost sharing for more services and are designated in the system as “WD NewCo”.

The cost sharing amounts for the “WD NewCo” eligibles is listed in the chart below:

Program Services	**New Co-Payment***
Ambulance	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiological Services	$10 per visit
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
Child Health Management Services	$10 per day
Chiropractor	$10 per visit
Dental (limited to individuals under age 21)**	$10 per visit (no co-pay on EPSDT dental screens)
Developmental Disability Treatment Center Services	$10 per day
Diapers, Underpads and Incontinence Supplies	None
Domiciliary Care	None
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Emergency Department: Emergency Services	$10 per visit
Emergency Department: Non-emergency Services	$10 per visit
End Stage Renal Disease Services	None
Early and Periodic Screening, Diagnosis and Treatment	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals age 21 and over)	10% of Medicaid maximum allowable amount.
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient	25% of the hospital’s Medicaid per diem for the first Medicaid-covered inpatient day
Hospital: Outpatient	$10 per visit

Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None
Laboratory and X-Ray	$10 per encounter, regardless of the number of services per encounter
Medical Supplies	None
Inpatient Psychiatric Services for Under Age 21	25% of the hospital's Medicaid per diem for the first Medicaid-covered day
Outpatient Mental and Behavioral Health	$10 per visit
Nurse Practitioner	$10 per visit
Private Duty Nursing	$10 per visit
Certified Nurse Midwife	$10 per visit
Orthodontia (not covered for individuals age 21 and older)	None
Orthotic Appliances	10% of Medicaid maximum allowable amount
Personal Care	None
Physician	$10 per visit
Podiatry	$10 per visit
Prescription Drugs	$10 for generic drugs; $15 for brand name
Prosthetic Devices	$10% of Medicaid maximum allowable amount
Rehabilitation Services for Persons with Physical Disabilities (RSPD)	25% of first day's Medicaid in-patient per diem (first covered day)
Rural Health Clinic	$10 per core service encounter
Targeted Case Management	10% of Medicaid maximum allowable rate per unit
Occupational Therapy (Age 21 and older have limited coverage***)	$10 per visit
Physical Therapy (Age 21 and older have limited coverage***)	$10 per visit
Speech Therapy (Age 21 and older have limited coverage***)	$10 per visit
Transportation (non-emergency)	None
Ventilator Services	None
Vision Care	$10 per visit

* **Exception**: Cost sharing for nursing facility services is in the form of "patient liability" which generally requires that patients contribute most of their monthly income toward their nursing facility care. Therefore, WD recipients (Aid Category 10) who temporarily enter a nursing home and continue to meet WD eligibility criteria will be exempt from the co-payments listed above.

**** Exception:** Dental services for individuals age 21 and older must be medically necessary, because the individual is experiencing a life-threatening condition.

***** Exception:** This service is NOT covered for individuals age 21 and older in the Occupational, Physical and Speech Therapy Program.

NOTE: Providers should consult the appropriate provider manual to determine coverage and benefits.

125.000 Medicaid Identification Card 10-13-03

125.100 Explanation of Medicaid Identification Card 10-13-03

Medicaid recipients are issued a magnetic identification card similar to a credit card. Each identification card displays a hologram, and for most Medicaid categories, a picture of the recipient. Children under the age of five, ARKids-B, nursing home and home and community-based waiver recipients are not pictured. New recipients of the Family Planning Wavier (Category 69) and ARKids-A are not pictured unless they were certified using an existing case number and have a previously issued photo ID card. The Division of County Operations issues the Medicaid identification card to Medicaid recipients.

THE MEDICAID IDENTIFICATION CARD DOES NOT GUARANTEE ELIGIBILITY FOR A RECIPIENT. Payment is subject to verification of recipient eligibility at the time services are provided. See Section 123.000 for verification of recipient eligibility procedures, and Section III for electronic eligibility verification information.

The following is an explanation of information contained on a Medicaid ID card:

A. Identification Number - A unique ten-digit number assigned to each individual Medicaid recipient by the Arkansas Division of County Operations.

B. Name of Eligible Recipient - Identifies the name of the recipient who is eligible to receive Medicaid benefits. The card reflects the recipient's name at time of issuance.

C. Birthdate - Month/Day/Year - This date represents the month, day and year of birth of the recipient listed.

D. Date of Issuance - This date represents the month, day and year the card was issued to the recipient.

E. Signature - This is the signature of the recipient named on the I.D. card.

View or print an example of the Medicaid ID card.

NOTE: ARKids First-B identification cards have a different appearance than the Medicaid identification card. See the ARKids First-B Manual for more information.

125.200 Non-Receipt or Loss of Card by Recipient 10-13-03

When recipients report non-receipt or loss of a Medicaid card, refer the recipients to the local DHS County Office or the Division of County Operations, Customer Assistance. **View or print the Division of County Operations, Customer Assistance contact information.**

125.300 Reporting Suspected Misuse of I.D. Card 10-13-03

When a provider suspects misuse of a Medicaid identification card, the provider should contact the Utilization Review Section of Arkansas Division of Medical Services. An investigation will then be made. **View or print the Utilization Review Section contact information.**

130.000 RECIPIENT RESPONSIBILITIES 10-13-03

131.000 Charges that are not the Responsibility of the Recipient 10-13-03

The recipient is not responsible for payment of a provider's charges for Medicaid covered services in the following situations:

A. The recipient may not be held liable for a claim or portion of a claim when a determination that the services were not medically necessary is made based on the professional opinion of appropriate and qualified persons performing peer review of Medicaid cases.

B. The recipient may not be held liable for billed charges above the Medicaid maximum allowable.

C. The recipient will not be responsible for billings denied because of provider errors. It is the responsibility of the provider to file claims in a timely manner, correct inappropriate codes and typographical errors and to provide essential information necessary to process the Medicaid claim.

D. The recipient will not be responsible for billings denied because of errors made by Medicaid or the fiscal agent or due to changes in state or federal mandates.

E. The recipient may not be billed for services denied because a provider failed to request required approval for a service or failed to meet procedural requirements. For instance, a provider may not bill a recipient for a non-emergency surgery for which prior authorization is required but was not requested.

F. The recipient is not responsible for the difference between the recipient Medicaid cost sharing responsibility, if any, and the Medicare deductible and co-insurance. This exclusion does not eliminate the client's responsibility for applicable Medicaid cost sharing when a recipient is dually eligible for Medicare and Medicaid.

G. If an individual who makes payment at the time of service is later found to be Medicaid eligible and Medicaid is billed, the individual must be refunded the full amount of his or her payment for covered services. If it is agreeable with the individual, these funds may be credited against unpaid non-covered services that are the responsibility of the recipient.

H. The recipient may not be billed for the completion and submission of a Medicaid claim form. If the provider agrees to accept the patient as a Medicaid recipient and agrees to bill Medicaid for the services rendered, the recipient may not be charged for this billing procedure.

132.000 Charges that are the Responsibility of the Recipient 10-13-03

A. Individuals may be billed if they are ineligible or if they have chosen to receive and agreed to pay for care not covered by the Medicaid Program.

B. If a Medicaid-eligible patient elects to receive a service for which DMS has denied a benefit extension or for which DMS subsequently denies a benefit extension, the patient is responsible for the payment.

C. If the provider chooses not to accept the recipient as a Medicaid patient in advance of providing the service, the recipient may be billed for care he or she has chosen to receive as a private pay patient.

D. The recipient is responsible for all expenses for non-covered services, such as services that are not covered under the scope of the Medicaid Program, services received in excess of Program benefit limitations or services received for which the provider and recipient agreed the Medicaid Program would not be billed.

E. The recipient is responsible for charges incurred during a time of ineligibility.

F. The recipient is responsible for the spend down liability on the first day of spend down eligibility.

G. The recipient is responsible for any applicable cost-sharing amount applied by the Medicaid Program.

H. Section 1902(a)(14) of the Social Security Act permits states to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments or similar cost sharing charges.

I. Information relating to cost sharing follows in Sections 133.000 through 133.400.

133.000 Cost Sharing 10-13-03

There are three forms of cost sharing in the Medicaid Program: co-insurance, co-payment and premiums. Each is discussed below.

133.100 Inpatient Hospital Coinsurance Charge to Non-Medicare Medicaid Recipients 10-13-03

For inpatient admissions, the coinsurance charge per admission for non-exempt Medicaid recipients age 18 and older is **10%** of the hospital's interim Medicaid per diem, applied on the first Medicaid covered day.

Example:

A Medicaid recipient is an inpatient for 4 days in a hospital whose Arkansas Medicaid interim per diem is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1950.00; the recipient will pay $50.00 (10% Medicaid coinsurance rate).

1. Four (4 days) times $500.00 (the hospital per diem) = $2000.00 (hospital allowed amount).
2. Ten percent (10% Medicaid coinsurance rate) of $500.00 = $50.00 coinsurance.
3. Two thousand dollars ($2000.00 hospital allowed amount) minus $50.00 (coinsurance) = $1950.00 (Medicaid payment).

133.200 Inpatient Hospital Coinsurance Charge to ARKids First-B Recipients 10-13-03

For inpatient admissions, the coinsurance charge per admission for ARKids First-B recipients is 20% of the hospital's Medicaid per diem, applied on the first Medicaid covered day.

Example:

An ARKids First-B recipient is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem amount is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1900.00 and the recipient will pay $100.00 (20% Medicaid coinsurance rate).

1. Four (4 days) times $500.00 (the hospital per-diem) = $2000.00 (hospital allowed amount).
2. Twenty percent (20% Medicaid coinsurance rate) of $500.00 = $100.00 coinsurance.
3. Two thousand dollars ($2000.00 hospital allowed amount) minus $100.00 (coinsurance) = $1900.00 (Medicaid payment).

133.300 Inpatient Hospital Coinsurance Charge to Medicare-Medicaid Dually Eligible Recipients 10-13-03

The coinsurance charge per admission for Medicaid recipients who are also Medicare Part A beneficiaries, is **10%** of the hospital's Arkansas Medicaid per diem amount, applied on the first Medicaid covered day only.

Example:

A Medicare beneficiary, also eligible for Medicaid, is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem amount is $500.00.

1. This is a patient's first hospitalization for the Medicare benefit year; so the patient has not met their Medicare Part A deductible.
2. Medicare pays the hospital its allowed Part A charges, less the $760.00 deductible, and forwards the payment information to Medicaid.
3. Ten percent (10% Medicaid coinsurance rate) of $500.00 (the Arkansas Medicaid hospital per diem) = $50.00 (Medicaid coinsurance). Medicaid coinsurance is due for the first day only of each admission covered by Medicare Part A.
4. Seven hundred sixty dollars ($760.00 Medicare Part A deductible) minus $50.00 (Medicaid coinsurance) = $710.00 (Medicaid payment).

If, on a subsequent admission, Medicare Part A assesses coinsurance; Medicaid will deduct from the Medicaid payment, an amount equal to 10% of one day's Medicaid per diem. The patient will be responsible for that amount.

133.400 Co-payment on Prescription Drugs 10-13-03

Arkansas Medicaid has a recipient co-payment policy in the Pharmacy Program. The co-payment for the Pharmacy Program is applied per prescription. Non-exempt recipients age 18 and older are responsible for paying the provider a co-payment amount based on the following table:

Medicaid Maximum Amount	Recipient Co-pay
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

134.000 Exclusions from Cost Sharing Policy 10-13-03

As required by 42 CFR 447.53(b), the following services are excluded from the recipient cost sharing (coinsurance/co-payment) policy:

A. Services provided to individuals under 18 years of age.

   1. There are two exceptions to the exclusion from cost sharing policy.
      a. ARKids First-B is an 1115 demonstration project for which Arkansas was granted permission to require cost sharing for individuals under age 18.
      b. Working Disabled is a category that specifically allows cost sharing for individuals under age 18.

B. Services provided to pregnant women.

C. Emergency services - Services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of a medical condition

manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy
2. Serious impairment to bodily functions or
3. Serious dysfunction of any bodily organ or part

D. Services provided to individuals who are inpatients in a long term care facility (nursing facility and intermediate care/MR facility) when, as a condition for receiving the institutional services, the individual is required to spend all but a minimal amount of his or her income required for personal needs for medical care costs.

The fact that a recipient is a resident of a nursing facility does not on its own exclude the Medicaid services provided to the recipient from the cost sharing policy. Unless a Medicaid recipient has applied for long term care assistance through the Arkansas Medicaid Program, been found eligible and Medicaid is making a vendor payment to the nursing facility (NF or ICF/MR) for the recipient, the Medicaid services are not excluded from the cost sharing policy.

E. Family planning services and supplies provided to individuals of childbearing age.

The provider must maintain sufficient documentation in the recipient's medical record that substantiates the exclusion from the recipient cost sharing policy.

135.000 Collection of Coinsurance/Co-payment 10-13-03

The method of collecting the coinsurance/co-payment amount from the recipient is the responsibility of the provider. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing (coinsurance/co-payment) from the recipient will remain the responsibility of the provider.

The provider may not deny services to any eligible individual due to the individual's inability to pay the cost of the coinsurance/co-payment amount. However, the individual's inability to pay does not eliminate his or her liability for the coinsurance/co-payment charge.

The recipient's inability to pay the coinsurance/co-payment amount will not alter the Medicaid reimbursement amount for the claim. Unless the recipient or service is excluded from the coinsurance/co-payment policy as listed in Section 134.000, the Medicaid reimbursement amount will be calculated according to current reimbursement methodology minus the appropriate coinsurance amount or appropriate co-payment amount.

136.000 Patient Self Determination Act 10-13-03

The Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L.101-508 requires that Medicaid certified hospitals and other health care providers and organizations, give patients information about their right to make their own health decisions, including the right to accept or refuse medical treatment. This legislation does not require individuals to execute advance directives.

Medicaid certified hospitals, nursing facilities, hospices, home health agencies and personal care agencies must conform to the requirements imposed by Centers for Medicare & Medicaid Services (CMS). The federal requirements mandate conformity to current state law. Accordingly, providers must:

A. Provide all adult patients (not just Medicaid patients) with written information about their rights under state law to make health care decisions, including the right to accept or refuse medical or surgical treatment and the right to execute advance directives. This information must be provided:

1. By hospitals at the time of the individual's admission as an inpatient.
2. By nursing facilities when the individual is admitted as a resident.
3. By a provider of home health or personal care services in advance of the individual receiving care.
4. By hospices at the time of initial election of hospice care.

B. Maintain written policies, procedures and materials concerning advance directives to ensure compliance with the law.

C. Inform all patients and residents about the provider's policy on implementing advance directives.

D. Document in each patient's medical record whether the patient has received information regarding advance directives. Providers must also document whether patients have signed an advance directive and must record the terms of the advance directive.

E. Not discriminate against an individual based on whether they have executed an advance directive. All parties responsible for the patient's care are obligated to honor the patient's wishes as stated in the patient's advance directive. A provider who objects to a patient's advance directive on moral grounds must, as promptly as practicable, take all reasonable steps to transfer care to another provider.

F. Educate staff and the community on advance directives.

G. Tell patients if they wish to complete a health care declaration, the health care provider will provide them with information and a health care declaration form. Providers should acquire a supply of the declaration forms and become familiar with the form.

H. Tell patients they have a right to reaffirm advance directives, to change the advance directive or to revoke the advance directive at any time and in any manner, including an oral statement to the attending physician or other health care provider.

A description of advance directive must be distributed to each patient. **View or print a sample form describing advance directives and a sample declaration form that meets the requirements of law.**

140.000 PROVIDER PARTICIPATION 10-13-03

141.000 Provider Enrollment 10-13-03

Any provider of services must be enrolled in the Arkansas Medicaid Program before reimbursement may be made for any services provided to Arkansas Medicaid recipients.

Providers must complete a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) and return them to the Division of Medical Services within 30 days from the date they were sent from the Provider Enrollment Unit. Section II of all provider manuals contains information relative to provider participation requirements.

Upon receipt and approval of the above information by the Provider Enrollment Unit, a provider number will be assigned to each approved provider. This number must be used on all claims and correspondence submitted to Arkansas Medicaid.

Provider eligibility will be retroactive 1 year from the date the provider agreement is approved by the Division of Medical Services, the effective date of the provider's license or certification or the date the service became a part of the Arkansas Medicaid Program, whichever date is the latest.

Instructions for billing and specific details concerning the Arkansas Medicaid Program are contained within this manual. Providers must read all sections of the manual **before** signing the contract. The manual is an extension of the Medicaid contract and providers must comply with its requirements in order to participate in the Arkansas Medicaid Program.

View or print the provider application (Form DMS-652), the Medicaid contract (Form DMS-653) and the Request for Taxpayer Identification Number and Certification (Form W-9).

All providers must sign an Arkansas Medicaid Provider Contract. The signature must be an original signature of the individual provider. The authorized representative of the provider must sign the contract for a group practice, hospital, agency or other institution.

142.000 Conditions of Participation 10-13-03

Providers enrolled in the Arkansas Medicaid Program must agree to the following conditions of participation:

A. Each provider must be licensed, certified or both, as required by law, to furnish all goods or services that may be reimbursed by the Arkansas Medicaid Program.

B. Providers must comply with applicable standards for professional and quality care.

C. It is the responsibility of each provider to read the Arkansas Medicaid provider manual provided by the Division of Medical Services and to abide by the rules and regulations specified in the manual.

D. All services provided must be medically necessary. The recipient is not liable for a claim or portion of a claim when the Medicaid Program, either directly or through a contractor or designee, determines that the services were not medically necessary.

E. It is the responsibility of each provider to be alert to the possibility of third party sources of payment and to report receipt of funds from these sources to the Division of Medical Services.

F. Any covered service performed by a provider must be billed only after the service has been provided. No service or procedure may be pre-billed.

G. Endorsement of the provider check issued by the Medicaid fiscal agent certifies that the services were rendered by or under the direct supervision of the provider as billed.

H. Each provider must accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any Medicare deductible or coinsurance due and payable under Title XIX (Medicaid).

I. Each provider must accept payment from Medicaid as payment in full for covered services, make no additional charges and accept no additional payment from the recipient for these services. Medicaid providers may not charge Medicaid recipients for the completion and submission of a Medicaid claim form. If the provider agrees to accept the patient as a Medicaid recipient and agrees to bill Medicaid for the services rendered, the recipient may not be charged for this billing procedure.

J. Services will be provided to qualified recipients without regard to race, color, national origin or disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

K. Claims for services provided to eligible Medicaid recipients must be submitted to the Medicaid claims processing contractor, EDS, within twelve months from the date of service.

L. The Medicaid Program has a compelling interest in preventing unnecessary provider costs and program utilization associated with provider efforts to encourage, solicit, induce or cause an individual to seek or obtain a Medicaid covered service. Therefore, except for Medicaid covered services and other professional services furnished in exchange for the provider's usual and customary charges, no Medicaid provider may knowingly give, offer, furnish, provide or transfer money, services or any thing of value to any Medicaid recipient, to anyone related to any Medicaid recipient within the third degree or any person residing in the household of a recipient, for less than fair market value.

This rule does not apply to:

1. Pharmaceutical samples provided to a physician at no cost or to other comparable circumstances where the provider obtains the sample at no cost and distributes the samples without regard to Medicaid eligibility
2. Provider actions taken under the express authority of state or federal Medicaid laws or rules or the provider's agreement to participate in the Medicaid Program.

M. Each provider must notify the Division of Medical Services in writing immediately regarding any changes to its application or contract, such as:

1. Change of address
2. Change in members of group, professional association or affiliations
3. Change in practice or specialty
4. Change in Internal Revenue Service (IRS) number or Federal Employee Identification Number (FEIN)
5. Retirement or death of provider
6. Change of ownership

N. Any provider who engages in fraudulent billing practices will be immediately suspended from participation until these practices are evaluated and resolved. Also, any provider discovered to be involved in fraudulent billing practices or found to be accepting or soliciting unearned rebates, refunds or other unearned considerations, whether in the form of money or otherwise, will be referred to the appropriate legal agency for prosecution under applicable federal or state laws.

O. Any provider who engages in abuse or over-utilization of services provided to Medicaid recipients, when such abuse or over-utilization has been determined by a peer review committee, Medicaid professional staff or medical consultants, may be terminated from participation in the Medicaid Program, required to repay monies paid by the Medicaid Program for such services or may have other appropriate action taken upon recommendation of the above referenced parties.

P. Within thirty days a provider must refund any money the state is obligated to repay the federal government as a result of disallowance, recoupment or other adverse action in connection with Medicaid payments to the provider.

Q. Each provider must prepare and keep complete and accurate original records that fully disclose the nature and extent of goods, services or both provided to eligible recipients. The delivery of all goods and services billed to Medicaid must be documented in the recipient's medical record.

R. If a provider maintains more than one office in the state, the provider must designate one such office as a home office. Original records must be maintained at the provider's home office. A copy of the records must be maintained at the provider's service delivery site. If the provider changes ownership or ceases doing business in the state, all required original records must be maintained at a site in the state that is readily accessible by the Arkansas Medicaid Program and its agents and designees.

S. Each provider must immediately furnish all original records in its possession regarding the furnishing or billing of Medicaid goods or services, upon request, to authorized representatives of the Division of Medical Services or their designated representatives, state Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services. The request may be made in writing or in person. No advance notice is required for an in-person request.

T. Each provider must immediately furnish records, upon request, establishing the provider's charges to private patients for services that are the same as or substantially similar to services billed to Medicaid patients.

U. Each provider must retain all records for five (5) years from the date of service or until all audit questions or review issues, appeal hearings, investigations or administrative or judicial litigation to which the records may relate are finally concluded, whichever period is longer.

V. Failure to comply with the above requirements may result in termination from the Medicaid Program and/or recovery of money paid for services by the Division of Medical Services.

W. Except where participation has been terminated, each provider who has been sanctioned may be required to participate in a provider education program as a condition of continued participation. Provider education programs will include, at a minimum:

1. Instruction on admissions and authorization for payments.
2. Instruction on the use and format of required program forms.
3. Instruction on key provisions of the Medicaid Program.
4. Instruction on reimbursement rates.
5. Instruction on how to inquire about program requirements, payment or billing problems and the overall operation of the program.

X. Nothing in the conditions of participation is a limitation on the ability of the Medicaid Program to take any action that is authorized by federal or state laws, regulations or rules or to refrain from taking any action that is not mandated by federal or state laws, regulations or rules.

142.100 Mandatory Assignment of Claims for "Physician" Services 10-13-03

The Omnibus Budget Reconciliation Act of 1989 requires the mandatory assignment of Medicare claims for "physician" services furnished to individuals who are eligible for Medicare **and Medicaid**, including those eligible as Qualified Medicare Beneficiaries (QMBs). According to Medicare regulations, "physician" services, for the purpose of this policy, are services furnished by **physicians, dentists, optometrists, chiropractors and podiatrists**.

As described above, "physician" services furnished to an individual enrolled under Medicare who is also eligible for Medicaid, including Qualified Medicare Beneficiaries may only be made on an assignment related basis.

150.000 ADMINISTRATIVE REMEDIES AND SANCTIONS 10-13-03

151.000 Grounds for Sanctioning Providers 10-13-03

Sanctions may be imposed against a provider for any one or more of the following reasons:

A. Presenting or causing to be presented for payment any claim for care, services or merchandise that fails to accurately represent the care, services or merchandise provided.

B. Submitting or causing to be submitted information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charging Medicaid patients more than other patients receiving the same service.

C. Submitting or causing to be submitted inaccurate or misstated information in connection with utilization controls, including prior authorization requirements.

D. Failing to disclose or make available, upon request, to the Division of Medical Services or its authorized representative, state Medicaid Fraud Control Unit and representatives of the Department of Human Services, all records relating to any Medicaid recipient and records of payments made.

E. Failing to provide and maintain quality services, within accepted medical community standards as adjudged by a body of peers.

F. Any act or omission that is abusive to the Medicaid Program.

G. Breaching the terms of the Medicaid provider agreement or failing to comply with the certification standards or with the terms of the provider certification.

H. Inducing, furnishing, arranging, referring or otherwise causing a recipient to receive tests, examinations, service(s) or merchandise that are not medically necessary.

I. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

J. Violating any state or federal provision of the Title XIX Program or any rule or regulation pertaining to Title XIX.

K. Submitting a false application for provider status.

L. Violating any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries.

M. Accepting patients for whom all required care and services obviously cannot be provided.

N. Being convicted of a civil or criminal offense relating to performance of a provider agreement or failure to comply with the applicable standard of care.

O. Failure to meet standards required by state or federal law for participation including licensure.

P. Exclusion from Medicare.

Q. Failure to accept Medicaid payment as payment in full for covered services.

R. Refusal to execute a new provider agreement when requested to do so.

S. Failure to correct deficiencies after receiving written notice of deficiencies from the Division of Medical Services or the licensing or certifying entity.

T. Formal reprimand or censure by a licensing, certifying or accrediting agency or entity.

U. Suspension, debarment, exclusion or termination from participation in another governmental program.

V. Failure to pay or make arrangements acceptable to the state for the repayment of any funds due to the state.

W. Billing the Medicaid Program for services before providing those services.

X. Any act or omission that subjects a provider to exclusion under DHS Policy 1088, titled DHS Participant Exclusion Rule.

Y. Any act or omission that violates a provision of any applicable Medicaid provider manual.

152.000 Sanctions 10-13-03

The following sanctions may be invoked against providers based on the grounds specified in Section 151.000:

A. Termination from participation in the Medicaid Program.

B. Suspension of participation in the Medicaid Program.

C. Suspension, withholding, recoupment, recovery or any combination thereof, of payments to a provider.

D. Cancellation of the provider agreement or shortening of an already existing provider agreement.

E. Mandatory attendance at provider education sessions.

F. Imposition of prior authorization of services.

G. Prepayment review of some or all of the provider's billings.

H. Referral to the State Licensing Board for investigation.

I. Referral to the Fraud Investigation Unit.

J. Transfer to a closed-end provider agreement not to exceed 12 months.

K. Referral to appropriate federal or state legal agency for prosecution under applicable federal or state laws.

L. Referral to the appropriate state professional health care association's peer review mechanism.

M. Exclusion under Department of Human Services (DHS) Policy 1088, titled DHS Participant Exclusion Rule.

153.000 Notice of Provider Sanction 10-13-03

A. When a provider has been sanctioned, the Department of Human Services shall notify the applicable professional society, and any licensing, certifying or accrediting agency of the findings made and the sanctions imposed.

B. Where a provider's participation in the Medicaid Program has been suspended or terminated, the Department of Human Services will notify the recipients for whom the provider claims payment for services that such provider has been suspended or terminated. Such notice may include the reason for suspension or termination.

154.000 Rules Governing the Imposition and Extent of Sanction 10-13-03

A. Imposition of a Sanction

1. The Director of the Division of Medical Services shall determine the sanction to be imposed as provided in paragraph A3.

2. The following factors shall be considered in determining the sanction(s) to be imposed:

a. Seriousness of the offense(s)

b. Extent of violation(s)

c. History of prior violation(s)

d. Whether an indictment or information was filed against the provider or a related party as defined in DHS Policy 1088, titled DHS Participant Exclusion Rule

3. Whenever a provider has been convicted of any Medicaid Program violation or is suspended or terminated from the Medicare Program for cause, the Department of Human Services shall institute proceedings to terminate the provider from the Medicaid Program.

B. Scope of Sanction

1. A sanction applies to all related parties as defined in DHS Policy 1088.

2. Suspension or termination from participation of any provider shall preclude such provider from submitting claims for payment, either personally or through claims submitted by a clinic, group, corporation or other association to DHS for any services or supplies provided after the suspension or termination.

3. No provider shall submit claims for payment for any goods or services provided by a person who has been debarred, excluded, suspended or terminated from participation in the Medicaid Program except for those services or supplies provided before the suspension or termination.

4. Any provider violating the provisions of paragraph B.3, along with the provider's related parties as defined in DHS Policy 1088, shall be suspended, terminated or excluded from participation.

160.000 REMEDIES FOR NON-COMPLIANCE 10-13-03

161.000 Notice of Violation 10-13-03

If the Division of Medical Services identifies an act or omission for which a sanction may be issued, the Division will notify the provider of the act or omission. The notification will be in writing and will set forth:

A. The nature of the act or omission.

B. The amount of any overpayment, recoupment or recovery, if known.

C. The method of computing such amount.

D. The sanction or sanctions to be imposed.

E. Notification of any actions required of the provider and the provider's right to appeal.

161.100 Withholding of Medicaid Payments 10-13-03

The Division of Medical Services may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that circumstances involve fraud, willful misrepresentation or both.

The Division of Medical Services may withhold payments without first notifying the provider of its intention to withhold.

The provider may request and will be granted administrative review. See Section 161.200.

Within five days of taking the action, the Division of Medical Services will send the Notice of Non-Compliance (form DMS-635) that explains the reasons for withholding payment and the provider's right for administrative review.

All withholdings or payment actions will be temporary and will not continue after:

A. The Division of Medical Services or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation or

B. Legal proceedings relating to the provider's alleged fraud or willful misrepresentations are completed.

161.200 Right to Informal Reconsideration 10-13-03

Within 10 calendar days after notice of adverse action, the provider may request an informal reconsideration. Requests must be in writing. Within 20 calendar days after the request, the provider must submit, in writing, all alleged facts, including supporting documentation and legal arguments that the provider asserts in opposition to the adverse action. Informal reconsideration does not postpone any adverse action that may be imposed pending appeal.

Unless a timely and complete request for informal reconsideration or appeal is received by the Department of Human Services, the findings of DHS shall be considered a final and binding administrative determination.

Within 20 days of receiving a timely and complete request for informal reconsideration, the Director of the Division of Medical Services will designate an individual who did not participate in the determination leading to the adverse action who is knowledgeable in the subject matter of the informal reconsideration to review the informal reconsideration request and associated documents. The reviewer shall recommend to the director that the adverse action be sustained, reversed or modified. The director may adopt or reject the recommendation in whole or in part.

No informal reconsideration or appeal is allowed if the adverse action is due to loss of licensure, accreditation or certification.

161.300 Appeal 10-13-03

Within 20 days of receiving notice of adverse action, or 10 days of receiving an informal reconsideration decision that upholds all or part of any adverse action, whichever is later, the provider may appeal. Each notice of appeal must be in writing and state with particularity all findings, determinations, and adverse actions that the provider alleges are not supported by the facts or the applicable laws (including state and federal laws and rules, and applicable professional standards) or both. Within 20 days of receiving a notice of appeal the Director of the Division of Medical Services shall designate a hearing officer and set a date for the formal hearing.

162.000 Notice of Appeal Hearing 10-13-03

When an appeal hearing is scheduled, the Division of Medical Services shall notify the provider or; if the provider is represented by an attorney, the provider's attorney, in writing, of the date, time and place of the hearing. Notice shall be mailed not less than 10 calendar days before the scheduled date of the hearing.

162.100 Conduct of Hearing 10-13-03

A. The hearing shall be conducted by a hearing officer who is authorized by the Director of the Division of Medical Services to conduct such hearings.

B. Testimony shall be taken only under oath, affirmation or penalty of perjury.

C. Each party shall have the right to call and examine parties and witnesses, to introduce exhibits, to question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination. Each party has the right to impeach any witness regardless of which party first called him to testify. Each party has the right to rebut the opposing evidence.

D. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs regardless of the existence of any common law or statutory rule that might make improper the admission of such evidence over objection in civil or criminal actions.

E. The hearing officer may provide for discovery by any means permitted by the Arkansas Rules of Civil Procedure and may assess the expense to the requesting party.

F. The hearing officer may question any party or witness and may admit any relevant and material evidence.

G. The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. Before taking evidence, the hearing officer shall explain the issues and the order in which evidence will be received.

H. The provider shall have the burden of proving by a preponderance of the evidence that it delivered all billed services in conformity with all applicable requirements.

I. Except as provide in H, the burden of producing evidence as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

162.200 Representation of Provider at a Hearing 10-13-03

Individual providers may represent themselves. A partner may represent the partnership. A limited liability company or corporation may be represented by an officer or the chief operating official. A professional association may be represented by a principal of the association. Representatives must be courteous in all activities undertaken in connection with the appeal, and must obey the orders of the hearing officer regarding the presentation of the appeal. Failure to do so may result in exclusion from the appeal hearing, or the entry of an order denying discovery.

162.300 Right to Counsel 10-13-03

Any party may appear and be heard at any proceeding described herein through an attorney-at-law. All attorneys shall conform to the standards of conduct practiced by attorneys before the courts of Arkansas. If an attorney does not conform to those standards, the hearing officer may exclude the attorney from the proceeding.

162.400 Appearance in Representative Capacity 10-13-03

A person appearing in a representative capacity shall file a written notice of appearance on behalf of a provider identifying himself by name, address and telephone number; identifying the party represented and shall have a written authorization to appear on behalf of the provider. The Department of Human Services shall notify the provider in writing of the name and telephone number of its representative.

163.000 Form of Papers 10-13-03

All papers filed in any proceeding shall be typewritten on legal-sized white paper using one side of the paper only. They shall bear a caption clearly showing the title of the proceeding in connection with which they are filed together with the docket number, if any.

The party and/or his authorized representative or attorney shall sign all papers, and all papers shall contain his address and telephone number. At a minimum, an original and two copies of all papers shall be filed with the Division of Medical Services.

163.100 Notice, Service and Proof of Service 10-13-03

A. All papers, notices and other documents shall be served by the party filing same upon all parties to the proceeding. Proof of such service upon all parties shall be filed with the Division of Medical Services.

B. Service shall be made by delivering, in person or by mail, properly addressed with postage prepaid, one copy to each party entitled thereto. When any party or parties have appeared by attorney, service upon the attorney shall be deemed service upon the party or parties.

C. Proof of service of any paper shall be by certificate of attorney, affidavit or acknowledgement.

D. Wherever notice or notification by the Division of Medical Services is indicated or required, notification shall be effective upon the date of first class mailing to a provider's or other party's business address or residence.

E. In addition to the methods provided for in these regulations, a provider may be served in any manner permitted by law.

164.000 Witnesses 10-13-03

A party shall arrange for the presence of his or her witnesses at the hearing.

165.000 Amendments 10-13-03

At any time prior to the completion of the hearing, amendments to the adverse action, the provider's notice of appeal, or both, may be allowed on just and reasonable terms to add any party who ought to have been joined, discontinued as to any party, change the allegations or defenses or add new causes of action of defenses.

Where the Division of Medical Services seeks to add a party or a cause of action or change an allegation, notice shall be given pursuant to Section 161.000, "Notice of Violation," and Section 163.100, "Notice, Service and Proof of Service," to the appropriate parties except that the provisions of Section 161.200, "Right to Informal Reconsideration," and Section 162.000, "Notice of Appeal Hearing," shall not apply.

Where a party other than the Division of Medical Services seeks to add a party or change a defense, notice shall be given pursuant to Section 163.100, "Notice, Service and Proof of Service."

The hearing officer shall continue the hearing for such time as he deems appropriate, and notice of the new date shall be given pursuant to Section 166.000, "Continuances or Further Hearings."

166.000 Continuances or Further Hearings 10-13-03

A. The hearing officer may continue a hearing to another time or place or order a further hearing on his or her own motion or upon showing of good cause at the request of any party.

B. Where the hearing officer determines that additional evidence is necessary for the proper determination of the case, he or she may, at his or her discretion:

1. Continue the hearing to a later date and order the party to produce additional evidence or

2. Conclude the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to both parties, and each party shall have the opportunity for rebuttal.

Written notice of the time and place of a continued or further hearing shall be given, except that when a continuance or further hearing is ordered following a hearing, oral notice of the time and place of the hearing may be given to each party present at the hearing.

167.000 Failure to Appear 10-13-03

If a party fails to appear at a hearing, the hearing officer may dismiss the appeal or enter a determination adverse to the non-appearing party. A copy of the decision shall be mailed to each party together with a statement of the provider's right to reopen the hearing

168.000 Record of Hearing 10-13-03

The Division of Medical Services (DMS) shall tape-record the hearings, or cause the hearings to be tape-recorded. If the final DMS determination is appealed, the tape recording shall be transcribed, and copies of other documentary evidence shall be reproduced for filing under the Administrative Procedures Act.

169.000 Decision 10-13-03

A. At the conclusion of the hearing, the hearing officer shall take the matter under consideration and shall submit a proposed decision to the Director of the Division of Medical Services.

B. The proposed decision shall be in writing and shall contain findings of fact, conclusions of and a proposed order.

C. The director may adopt the proposed decision, or he may reject the proposed decision and have a decision prepared based upon the record, or he may remand the matter to the hearing officer to take additional evidence. In the latter case, the hearing officer, thereafter, shall submit to the director a new proposed decision.

D. The director's decision is the final agency determination under the Administrative Procedures Act. The director shall cause a copy of the decision to be mailed to the provider at the provider's last known address, or, if the provider was represented by an attorney, to the address provided by the attorney.

170.000 THE ARKANSAS MEDICAID PRIMARY CARE CASE MANAGEMENT PROGRAM 10-13-03

Arkansas Medicaid's Primary Care Case Management Program, ConnectCare, is a statewide program that operates under the authority of a Social Security Act Section 1915(b)(2) waiver. Most Medicaid recipients and all ARKids First-B participants must enroll with a primary care physician (PCP). The PCP provides primary care services and health education. They make referrals for medically necessary specialty physician's services, hospital care and other services.

PCPs assist their enrollees in locating services to which he or she refers them. PCPs coordinate and monitor, on behalf of their enrollees, prescribed medical and rehabilitation services. ConnectCare enrollees may receive services only from their PCP unless their PCP refers them to another provider, or unless they obtain a service that does not require a PCP referral. Section 176.000 lists services that do not require a PCP referral.

171.000 Medicaid-Eligible Individuals that may not Enroll with a PCP 10-13-03

All Medicaid-eligible individuals and ARKids First-B eligibles must enroll with a PCP unless they are among the following:

A. Individuals with Medicare as their primary insurance.

B. Individuals in a long term care aid category that are residents of a nursing facility.

C. Individuals who reside in an intermediate care facility for the mentally retarded (ICF/MR).

D. Individuals in Medically Needy-Spend Down categories of eligibility. See Section 124.000 for aid category information.

E. Individuals with a retroactive eligibility period. Medicaid does not require PCP enrollment for the period between the beginning of the retroactive eligibility segment and the date of the eligibility authorization. If eligibility extends beyond the authorization date, Medicaid requires enrollment with a PCP unless the recipient is otherwise exempt from PCP program requirements.

172.000 PCP-Qualified Physicians and Single-Entity Providers 10-13-03

A. Physicians whose sole or primary specialty is among those listed below (except obstetrician/gynecologists) must enroll as ConnectCare primary care physicians (PCPs). Physicians with multiple specialties may elect to enroll as PCPs if a secondary or tertiary specialty in their Medicaid provider file is listed below.

1. Family Practitioner
2. General Practitioner
3. Internal Medicine
4. Obstetrician/gynecologist
5. Pediatrician

B. Certain clinics have been designated single-entity PCPs. Individuals enrolled with a single-entity PCP may see anyone at that clinic without a referral. Qualified single-entity PCP providers are listed below.

1. Area Health Education Centers (AHEC)
2. Federally Qualified Health Centers (FQHC)
3. Family practice and internal medicine clinics at the University of Arkansas Medical Sciences campus

173.000 Selecting and Enrolling with a PCP 10-13-03

A. Medicaid-eligible individuals, who are not exempt from ConnectCare PCP enrollment requirements, need PCP referrals to access many Medicaid-covered services. All newly eligible individuals are given opportunities to enroll. Those who do not enroll with a PCP at their first opportunity receive regular reminders from ConnectCare of the advantages of PCP enrollment. There are several ways to enroll.

B. An individual must select a PCP that is located near his or her residence. He or she may select a PCP in his or her county of residence, counties adjacent to the county of residence or counties that adjoin the counties adjacent to the county of residence. When the county of residence is an Arkansas county bordering another state, the individual may select a PCP in the state bordering the county of residence.

173.100 PCP Selection at Local County DHS Offices 10-13-03

The individual will receive information from the county office staff describing and explaining ConnectCare. An Arkansas Medicaid Primary Care Physician Managed Care Program Primary Care Physician Selection and Change Form (form DCO-2609) is completed for and signed by the recipient for each person included in the medical assistance. Each Medicaid person in a family may select the same physician or different physicians. The form is designed for three entries: an individual's first, second and third choices. When Medicaid or ARKids First-B eligibility is determined, a DHS worker uses a Web-based application or a telephonic voice response system to complete the PCP enrollment, beginning with the first choice. If the first PCP on a DCO-2609 form has a full caseload, the worker tries the second choice and so on. The county office forwards confirmation of the PCP enrollment to each new enrollee.

Individuals applying for ARKids First A and B indicate their preference for a primary care physician on the mail-in application, form DCO-995.

173.200 PCP Selection at PCP Offices and Clinics 10-13-03

Physician and single-entity PCPs may enroll Medicaid-eligibles by means of the telephonic voice response system (VRS). A selection and change form must be completed, dated and signed by the enrollee. The enrollee may request and receive a copy of the form.

Enrollees must document their PCP choice on the Primary Care Physician Selection and Change form (form DCO-2609). Enrolling the patient is performed by accessing the VRS and following the instructions. The PCP office must retain a copy of the form in the enrollee's file.
View or print Voice Response System (VRS) contact information.

When a PCP wants to enroll a patient but the PCP's Medicaid caseload is full, or a PCP wants to increase or decrease the caseload limit for any reason, the PCP may write Provider Enrollment to request the desired revision. Caseload limits may be raised or lowered by 10 or more slots per written request.

173.300 PCP Enrollment Through ConnectCare Helpline 10-13-03

Enrollment through the ConnectCare Helpline is simple and convenient. ConnectCare Helpline is a service performed by Medicaid Outreach and Education for ConnectCare and ARKids First-B.

ConnectCare staff is available for PCP enrollments and transfers 24 hours a day. The Helpline number is prominently displayed in ConnectCare publications, frequently in more than one place.
View or print ConnectCare contact information.

Helpline staff members help potential enrollees locate PCPs in their area. They also help non-English-speaking individuals locate PCP offices or clinics where they can communicate in their native language.

173.400 PCP Selection and Enrollment at Participating Hospitals 10-13-03

A. Most hospital services require PCP referral.

   1. Some hospital services do not require a referral but are covered only if the patient is enrolled with a PCP.

   2. Additionally, the referral requirement is waived for certain hospital services when the effective date of the PCP enrollment is one day before the date of service or the same as the date of service.

B. Arkansas Medicaid pays acute care hospitals for helping Medicaid beneficiaries enroll with PCPs.

   1. Enrollment is by means of the Selection and Change form, form DCO-2609, and the voice response system (VRS).

2. Hospital personnel enter the PCP selection via the VRS.
3. The enrollment is effective immediately upon its acceptance by the online transaction processor (OLTP) that interfaces with the VRS.
4. The OLTP automatically updates the Medicaid Management Information System (MMIS) within 24 hours, but in the meantime, the enrollment information is part of the Medicaid eligibility file in the system.
5. The date the enrollment is electronically accepted is the effective date of the PCP enrollment.
6. The enrollee may request and receive a copy of the completed selection form.
7. The hospital staff must forward a copy of the selection form to the PCP accepted by the VRS.

173.500 PCP Selection for Medicaid Beneficiaries with Supplemental Security Income (SSI) Benefits 10-13-03

Individuals that are eligible for Medicaid because they are Supplemental Security Income (SSI) beneficiaries do not have an opportunity to select a PCP when they apply for SSI, because SSI application is made in a federal government office.

When an SSI beneficiary's Medicaid eligibility determination is made, EDS generates a letter that describes ConnectCare. The letter lists the services that do not require PCP referral and the groups of individuals that are not required to enroll with PCPs. It explains how to select and enroll with a PCP and how to transfer from one PCP to another.

A Primary Care Physician Selection and Change form, DCO-2609, is enclosed in the mailing. SSI beneficiaries may enroll with PCPs by any of the methods used by other Medicaid eligibles.

174.000 Automated PCP Enrollment Verification 10-13-03

An enrollee's Medicaid electronic eligibility verification response includes the PCP's name and telephone number and the beginning date of the current enrollment period. If there is no current PCP listed on the eligibility response, the individual is not enrolled with a PCP. He or she should be referred to the ConnectCare Helpline for information and assistance. **View or print the ConnectCare Helpline contact information.** ConnectCare enrollees are responsible for any charges for services they receive without obtaining required referrals.

175.000 Transferring PCP Enrollment 10-13-03

175.100 PCP Transfers by Enrollee Request 10-13-03

ConnectCare enrollees may change PCPs at any time, for any stated reason.

PCP transfer for any reason may be done at the local county office in the enrollee's county of residence. Enrollees transferring PCP enrollment at their local county DHS office must request the transfer in person and in writing by means of form DCO-2609. DHS staff will enter the change in real time by VRS or a Web-based application. The enrollment is effective immediately.

Enrollees transferring their PCP enrollment because the arrangement is unacceptable to the enrollee or because the arrangement is unacceptable to the PCP must do so only at their local DHS county office. In such a case, the enrollee must state in writing that the arrangement with the PCP is unacceptable to him or her, or that he or she has been instructed in writing by the PCP to transfer his or her enrollment.

The ConnectCare Helpline is authorized to transfer a PCP enrollment by telephone for any stated reason except those that must go through a DHS county office. **View or print the ConnectCare Helpline contact information.**

175.200 PCP Transfers by PCP Request 10-13-03

Only DHS county offices are authorized to transfer an individual's enrollment when his or her PCP states that the arrangement with the enrollee is unacceptable. To transfer a patient's enrollment, a PCP must submit a written change request to the local county DHS office. The county office will send a Selection and Change form to the enrollee with instructions to make a new selection.

At least 30 days in advance of the effective date of the termination, the PCP must give the enrollee written notice that the enrollee's removal from the PCP's caseload has been requested. The notice must further state that the enrollee has 30 days to enroll with a different PCP. The PCP continues as the enrollee's primary care physician during the 30 days or until the enrollee transfers to another PCP, whichever comes first.

A PCP may request that a recipient transfer PCP enrollment because the arrangement with the recipient is not acceptable to the PCP. Examples of unacceptable arrangements include, but are not limited to:

A. The enrollee fails to appear for 2 or more appointments without contacting the PCP before the scheduled appointment time.

B. The recipient is abusive to the PCP.

C. The recipient does not comply with the PCP's medical instruction.

The PCP must request the transfer in writing, forwarding a copy to the enrollee and to the local DHS office in the recipient's county of residence.

175.300 PCP Enrollment Transfers Initiated by the State 10-13-03

A. The state may initiate PCP enrollment transfers whenever they are necessary. State-initiated enrollment transfers come about because DMS, in exercising its regulatory function, sometimes must sanction, suspend or terminate a provider. For instance, a provider may lose his or her PCP or Medicaid contract for:

1. Failure to meet PCP or Medicaid contractual obligations,
2. Proven and consistent excessive utilization or
3. Unnecessarily *limited* utilization of medically necessary services.

B. When the state terminates a physician's provider application (form DMS-652) or Medicaid contract (form DMS-653), DMS contacts the Medicaid beneficiaries on the physician's caseload with instructions for transferring their PCP enrollment.

C. Occasionally, the Division of Medical Services (DMS) must cancel a provider's Medicaid contract for legal reasons. When the terminated provider is a PCP, DMS contacts all the PCP's enrollees by mail with instructions for locating and enrolling with another PCP.

176.000 Services Not Requiring a Primary Care Physician Referral 10-13-03

Most non-physician services and most medical services that a PCP does not provide require PCP referrals. However, Medicaid beneficiaries may access some services without being referred by their PCP. The services listed below do not require a PCP referral.

A. Alternatives for Adults with Physical Disabilities (Alternatives Program) Waiver services.

B. Ambulance (emergency and non-emergency) services and non-emergency medical transportation.

C. Anesthesia services, except outpatient pain management.

D. Assessment in the emergency department of an acute care hospital (including the physician's assessment) to determine whether an emergency or non-emergency condition exists. The physician and facility assessment services are exempt from PCP referral requirements only if the Medicaid recipient is enrolled with a PCP.

E. DDS Alternative Community Services (ACS) Waiver services.

F. Dental services.

G. Developmental Day Treatment Clinic Services (DDTCS).

H. Disease control services for communicable diseases, including sexually transmitted diseases, human immunodeficiency virus (HIV), and acquired immune deficiency syndrome (AIDS). Medicaid imposes no PCP referral requirement on testing for and treatment of diseases that the Arkansas Department of Health requires practitioners to report to the Division of Epidemiology.

I. Domiciliary Care.

J. ElderChoices waiver services.

K. Emergency services in an acute care hospital emergency department, including emergency physician services.

L. Family Planning services.

M. Gynecological care.

N. Nursing facility services and intermediate care facility for mentally retarded (ICF/MR) services.

O. Obstetrical (antepartum, delivery and postpartum care) services. When a woman's obstetrician is not her PCP, she must obtain PCP referrals for her non-obstetrical, non-gynecological services. A woman's obstetrician or the PCP may order home health care for postpartum complications. The PCP must perform other medical services for a pregnant woman or refer her to an appropriate provider.

P. Pharmacy services.

Q. Physician services for inpatients in an acute care hospital. This includes direct patient care (initial and subsequent evaluation and management services, surgery, etc.) and indirect care (pathology, interpretation of X-rays, etc.).

R. Physician visits in the outpatient departments of acute care hospitals, when the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limits.

S. Professional components of diagnostic laboratory, radiology and machine tests in the outpatient departments of acute care hospitals. Medicaid covers these services without a PCP referral only if the Medicaid recipient is enrolled with a PCP and the services are within applicable benefit limitations.

T. Visual care services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye. Visual care services do not require PCP referral, whether performed by medical doctors or optometrists.

U. ConnectCare may waive the PCP referral requirement for other services not listed in this section if restricting access to them would create unnecessary hardship for Medicaid beneficiaries or providers. This category currently includes:

1. Critical care (physician critical care services).
2. Sexual abuse examinations.

177.000 PCP Referral Requirements for Medicaid Waiver Program Participants 10-13-03

Some participants become Medicaid eligible under the guidelines of the home and community based waiver programs and do not need a PCP referral for their waiver services. When accessing any other Medicaid services, participants in those waiver programs are subject to all ConnectCare requirements.

178.000 Primary Care Physician Participation 10-13-03

178.100 Mandatory PCP Enrollment 10-13-03

Only the physicians and clinics listed in Section 172.000 may qualify as PCPs. Physicians whose only specialty is emergency care or who practice exclusively in hospital emergency departments may not enroll as PCPs. Physicians practicing in PCP qualified specialties must enroll as PCPs. Obstetricians and gynecologists may choose whether to enroll as PCPs.

178.200 Additional Conditions of Participation 10-13-03

A. A federally qualified health center (FQHC) or a Medicaid-enrolled physician practicing in a PCP-qualified specialty is required to sign an agreement to participate as a screening provider in the Child Health Services (EPSDT) Program and an agreement to participate in ConnectCare as a primary care physician.

1. Internal medicine practitioners, obstetricians and gynecologists are exempt from mandatory Child Health Services (EPSDT) enrollment.
2. Area Health Education Centers (AHECs), and the family practice and internal medicine clinics at the University of Arkansas Medical Sciences campus, are the only physician group providers that may enroll as single-entity primary care physician providers.

B. A PCP must be physically located in Arkansas with the following exceptions:

1. The trade-area cities: Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff, Missouri; Poteau and Salisaw, Oklahoma; Memphis, Tennessee and Texarkana, Texas.
2. To help ensure adequate access to service, the state may enroll physicians in bordering state cities that are not trade-area cities. The state considers, on a case-by-case basis, requests by those physicians to participate in ConnectCare as PCPs.

C. A physician must have hospital admitting privileges in order to enroll as a PCP. The state may waive this requirement to help insure adequate access to services. On the primary care physician participation agreement, a physician may name a physician that has hospital admitting privileges and with whom he or she has an agreement by which they handle hospital admissions. A copy of the agreement must be submitted with the PCP agreement.

D. A physician whose only specialty is emergency care may not enroll as a PCP.

E. A PCP may not refuse to enroll and may not otherwise discriminate against, a beneficiary because of the individual's age, sex, race, national origin or type of illness or condition. A

PCP may refuse an enrollee if it is customary for a physician or if it is the practice of his or her specialty not to accept certain types of patients. For instance:

1. A pediatrician may refuse to enroll an individual aged 14 years or older.
2. An obstetrician/gynecologist may refuse to enroll a male.
3. An obstetrician/gynecologist may refuse to enroll a female under the age of 12.
4. A PCP whose specialty is internal medicine may refuse to enroll an individual 16 or younger.

F. A PCP must give an enrollee written notice, 30 days in advance of the effective date of termination, that the PCP has requested the enrollees removal from his or her caseload and that the enrollee must enroll with another PCP. The enrollee may remain on the PCP's caseload for 30 days.

G. A PCP must perform an examination and/or make necessary referral within 24 hours of contact by government officials in alleged or substantiated cases of abuse, neglect or severe maltreatment of a Medicaid-eligible individual and when the state has custody of a Medicaid-eligible individual.

H. A PCP must contact the Arkansas Department of Health Immunizations Data Entry Office to determine the immunization status and requirements of any Medicaid-eligible individual under the age of 21 for whom the PCP does not have this information. **View or print the Immunizations Data Entry Office contact information.**

I. A PCP must monitor and maintain the Child Health Services (EPSDT) screening periodicity for each of his or her enrollees under the age of 21. The date of the most recent EPSDT screens are displayed on electronic responses. Users select the screen types they want displayed. PCPs may refer enrollees to other providers for EPSDT screens. The screening providers must report the results to the referring PCPs. The PCPs are responsible for coordinating and monitoring subsequent referrals, treatment or testing.

179.000 PCP Caseload Requirements 10-13-03

Each PCP may establish his or her Medicaid caseload limit, from a minimum of 10 enrollees to a maximum of 1000. The state may permit higher maximum caseloads in areas the federal government has designated as medically underserved. The state may permit higher maximum caseloads for PCPs who so request because the limit would create a hardship on their practice. The state will not require any PCP to accept a caseload greater than the PCP's requested caseload maximum. A PCP may increase or decrease his or her maximum desired caseload by 10 or more slots at a time by submitting a signed request to the Division of Medical Services, Provider Enrollment Unit.

180.000 REQUIRED PCP SERVICES AND ACTIVITIES 10-13-03

A primary care physician (PCP) provides primary care physician services as well as these additional services:

A. Health education.

B. Assessment of each enrollee's medical condition, initiating and recommending treatment or therapy when needed.

C. Referrals to specialty physicians, hospital care and other medically necessary services.

D. Assistance with locating needed medical services.

E. Coordination of prescribed medical and rehabilitation services with other professionals.

F. Monitoring the enrollees' prescribed medical and rehabilitation services.

181.000 Access Requirements for Primary Care Physicians 10-13-03

A PCP must have hours of operation that are reasonable and adequate to serve his or her caseload. The office must be open to Medicaid enrollees **during the same hours and for the same number of hours as it is for self-pay and insured patients.**

ConnectCare enrollees must have the same access as private pay and insured persons to emergency and non-emergency medical services. A PCP must make available 24-hour, 7 days per week telephone access to a live voice (an employee of the primary care physician or an answering service) or to an answering machine that will immediately page an on-call medical professional. The on-call professional will provide information and instructions for treating emergency and non-emergency conditions, make appropriate referrals for non-emergency services and provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed. Response to after-hours calls regarding non-emergencies must be within 30 minutes.

All PCPs are subject to the same access requirements. However, ConnectCare recognizes that there are insufficient physicians available in some areas to provide 24-hour "on-call" coverage, limiting alternative means of access to after-hours care. PCPs in under-served and sparsely populated areas may refer their patients to the nearest facility available, but enrollees must be able to obtain the necessary instructions by telephone. PCPs must make the telephone number as widely available as possible to their patients. When employing an answering machine with recorded instructions for after-hours callers, they should regularly check to ensure that the machine functions correctly and that the instructions are up to date.

In areas where physicians customarily rotate call, PCPs are required to provide the same level of service for their ConnectCare enrollees.

Physicians and facilities treating a PCP's enrollees after hours must report diagnosis, treatment, significant findings, recommendations and any other pertinent information to the PCP, for inclusion in the patient's medical record.

PCPs are not allowed to refer ConnectCare enrollees to emergency departments for non-emergency conditions during the PCP's regular office hours.

182.000 PCP Referrals 10-13-03

PCPs may make only medically necessary referrals. ConnectCare enrollees must obtain Medicaid covered services, except for the services listed in Section 176.000 from their PCP or by referrals from their PCP to other providers.

A PCP may not restrict an enrollee's right to choose which provider he or she may see for a PCP-referred service. A PCP may refer an enrollee to a specific provider by name only if the PCP allows the enrollee free choice by naming two or more providers of the same type or specialty.

PCP enrollees are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in Section 176.000.

PCPs are not required to make retroactive referrals.

PCPs are responsible for coordinating and monitoring all medical and rehabilitative services received by their enrollees. Therefore, they must accept co-responsibility for the ongoing care of patients they refer to other professionals.

Services requiring PCP referrals may not begin until the PCP makes the referral. PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. There is no limit on the number of

times a referral may be renewed, but renewals must be medically necessary and at least every six months. It is left to a PCP's judgment whether it is necessary to see a patient before making or renewing a referral.

182.100 Referral Form (DMS-2610) 10-13-03

Medicaid provides an optional referral form, the DMS-2610, which the PCP may use to facilitate referrals. **View or print form DMS-2610.** PCP referrals may also be oral, by note or by letter. Medicaid requires documentation of the referral in the enrollee's medical record, regardless of the means by which the PCP makes the referral. Medicaid also requires the documentation of the referral by the provider to whom the referral is made. Providers of referred services must correspond with the PCP as necessary to coordinate patient care and as requested by the PCP.

182.200 PCP Substitutes 10-13-03

182.210 PCP Substitutes; General Requirements 10-13-03

Medicaid permits physicians to substitute for PCPs in some situations. In addition to the requirements found in the Physicians/Independent Lab/CRNA/Radiation Therapy Center provider manual, the following requirements apply to all PCP substitutions *by physicians*.

A. The PCP and the substitute physician must document the substitution in the patient's record(s) as a referral, and include the specific reason for the substitution.

B. The substitute physician must provide the PCP's name and provider number to any other service provider to whom he or she refers the patient.

C. The substitute physician need not be a PCP.

182.220 PCP Substitutes; Rural Health Clinics and Physician Group Practices 10-13-03

Physicians affiliated with a rural health clinic or enrolled in a Medicaid-enrolled physician group may substitute for an enrollee's PCP when the PCP is unavailable.

Acceptable reasons for a PCP not to be available are: the PCP's schedule is full because of an unusual number of urgent or time-consuming cases; enrollees require services outside the PCP's normal working hours; or the PCP is ill, on vacation or other leave of absence or in surgery.

Habitual over scheduling of patients is not an acceptable reason for a PCP's use of a substitute. PCPs and substitutes must document each substitution as a PCP referral.

182.230 PCP Substitutes; Individual Practitioners 10-13-03

A PCP that is an individual practitioner must designate a substitute physician to take telephone calls, see enrollees and make appropriate referrals when the PCP is unavailable.

Acceptable reasons for a PCP not to be available are: enrollees require services outside the PCP's normal working hours; or the PCP is ill, on vacation or other leave of absence or in surgery.

Habitual over scheduling or having too great a caseload are not acceptable reasons for a PCPs use of a substitute. PCPs and substitutes must document each substitution as a PCP referral.

182.240 Nurse Practitioners and Physician Assistants in Rural Health Clinics 10-13-03

Licensed nurse practitioners or licensed physician assistants employed by a Medicaid-enrolled rural health clinic (RHC) provider may not function as PCP substitutes. However, they may provide primary care for the PCP recipients, with certain restrictions.

A. The PCP affiliated with the RHC must issue a standing referral for primary care services furnished by nurse practitioners and physician assistants in or on behalf of the RHC.

B. Nurse practitioners and physician assistants may not make referrals for medical services except for pharmacy services per established protocol.

C. The PCP must maintain a supervisory relationship with the nurse practitioners and physician assistants.

183.000 Primary Care Physician Case Management Fee 10-13-03

PCP reimbursement for physician services is on a fee for service basis. Additionally, Medicaid pays a monthly, per enrollee case management fee. The amount due for each month is determined by multiplying the established fee by the number of enrollees on the last day of the month. Medicaid pays case management fees quarterly, in October, January, April and July. An accompanying Medicaid Remittance and Status Report itemizes the payments, number of enrollee and enrollment month. Enrollees are listed alphabetically with their Medicaid identification numbers and addresses included.

SECTION III - BILLING DOCUMENTATION

CONTENTS

300.000 GENERAL INFORMATION 10-13-03

301.000 Introduction 10-13-03

The purpose of Section III of the Arkansas Medicaid Manual is to explain the general procedures for billing in the Arkansas Medicaid Program.

Two major areas are covered in this section:

A. General Information: This section contains information about electronic options, timely filing of claims, claim inquiries and supply procedures.

B. Financial Information: This section contains information on the paper Remittance and Status Report, or Remittance Advice (RA), adjustments, refunds and additional payment sources.

301.100 Electronic Claims Submission 10-13-03

EDS furnishes software and X.12/NCPDP companion documents at no charge to the provider for all transactions utilized by Arkansas Medicaid.

When submitting claims electronically, Medicaid providers use the following claim types: ASC X.12N 4010A 837P (professional), 837I (institutional and long-term care), 837D (dental), NCPDP 5.1/1.1 (pharmacy). Your provider type is determined by the last two digits of your Arkansas Medicaid provider ID. For example, the provider type of a hospital with the Arkansas Medicaid provider ID 123456705 is 05.

The following provider types can bill on an 837P:

01	02	03	04	05	08	09	10	15	16
17	18	19	20	21	22	23	24	26	27
28	29	30	31	32	33	34	35	37	38
39	40	41	42	43	44	45	46	48	49
50	51	52	53	54	55	56	57	58	59
60	61	62	63	65	66	67	68	69	70
71	72	73	74	75	76	77	78	79	80
81	82	83	84	85	86	87	88	89	90

91	92	93	94	95	96	97	98	99	

The following provider types can bill on an 837I:

05	11	12	13	14	15	21	25	26	27
28	29	36	41	42	47	64	99		

The following provider types can bill on an 837D:

08	30	31	79	80

The following provider types can bill on an NCPDP:

07	16

EDS processes each week's accumulations of claims during a weekend cycle. The deadline for each weekend cycle is midnight Friday.

Providers submitting claims electronically must maintain a daily electronic claim transaction summary, signed by an authorized individual. Please refer to the Provider Contract (Form DMS-653), Item "K." **View or print form DMS-653.**

301.105 Replacement of Types of Service With Modifiers For Electronic Billing

10-13-03

Effective October 13, 2003, electronic claims may require modifiers in addition to local codes and National Standard Codes. The following table shows all modifiers associated with each provider type, based on the type of service being rendered. Your provider type is determined by the last two digits of your Arkansas Medicaid provider ID. For example, the provider type of a hospital with the Arkansas Medicaid provider ID 123456705 is 05.

Provider Type Code	Provider type	Modifier	Description	Former Type of Service Code
01	Physician, MD	EP	Service provided as part of Medicaid EPSDT program	6
		FP	Service provided as part of Medicaid Family Planning Program	A
		26	Professional component, lab and X-ray procedures	P
		TC	Technical component, lab and X-ray procedures	T
		80	Assistant surgeon	8
		81	Minimum assistant surgeon	
		82	Assistant surgeon (when qualified resident surgeon not available)	

Provider Type Code	Provider type	Modifier	Description	Former Type of Service Code
		U6	Use both FP and U6 for family planning services formerly submitted with type of service J	J
		U9	For telemedicine procedure codes.	V, Z
03	Physician, DO	EP	Service provided as part of Medicaid EPSDT program	6
		FP	Service provided as part of Medicaid Family Planning Program	A
		26	Professional component, lab and X-ray procedures	P
		TC	Technical component, lab and X-ray procedures	T
		80	Assistant surgeon	8
		81	Minimum assistant surgeon	
		82	Assistant surgeon (when qualified resident surgeon not available)	
		U6	Use both FP and U6 for family planning services formerly submitted with type of service J	J
		U9	For telemedicine procedure codes.	V, Z
09	Independent Laboratory	FP	Service provided as part of Medicaid Family Planning Program	A
		26	Professional component, lab and X-ray procedures	P
		TC	Technical component, lab and X-ray procedures	T
10	Independent Radiology	26	Professional component, lab and X-ray procedures	P
		TC	Technical component, lab and X-ray procedures	T
14	Home Health	EP	Service provided as part of Medicaid EPSDT program	6
15	Transportation	None		
16	Prosthetics	NU	New equipment, prosthetics and DME	H
		UE	Used durable medical equipment	U

Provider Type Code	Provider type	Modifier	Description	Former Type of Service Code
		EP	Service provided as part of Medicaid EPSDT program	6
17	Podiatrist	None		
18	Chiropractor	None		
19	Psychology	EP	Service provided as part of Medicaid EPSDT program	6
20	Hearing	EP	Service provided as part of Medicaid EPSDT program	6
		26	Professional component, lab and X-ray procedures	P
		TC	Technical component, lab and X-ray procedures	T
21	Therapy	EP	Service provided as part of Medicaid EPSDT program	6
22	Optometrist/ Optician	EP	Service provided as part of Medicaid EPSDT program	6
23	Optical Dispensing Contractor	80	Assistant surgeon	8
		81	Minimum assistant surgeon	
		82	Assistant surgeon (when qualified resident surgeon not available)	
		TC	Technical component, lab and X-ray procedures	T
24	Clinics	EP	Service provided as part of Medicaid EPSDT program	6
25	Psychiatric Facility--Inpatient	None		
26	Rehabilitation Center	HA	Child/adolescent program (RSPMI procedures for patients under 21 years of age)	9
27	Day Care Facility	None		
28	Ambulatory Surgical Center	EP	Service provided as part of Medicaid EPSDT program	6
		26	Professional component, lab and X-ray procedures	P
		TC	Technical component, lab and X-ray procedures	T
29	Rural Health Clinic	EP	Service provided as part of Medicaid EPSDT program	6
30	Health Department	EP	Service provided as part of Medicaid EPSDT program	6

Provider Type Code	Provider type	Modifier	Description	Former Type of Service Code
		FP	Service provided as part of Medicaid Family Planning Program	A
		26	Professional component, lab and X-ray procedures	P
		TC	Technical component, lab and X-ray procedures	T
		80	Assistant surgeon	8
		81	Minimum assistant surgeon	
		82	Assistant surgeon (when qualified resident surgeon not available)	
31	Dental Group	None		
32	Personal Care	None		
33	Hyperalimentation	None		
34	Hemodialysis	None		
35	Family Planning	FP	Service provided as part of Medicaid Family Planning Program	A
		TC	Technical component, lab and X-ray procedures	T
		80	Assistant surgeon	8
		81	Minimum assistant surgeon	
		82	Assistant surgeon (when qualified resident surgeon not available)	
37	Ventilator Equipment	FP	Service provided as part of Medicaid Family Planning Program	A
38	Private Duty Nursing	None		
39	DDS Waiver—Community Services	None		
40	DDS Waiver—Case Management	None		
41	Medicare/ Medicaid Crossovers	None		
42	Therapy—Regular Group	None		
43	Therapy School District/Education	EP	Service provided as part of Medicaid EPSDT program	6

Provider Type Code	Provider type	Modifier	Description	Former Type of Service Code
	Service Cooperative Special			
45	School-Based Child Health Service Clinic	None		
46	Targeted Case Management	None		
47	Hospice	None		
48	Podiatry Group	None		
49	FQHC	None		
50	ElderChoices—Chore Services	None		
51	ElderChoices—Adult Foster Care	None		
52	ElderChoices—Homemaker	None		
53	ElderChoices—Home Delivered Meals	None		
54	ElderChoices—Personal Emergency Response Systems	None		
55	ElderChoices—Adult Day Care	None		
56	ElderChoices—Adult Day Health Care	None		
57	ElderChoices—Respite Care	None		
58	Nurse Practitioner	EP	Service provided as part of Medicaid EPSDT program	6
		FP	Service provided as part of Medicaid Family Planning Program	A
60	School Based—Vision Screener	None		
61	School Based—Vision And Hearing Screener	None		
62	Nurse Practitioner Group	None		

Provider Type Code	Provider type	Modifier	Description	Former Type of Service Code
63	Targeted Case Management Group, U21—EPSDT	None		
64	Hospice Physician Group	None		
65	TCM Organization/ Facility	None		
66	Hearing Aids	None		
67	ACS Waiver Integrated Supports	None		
68	Managed Care—Individual Resident	EP	Service provided as part of Medicaid EPSDT program	6
		FP	Service provided as part of Medicaid Family Planning Program	A
		26	Professional component, lab and X-ray procedures	P
		TC	Technical component, lab and X-ray procedures	T
		80	Assistant surgeon	8
		81	Minimum assistant surgeon	
		82	Assistant surgeon (when qualified resident surgeon not available)	
		U6	Use both FP and U6 for family planning services formerly submitted with type of service J	J
		U9	For telemedicine procedure codes.	V, Z
69	Managed Care—Resident Group	FP	Service provided as part of Medicaid Family Planning Program	A
70	ACS Waiver Crisis Abatement	None		
71	ACS Waiver Consultation Service	None		
72	ACS Waiver Environmental Modifications/ Physical Adaptations	None		

Provider Type Code	Provider type	Modifier	Description	Former Type of Service Code
73	ACS Waiver Specialized Medical Supplies	None		
74	ACS Waiver Case Management Services	None		
75	ACS Waiver Supported Employment	None		
76	TCM/CMS	None		
77	TCM/DCFS	None		
78	Developmental Rehabilitation Services	None		
79	Oral Surgeon, Individual	EP	Service provided as part of Medicaid EPSDT program	6
		26	Professional component, lab and X-ray procedures	P
		TC	Technical component, lab and X-ray procedures	T
		80	Assistant surgeon	8
		81	Minimum assistant surgeon	
		82	Assistant surgeon (when qualified resident surgeon not available)	
80	Oral Surgeon, Group	None		
81	AHEC/UAMS PCP Group	None		
82	DDS—Organized Health Care Delivery System	None		
83	APD Attendant Care	None		
84	APD Environmental Adaptations	None		
85	ACS Waiver Crisis Center/ Intervention Services	None		
86	DDS non-Medicaid	None		
87	Independent Choices	None		

Provider Type Code	Provider type	Modifier	Description	Former Type of Service Code
88	DYS/TCM Organization And Rehabilitative Services For Youth And Children Organization	None		
89	DYS/TCM Organization And Rehabilitative Services For Youth And Children Performing	None		
90	Children's Medical Services/ Respite Care	None		
91	School Based Mental Health	None		
92	School District Outreach For ARKids	None		
94	Assisted Living	None		
99	Benefit Arkansas and Other	EP	Service provided as part of Medicaid EPSDT program	6
		SB	Nurse midwife	9
		FP	Service provided as part of Medicaid Family Planning Program	A

301.110 Provider Electronic Solutions (PES) Application Software 10-13-03

Provider Electronic Solutions (PES) Application software is available at no cost to any provider who submits Medicaid claims. PES supports submission of claims in a batch mode only. The software requires, at a minimum, a Pentium II processor with 64 MB RAM, a 28.8 kb/s (or greater) modem, 100 MB free space, a CD-ROM drive, a monitor with 800 x 600 resolution, and Windows 98/2000/XP. Claims can be transmitted for processing by almost any modem, with the exception of "Win voice" modems. The software supports all claim types. In addition to submitting claims, providers can also view claim responses using the PES software. Instructions for using the PES application software are available by using the application's Help feature.

301.120 Web Application 10-13-03

Providers with PCs can now submit claims via the Web using an internet browser such as Internet Explorer (minimum 5.0) or Netscape Navigator (minimum 6.0). All claim types can be submitted via the Web, including long-term care census. Claims can only be submitted interactively (one at a time). Access this site via the Arkansas Medicaid Web site at **http://www.medicaid.state.ar.us/**.

Instructions for submitting claims and verifying eligibility via the Web are available by using the site's online Help feature.

301.130 Vendor Systems 10-13-03

Providers who have office management systems can opt to have their vendors upgrade their systems to support online transactions. EDS provides X.12 companion guides to interested vendors. The cost of upgrading the provider's system to support online transactions is the responsibility of the provider.

301.200 Electronic Transactions 10-13-03

With the implementation of the new Health Insurance Portability and Accountability Act (HIPAA) regulations, EDS offers a variety of transactions to improve providers' access to information. These transactions are available for submission through multiple means.

301.210 Eligibility Verification 10-13-03

Providers can check a recipient's eligibility through the PES software or via the Web. Eligibility requests can be submitted through PES in a batch or interactive (one at a time) mode. Eligibility requests can be submitted interactively (one at a time) via the Web. Instructions for verifying eligibility via the Web are available by using the site's online Help feature. Instructions for using the PES software are available by using the application's Help feature.

Providers with vendor systems can also verify eligibility by utilizing the ASC X.12 4010A 270/271 transactions with the appropriate X.12 companion guide.

301.220 Claim Status Inquiry 10-13-03

Providers can check the status of one or more claims through the PES software or via the Web. Claim status requests can be submitted through PES in a batch mode. Claim status requests can be submitted interactively (one at a time) via the Web. Instructions for checking a claim status via the web are available by using the site's online Help feature. Instructions for checking a claim status using the PES software are available using the application's help feature.

The claim status feature will only be available for claims submitted after October 12, 2003.

Providers with vendor systems can also check a claim's status by utilizing the ASC X.12 4010A 276/277 transactions with the appropriate X.12 companion guide.

301.230 Electronic Remittance Advices 10-13-03

Providers can retrieve their electronic remittance advices through the PES software. Because the HIPAA standard for remittance advices does not support the reporting of pended claim information, this information will be available using a separate screen within the PES software. Instructions for retrieving a remittance advice and pended claim information using the PES software are available using the application's Help feature.

Providers with vendor systems can also receive remittance advices by utilizing the ASC X.12 4010A 835 transaction with the appropriate X.12 companion guide.

Because the ASC X.12 835 does not support the reporting of pended claim information, EDS will create a separate ASC X.12 4010A 277 transaction that will accompany the ASC X.12 4010A 835 transaction.

301.240 Prior Authorization Request 10-13-03

With the implementation of the new HIPAA regulations, providers can submit electronic prior authorization requests through the PES software in a batch mode. PES supports electronic

submission of CMS, DDS, Benefit Extensions, Hyperalimenation, Personal Care, Home Health, Dental, DME, Hearing and Vision prior authorization requests. Providers can retrieve prior authorization determinations through PES. Timeframes for prior authorization determinations are dependent upon the guidelines established by the reviewing department. Instructions for submitting prior authorization requests and retrieving determinations using the PES software are available by using the application's Help feature.

The prior authorization feature will only be available for requests submitted after October 12, 2003.

Providers with vendor systems can also submit prior authorization requests and retrieve determinations by utilizing the ASC X.12 4010A 278 transaction with the appropriate X.12 companion guide.

301.250 National Council for Prescription Drug Programs (NCPDP) Eligibility Verification 10-13-03

Pharmacy providers can check a recipient's eligibility via the Web. Eligibility requests can be submitted through the Web in an interactive (one at a time) mode. Instructions for verifying eligibility via the Web are available by using the site's online Help feature.

Providers with vendor systems can also verify eligibility by utilizing the NCPDP 5.1 eligibility transaction with the appropriate companion guide.

301.260 NCPDP Reversal 10-13-03

Pharmacy providers can reverse a pharmacy claim with dates of service within one year through the PES software or via the Web. Reversals can be submitted in an interactive (one at a time) mode. Instructions for submitting reversals via the Web are available using the site's online Help feature. Instructions for using the PES application software are available by using the application's Help feature.

Providers with vendor systems can also submit reversals using the NCPDP 5.1 transaction with the appropriate companion guide.

301.300 Contacts 10-13-03

EDS maintains a Provider Assistance Center (PAC) to assist Medicaid providers during regular business hours from 8:00 a.m. to 4:30 p.m. Central Standard Time. **View or print EDS PAC contact information.**

EDS has a staff of representatives available during regular business hours from 8:00 a.m. to 4:30 p.m. to assist with any needs concerning electronic solutions. **View or print EDS PAC contact information.**

EDS has a full-time staff of Provider Representatives available for consultation regarding billing problems that cannot be resolved through the Provider Assistance Center. Provider Representatives are also available to visit providers' offices to provide training on billing.

302.000 Timely Filing 10-13-03

The Code of Federal Regulations (42 CFR), at 447.45 (d) (1), states "The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service." The 12-month filing deadline applies to all claims, including:

A. Claims for services provided to recipients with joint Medicare/Medicaid eligibility.

B. Adjustment requests and resubmissions of claims previously considered.

C. Claims for services provided to individuals who acquire Medicaid eligibility retroactively.

There are no exceptions to the 12-month filing deadline policy. However, the definitions and additional federal regulations in the next section will permit some flexibility for those who adhere closely to them.

302.100 Medicare/Medicaid Crossover Claims 10-13-03

Federal regulations dictate that providers must file the Medicaid portion of claims for dually eligible beneficiaries within 12 months of the beginning date of service. The Medicare claim will establish timely filing for Medicaid, if the provider files with Medicare during the 12-month Medicaid filing deadline. Medicaid may then consider payment of a Medicare deductible and/or coinsurance, even if the Medicare intermediary or carrier crosses the claim to Medicaid after more than a year has passed since the date of service. Medicaid may also consider such a claim for payment if Medicare notifies only the provider and does not electronically forward the claim to Medicaid. Federal regulations permit Medicaid to pay its portion of the claim within 6 months after the Medicaid "agency or the provider receives notice of the disposition of the Medicare claim."

Providers may not electronically transmit to EDS any claims for dates of service over 12 months in the past. To submit a Medicare/Medicaid crossover claim meeting the timely filing conditions in the first paragraph above, please refer to *Patients With Joint Medicare/Medicaid Coverage*, Section 332.000 of this manual. In addition to following the billing procedures explained in Section 332.000, enclose a signed cover memo or Medicaid Claim Inquiry Form requesting payment for the Medicaid portion of a Medicare claim filed to Medicare within 12 months of the date of service and that Medicare adjudicated more than 12 months after the date of service.

302.200 Clean Claims and New Claims 10-13-03

The definitions of the terms *clean claim* and *new claim* help to determine which claims and adjustments Medicaid may consider for payment when more than 12 months have passed since the beginning date of service.

42 CFR, at 447.45 (b), defines a clean claim as a claim that Medicaid can process "...without obtaining additional information from the provider of the service or from a third party." The definition "...includes a claim with errors originating in a State's claims system."

A claim that denies for omitted or incorrect data or for missing attachments is <u>not</u> a clean claim. A claim filed more than 12 months after the beginning date of service is not a clean claim, except under the special circumstances described below.

A new claim is a claim that is unique, differing from all other claims in at least one material fact. It is very important to note that identical claims received by Medicaid on different days differ in the material fact of their receipt date and are both new claims unless defined otherwise in the next paragraph.

302.300 Claims Paid or Denied Incorrectly 10-13-03

Sometimes a clean claim pays incorrectly or denies incorrectly. When a provider files an adjustment request for such a claim, or refiles the claim after 12 months have passed from the beginning date of service, the submission is not necessarily a new claim. The adjustment or claim may be within the filing deadline. For Medicaid to consider that the submission is not a new claim and therefore within the filing deadline, the adjustment or claim must meet two requirements:

A. The only material fact that differs between the two filings is the claim receipt date, because the Medicaid agency or its fiscal agent processed the initial claim incorrectly *and*

B. The provider includes documentation that the Medicaid agency or fiscal agent error prevented resubmittal within the 12-month filing deadline.

302.400 Claims With Retroactive Eligibility 10-13-03

Retroactive eligibility does not constitute an exception to the filing deadline policy. If an appeal or other administrative action delays an eligibility determination, the provider must submit the claim within the 12-month filing deadline. If the claim is denied for recipient ineligibility, the provider may resubmit the claim when the patient becomes eligible for the retroactive date(s) of service. Medicaid may then consider the claim for payment because the provider submitted the initial claim within the 12-month filing deadline and the denial was not the result of an error by the provider.

To submit a claim for services rendered to a patient who is not yet eligible for Medicaid enter, on the claim form or on the electronic format, a pseudo Medicaid recipient identification number, 9999999999. Medicaid will deny the claim. Retain the denial or rejection for proof of timely filing if eligibility determination occurs more than 12 months after the date of service.

Occasionally the state Medicaid agency or a federal agency, such as the Social Security Administration, is unable to complete a Medicaid eligibility determination in time for service providers to file timely claims. Arkansas Medicaid's claims processing system is unable to accept a claim for services rendered to an ineligible individual or to suspend that claim until the individual is retroactively eligible for the claim dates of service. To resolve this dilemma, Arkansas Medicaid considers the pseudo recipient identification number 9999999999 to represent an "...error originating within (the) State's claims system." Therefore, a claim containing that number is a clean claim if it contains all other information necessary for correct processing. By defining the initial claim as a clean claim denied by processing error, we may allow the provider to refile the claim when the government agency completes the eligibility determination. With the claim, the provider must submit proof of the initial filing and a letter or other documentation sufficient to explain that administrative processes (such as determination of SSI eligibility) prevented the resubmittal before the filing deadline.

302.500 Submitting Adjustments and Resubmitting Claims 10-13-03

When it is necessary to submit an adjustment or resubmit a claim to Medicaid after 12 months have passed since the beginning date of service, the procedures below must be followed.

302.510 Adjustments 10-13-03

If the fiscal agent has incorrectly paid a clean claim and the error has made it impossible to adjust the payment before 12 months have passed since the beginning date of service, a completed Adjustment Request Form (EDS-AR-004) must be submitted to the address specified on the form. Attach the documentation necessary to explain why the error has prevented refiling the claim until more than 12 months have passed after the beginning date of service. **View or print form EDS-AR-004 and instructions for completion.**

302.520 Claims Denied Incorrectly 10-13-03

Submit a paper claim to the address below, attaching:

A. A copy of the Remittance and Status Report or Remittance Advice (RA) page that documents a denial within 12 months after the beginning date of service, *or*

B. A copy of the error response to an electronic transmission, **computer-dated** within twelve (12) months after the beginning date of service and

C. Additional documentation to prove that the denial or rejection was due to the error of the Division of Medical Services or the fiscal agent. Explain why the error has prevented refiling the claim until more than 12 months have passed after the beginning date of service.

Send these materials to the Provider Assistance Center (PAC). **View or print PAC contact information.**

302.530 Claims Involving Retroactive Eligibility 10-13-03

Submit a paper claim to the address below, attaching:

A. A copy of the Remittance and Status Report page, or Remittance Advice (RA) page, documenting a denial of the claim with 9999999999 as the Medicaid recipient identification number, dated within 12 months after the beginning date of service, *or*

B. A copy of the error response to an electronic transmission of the claim with 9999999999 as the Medicaid recipient identification number, the error response **computer-dated** within 12 months after the beginning date of service *and*

C. Any additional documentation necessary to explain why the error has prevented refiling the claim until more than 12 months have passed after the beginning date of service.

Send these materials to the Provider Assistance Center (PAC). **View or print PAC contact information.**

302.600 ClaimCheck® Enhancement 10-13-03

To solve some of the billing problems associated with differing interpretations of procedure code descriptions, EDS implemented the ClaimCheck® enhancement to the Arkansas Medicaid Management Information System (MMIS). This software analyzes procedure codes and compares them to nationally accepted published standards to recommend more accurate billing. If you think your claim was paid incorrectly, see Section 320.000 for information about how to use the Adjustment Request Form. If you think your claim was denied incorrectly, contact the Provider Assistance Center (PAC).

ClaimCheck® developers based the software's edits on the guidelines contained in the *Physicians' Current Procedural Terminology* (CPT) book, and Arkansas Medicaid customized the software for local policy and procedure codes. Please note that ClaimCheck® implementation does not affect Medicaid policy.

If there are other questions regarding the function of ClaimCheck® edits, contact the Provider Assistance Center (PAC). **View or print PAC contact information.**

303.000 Claim Inquiries 10-13-03

The Arkansas Medicaid Program distributes a weekly Remittance and Status Report, or Remittance Advice (RA), to each provider with claims paid, denied or pending, as of the previous weekend processing cycle. (Sections 310.000 through 314.800 of this manual contain a complete explanation of the paper RA.) Use the RA to verify claim receipt and to track claims through the system. Claims transmitted electronically will appear on the RA within two weeks of transmission. Paper claims and adjustments may take as long as six weeks to appear on the RA.

If a claim does not appear on the RA within the amount of time appropriate for its method of submission, contact the EDS Provider Assistance Center (PAC). **View or print PAC contact information.** A Provider Assistance Center representative can explain what system activity, if any, regarding the submission has occurred since EDS printed and mailed the last RA. If the transaction on the RA cannot be understood or is in error, the representative can explain its status and suggest remedies when appropriate. If there is no record of the transaction, the representative will suggest that the claim be resubmitted.

A provider can also perform a claim status inquiry via the Web or the PES software, as described in Section 301.220.

303.100 Claim Inquiry Form 10-13-03

When a written response to a claim inquiry is preferred, use the Medicaid Claim Inquiry Form, EDS-CI-003, provided by EDS. **View or print form EDS-CI-003.** A separate form for each claim in question must be used. EDS is required to respond in writing only if they can determine the nature of the questions. The Medicaid Claim Inquiry Form is for use in locating a claim transaction and understanding its disposition. If help is needed with an incorrect claim payment, refer to Section 320.000 of this manual for the Adjustment Request Form (EDS-AR-004) and information regarding adjustments. **View or print form EDS-AR-004 and instructions for completion.**

303.200 Completion of the Claim Inquiry Form 10-13-03

To inquire about a claim, providers must complete the following items on the Medicaid Claim Inquiry Form (EDS-CI-003). In order for your inquiry to be answered as quickly and accurately as possible, please follow these instructions:

A. Submit one Medicaid Claim Inquiry Form (EDS-CI-003) for each claim inquiry.

B. Include supporting documents for your inquiry. (Use claim copies, electronic transaction printouts, RA copies and/or medical documents as appropriate.)

C. Provide as much information as possible in Field 9. This information makes it possible to identify the specific problem in question and to answer your inquiry.

View or print form EDS-CI-003 and instructions for completion.

304.000 Supply Procedures 10-13-03

304.100 Ordering Forms from EDS 10-13-03

To order EDS-supplied forms, please use the Medicaid Form Request (EDS-MFR-001). **View or print form EDS-MFR-001.** **View or print a list of EDS-supplied forms.** Complete the Medicaid Form Request and indicate the quantity needed for each form. Send these materials to the Provider Assistance Center (PAC). **View or print PAC contact information.**

The Medicaid Program does not provide copies of the CMS-1500 (formerly HCFA-1500) claim form. The provider may request a supply of this claim form from any available vendor. **View a CMS-1500 sample form.**

The Medicaid Program does not provide copies of the CMS-1450 (formerly UB-92) claim form. The provider may request a copy of this claim form from any available vendor. **View a CMS-1450 sample form.**

An available vendor is the U.S. Government Printing Office. Orders may be submitted to the U.S. Government Printing Office via phone, fax, letter, e-mail or the Internet. **View or print the U.S. Government Printing Office contact information.** EDS requires the use of red-ink (sensor coded) CMS-1500 (formerly HCFA-1500) claim originals instead of copies. A new processing system uses scanners to distinguish between red ink of the form fields and blue or black ink claim data (provider number, Recipient Identification Number (RID), procedure codes, etc.).

310.000 PAPER REMITTANCE AND STATUS REPORT 10-13-03

311.000 Introduction of Remittance and Status Report 10-13-03

The Remittance and Status Report, or Remittance Advice (RA), is a computer-generated paper document that reports the status and payment breakdown of all claims submitted to Medicaid for processing. It is designed to simplify provider accounting by facilitating reconciliation of claim and payment records.

An RA is generated and mailed each week a provider has claims paid, denied or in process. Once a week, all claims completed in a daily cycle are processed through the financial cycle. The RA is produced at the time checks are issued. The RA explains the provider's payment on a claim-by-claim basis. Only providers who have finalized claims or claims in process (claims that have been through at least one financial cycle) will receive an RA.

Since the RA is a provider's only record of paid and denied claims, it is necessary for the provider to retain all copies of the RAs.

311.100 Electronic Funds Transfer (EFT) 10-13-03

Electronic Funds Transfer (EFT) allows providers to have their Medicaid payments automatically deposited instead of receiving a check. See Section I of the provider manual for an enrollment form and additional information.

312.000 Purpose of the RA 10-13-03

The RA is a status report of active claims. It is the first source of reference to resolve questions regarding a claim. If the RA does not resolve the question, it may be necessary to contact the EDS Provider Assistance Center (PAC). PAC will need the claim number from the RA to research the question. **View or print the PAC contact information.**

If a claim does not appear on the RA within six weeks after submission, contact PAC. If PAC can find no record of the claim, the representative will suggest resubmitting it.

313.000 Segments of the RA 10-13-03

There are nine main segments of an RA:

Report Heading

Paid Claims

Denied Claims

Adjusted Claims

Claims In Process

Financial Items

Electronic Transactions

Claims Payment Summary

HEOB Codes/Messages

313.100 Remittance Advice Descriptions and Samples 10-13-03

The printed column headings at the top of each example page and the numbered field headings are described to help in reading the RA.

View or print Remittance Advice samples for the following provider types: **Dental**, **Institutional**, **Pharmacy** or **Professional**.

View or print Remittance Advice field names and descriptions for the following provider types: **Dental**, **Institutional**, **Pharmacy** or **Professional**.

314.000 Explanation of the Remittance and Status Report 10-13-03

There are four different types of remittance and status reports: Institutional, Professional, Pharmacy and Dental. The remittance advice a provider receives will depend upon the claim types submitted. Each remittance type contains the same categories of information. These categories are described in the following subsections. Detailed descriptions of each remittance type, as well as samples of each type, are located in Section 313.100.

314.100 Report Heading 10-13-03

This section contains provider information and any remittance advice messages.

314.200 Paid Claims 10-13-03

This section shows the claims that have been paid, or partially paid, since the previous checkwrite.

314.300 Denied Claims 10-13-03

This section identifies denied claims and denied adjustments. Denial reasons may include ineligible status, non-covered services and claims billed beyond the filing time limits. Claims in this section will be referenced alphabetically by the recipient's last name, thereby facilitating reconciliation with provider records. Up to three code numbers appear in the column for HEOB (HIPAA Explanation of Benefits) codes. Definitions of HEOB codes are on the last page of the RA. The HEOB messages regarding denied claims specify the reason EDS is unable to process the claims further.

Denied claims are final. No additional action will be taken on denied claims.

Denied claims are listed on the RA in the same format as paid claims.

314.400 Adjusted Claims 10-13-03

Payment errors, such as underpayments and overpayments as well as payments for the wrong procedure code, wrong dates of service, wrong place of service, etc., can be adjusted by canceling ("voiding") the incorrectly adjudicated claim and processing the claim as if it were a new claim. Most adjustment transactions appear in the *Adjusted Claims* section of the RA. Denied adjustments appear at the end of the *Denied Claims* section of the RA.

The simplest explanation of an adjustment transaction is:

A. EDS subtracts from today's check total the full amount paid on a claim that contained at least one payment error.

B. EDS reprocesses the claim - or processes the corrected claim - and pays the correct amount.

C. EDS adds the difference to the remittance advice (or subtracts the difference if it is a negative amount).

Adjustments sometimes appear complicated because the necessary accounting and documentation procedures add a number of elements to an otherwise routine transaction. Also, there are variations in the accounting and documentation procedures, because there is more than one way to submit an adjustment and there is more than one way to adjudicate and record adjustments. There are positive (additional payment is paid to the provider) and negative (the provider owes EDS additional funds) adjustments, adjustments involving withholding of

previously paid amounts, adjustments submitted with check payments and denied adjustments. The following sections thoroughly explain adjustments, how they appear on the RA, and the meaning, from a bookkeeping perspective, of each significant element.

314.410 The Adjustment Transaction 10-13-03

The *Adjusted Claims* section has two parts. Each part is divided into two segments. The first part is the adjustment transaction. The adjustment transaction is divided into a "Credit To" segment and a "Debit To" segment.

314.411 The "Credit To" Segment 10-13-03

The first segment of the adjustment transaction is the "Credit To" segment. In this section, EDS identifies the adjustment transaction, the adjusted claim and the previously paid amount EDS will withhold from today's check as a result of this adjustment. The adjustment transaction is identified by an internal control number (ICN) that follows the field heading "Claim Number." Adjustment ICNs are formatted in the same way as claim numbers; the first two digits of an adjustment ICN are "50." Immediately to the right of the adjustment ICN are the words "Credit To," followed by the claim number and paid date of the original claim that was paid in error.

Underneath the "Credit To" line are displayed the recipient's Medicaid ID number, the claim beginning and ending dates of service and the provider's medical record number (or the patient account number) from the original claim, followed by the original billed amount. Keep in mind that EDS adjusts the entire claim, even if only one detail paid in error, so the total billed amount shown here is the total billed amount of the entire claim being adjusted. At the right end of this line, in the "Paid Amount" column, is the amount originally paid on the claim, which is the amount EDS will withhold from today's remittance.

The actual withholding of the original paid amount does not occur in the *Adjusted Claims* section; it occurs in the *Financial Items* section of the RA. Adjustments are listed in *Financial Items*, with the appropriate amounts displayed under the field headings "Original Amount," "Beginning Balance," "Applied Amount" and "New Balance." (See the discussion of *Financial Items* in Section 314.600.) Finally, the total of all amounts withheld from the remittance (except transaction fees) is displayed under "Withheld Amount," in the *Claims Payment Summary* section of the RA.

314.412 The "Debit To" Segment 10-13-03

A. The second segment of the adjustment transaction is the "Debit To" segment. In this segment, EDS displays the adjudication of the reprocessed claim and, for informational purposes, the net adjustment amount. The net adjustment amount is the additional amount to be paid in this remittance because of the adjustment, or it is the amount by which the remittance will be less than the total of all paid claims minus transaction fees and other withheld amounts.

B. The "Net Adjustment" amount—the amount due to EDS when adjusting an overpayment, or the amount due to the provider when adjusting an underpayment—is on the second line of the "Debit To" segment.

   1. In the case of an adjustment of an underpayment, the "Net Adjustment" amount will be added to the total paid claims amount on today's remittance.

   2. If EDS is due the amount shown as the net adjustment, the letters "CR" will immediately follow the amount. "CR" means that the claim's original paid amount is greater than the new paid amount (as when the original payment is an overpayment), and the amount denoted by "CR" is the (negative) difference.

C. Adjudication:
Immediately following the "Net Adjustment" line is the complete adjudication of the reprocessed claim, cross-referenced to the original claim number. The last line displays

the new paid amount. The difference between the paid amount in the "Credit To" segment and the paid amount in the "Debit To" segment is the amount shown in "Net Adjustment." (See part B, above.)

314.420 Adjusted Claims Totals 10-13-03

At the end of the adjustment transactions is the total number of adjusted claims in today's RA, the total of all billed amounts, the total non-allowed amounts and the total of all paid amounts, the last being the total "Debit To" amount, as well.

For information purposes, the last segment is the total of all "Net Adjustment" amounts in today's RA. Net adjustment amounts displayed with "CR" are treated as negative numbers in the calculation of the net adjustment total.

314.430 Adjustment Submitted with Check Payment 10-13-03

Some providers prefer to send a check for the overpayment amount with their adjustment request. In such a case, the original paid amount displayed in the "Credit To" segment is listed in the *Financial Items* section of the RA with an HEOB code indicating that EDS has received a check for that amount. Also, since EDS does not withhold that amount from the remittance, it appears in the *Claims Payment Summary* section under "Credit Amount" (instead of appearing under "Withheld Amount"). If EDS acknowledges more than one payment by check in *Financial Items*, the total of those check payments appears under "Credit Amount" in the *Claims Payment Summary* section. Amounts shown under "Credit Amount" are never deducted from the remittance because they are already paid.

314.440 Denied Adjustments 10-13-03

Occasionally an adjusted claim is denied. Adjustments can be denied for any of the reasons for which any other claim can be denied. Denied adjustments do not appear in the *Adjusted Claims* section. Denied adjustments do not have "Credit To" segments. Denied adjustments do not reflect a cross-reference to the original claim. Denied adjustments appear at the end of the *Denied Claims* section. Their adjudication is displayed by detail, in the same manner as an adjustment "Debit To" segment. The original paid amount of the claim intended to be adjusted is withheld from the remittance and it is so indicated in the *Financial Items* section, listed under the adjustment ICN.

314.500 Claims In Process 10-13-03

This section lists claims that have been entered into the processing system but have not reached final disposition. Do not rebill a claim shown in this section, because it is already being processed and will result in a rejection as a duplicate claim. These claims will appear in this section until they are paid or denied.

Summary totals follow this section.

314.600 Financial Items 10-13-03

This section lists payments refunded by the provider, amounts recouped since the previous checkwrite, payouts and other transactions. It also includes other recoupment activities that will negatively affect the provider's total earnings for the year. The HIPAA Explanation of Benefit codes beside each item indicate the action taken.

The "Credit To" entries from the *Adjusted Claims* section that are being recouped are listed in the *Financial Items* section. The "Credit To" portion of adjusted claims appears in the *Adjusted Claims* section as information only and is actually applied in the *Financial Items* section.

314.700 Electronic Transactions 10-13-03

This section lists all electronic transactions by the transaction category and transaction type submitted by the provider. It also contains separate totals for claim transactions, reversal transactions and total transactions for this provider.

314.800 Claims Payment Summary 10-13-03

This section summarizes Medicaid payments and credits made to the provider for the specific RA pay period under "Current Processed" and for the year under "Year to Date Total."

320.000 ADJUSTMENT REQUEST FORM 10-13-03

Use the Adjustment Request Form (EDS-AR-004) to correct a claim payment (even if the paid amount is $0.00) or to correct erroneous information on a paid claim. Include sufficient information on the request form to process the adjustment correctly. A copy of the corrected claim or transaction and a copy of the page of the RA it was paid on may be attached to offer further clarification. However, on joint Medicare/Medicaid claims, the appropriate redlined Medicare-Medicaid Crossover Invoice must be attached. If a provider submits an Adjustment Request Form that is not valid, the EDS Adjustment Unit will notify the provider by mail.

Adjustment Request Forms should be filed as soon as the incorrect payment has been identified. Requests for correction or review must be submitted to EDS within the 12-month timely filing deadline. Adjustment requests cannot be processed if more than 12 months have passed since the date of service.

View or print form EDS-AR-004 and instructions for completion. Read the instructions carefully. Be sure to complete all Adjustment Request Forms thoroughly and accurately so that they may be processed efficiently and correctly.

321.000 Explanation of Check Refund Form 10-13-03

If an overpayment occurs, the provider is responsible for refunding the Medicaid Program.

Providers may refund the Medicaid Program by sending a check in the amount of the overpayment, made payable to the Arkansas Medicaid Program or by returning the original check issued by EDS. Submit a completed Explanation of Check Refund Form (EDS-CR-002) with the refund. **View or print form EDS-CR-002 and instructions for completion.**

In instances of underpayment, some providers prefer returning the original check or forwarding a check in the amount of the underpayment instead of requesting an adjustment. When EDS posts the refund, the amount of the refund appears in the *Claims Payment Summary* section of the RA. Once the refund is posted, the provider may resubmit the original or corrected claim for correct adjudication and payment.

Provide the following information in the appropriate fields on an Explanation of Check Refund Form (EDS-CR-002) for each refund you send to EDS:

A. Provider Name and Medicaid Provider Number

B. Refund Check Number, Check Date and Check Amount

C. 13-digit Claim Number (from RA)

D. Recipient ID Number and Name (as it appears on the RA)

E. Dates of Service on claim

F. Date of Medicaid Payment

G. Date of Service Being Refunded

H. Services Being Refunded (Enter procedure codes for all claims. Enter the type of service codes for paper claims only.)

I. Amount of Refund

J. Amount of Insurance Received

K. Insurance Name, Address and Policy Number

L. Reason for Return (from codes listed on form)

M. Signature, Date and Telephone Number

This information allows the refund to be processed accurately and efficiently.

330.000 ADDITIONAL PAYMENT SOURCES 10-13-03

331.000 Introduction 10-13-03

The Medicaid Program is required by federal regulations to utilize all third party sources and to seek reimbursement for services that have also been paid by Medicaid. "Third party" means an individual, institution, corporation or public or private agency that is liable for payment of all or part of the medical cost of injury, disease or disability of a Medicaid recipient. Examples of third party resources are:

A. Medicare (Title XVIII)

B. Railroad Retirement Act

C. Insurance Policies

1. Private health
2. Group health
3. Liability
4. Automobile/medical insurance
5. Family health insurance carried by an absent parent

D. Worker's Compensation

E. Veteran's Administration

F. CHAMPUS

G. Social Security Disability Determination

The Medicaid policies concerning the handling of cases involving dual Medicare/Medicaid eligibility and coverage differ from the policies concerning other third party coverage.

Arkansas Rehabilitation Services (ARS) is not a third party source. If ARS and Medicaid pay for the same service, refund ARS.

332.000 Patients With Joint Medicare-Medicaid Coverage 10-13-03

The following provider types accept Medicare-Medicaid Crossovers: Ambulatory Surgical Center, Chiropractic, Clinics, Dental, Domiciliary Care, Family Planning, Federally Qualified Health

Center, Health Department, Hearing Services, Hemodialysis, Home Health, Hospital, Hyperalimentation, Independent Laboratory, Independent Radiology, Inpatient Psychiatric Services for Under Age 21, Nurse Practitioner, Nursing Home, Occupational, Physical and Speech Therapy Services, Physician, Podiatrist, Prosthetics, Rehabilitation Center, Rehabilitative Services for Persons with Mental Illness, Rural Health Clinic Services, Transportation, Ventilator Equipment and Visual Care.

Claim filing procedures for these provider types are in Sections 332.100 through 332.300.

332.100 Medicare-Medicaid Crossover Claim Filing Procedures 10-13-03

If medical services are provided in Arkansas to a patient who is entitled to Medicare under the Social Security Act and also to Medicaid benefits, it is necessary to file a claim only with Medicare. If the Medicare fiscal intermediary is Arkansas Blue Cross/Blue Shield or Mississippi Blue Cross/Blue Shield (Medicare intermediary for Louisiana, Missouri and Mississippi), the claim should be filed according to Medicare's instructions and sent to the Medicare intermediary. The claim will automatically cross to Medicaid. Mississippi Blue Cross/Blue Shield will cross over only Medicare Part A claims.

If you provide services under the Prosthetics Program, your Medicare fiscal intermediary is Palmetto Government Benefits. You must submit a letter from Palmetto that reflects place of service and Medicare provider number for each location that you currently have enrolled in the Arkansas Medicaid Program. Failure to do this will result in your Medicare claims not crossing over from Medicare electronically.

According to the terms of the Medicaid provider contract, a provider must "accept Medicare assignment under Title XVIII in order to receive payment under Title XIX for any appropriate deductible or coinsurance which may be due and payable under Title XIX."

When the Medicare intermediary or carrier completes the processing of the claim, they will forward it to EDS on computer tape. EDS will process it in the next weekend cycle for payment of coinsurance and deductible. The transaction will usually appear on the Medicaid RA within three weeks of payment by Medicare. If it does not appear within that time, payment should be requested according to the instructions below.

When a provider learns of a patient's Medicaid eligibility only after filing a claim to Medicare, the instructions below should be followed after Medicare pays the claim.

Some Medicare carriers and intermediaries do not cross claims to Arkansas Medicaid. Claims for Medicare beneficiaries entitled under the Railroad Retirement Act never cross to Medicaid.

EDS provides software with which to electronically bill Medicaid for crossover claims that do not cross to Medicaid. Institutional providers and those without electronic billing capability must mail a red-lined copy of the appropriate crossover invoice to the address on the top of the form.

To order copies of the appropriate Medicare-Medicaid crossover invoice, please use the Medicaid Form Request (EDS-MFR-001). **View or print form EDS-MFR-001.** Instructions for filling out the invoice are included with the ordered forms. Indicate the quantity of each form needed and send the request to the Provider Assistance Center (PAC). **View or print PAC contact information.**

When you complete the appropriate red-lined Medicare-Medicaid crossover form, sign and date the form and mail it to the address printed at the top of the form.

332.200 Denial of Claim by Medicare 10-13-03

Any charges denied by Medicare will not be automatically forwarded to Medicaid for reimbursement. In cases where the patient does not have Medicare coverage but is eligible for Medicaid, it will be necessary for the provider to file a claim with Medicaid. A Medicaid claim form should be completed as usual and a copy of the Medicare denial statement attached.

Claims of this nature should be forwarded to the Provider Assistance Center (PAC) for processing. **View or print PAC contact information.**

332.300 Adjustments by Medicare 10-13-03

Any adjustment made by Medicare will not be automatically forwarded to Medicaid. If Medicare makes an adjustment that results in an overpayment or underpayment by Medicaid, the provider may submit an adjustment using the PES software provided by EDS. Alternatively, providers may submit an Adjustment Request Form (EDS-AR-004) with a copy of the appropriate red-lined crossover form reflecting Medicare's adjustment. Enter the Medicaid provider number and the patient's Medicaid identification number on the red-lined crossover form.

340.000 OTHER PAYMENT SOURCES 10-13-03

341.000 General Information 10-13-03

Many persons eligible for Arkansas Medicaid are covered by private insurance or may sustain injuries for which a third party could be liable. The following is an explanation of the patient's and the provider's role in the detection of third party sources and in the reimbursement of the third party payment to the Medicaid Program for services that have been reimbursed by Medicaid.

EDS has a full-time staff of trained professionals available to assist with any questions or problems regarding third party liability, including payment of claims involving third party liability and requests for insurance information. Providers should contact the EDS Provider Assistance Center (PAC) for any questions regarding third party liability. **View or print PAC contact information.**

342.000 Patient's Responsibility 10-13-03

It is the responsibility of the recipient to report the name and policy number of any other payment source to the provider of medical services at the time services are provided. The recipient must also authorize the insurance payment to be made directly to the provider.

343.000 Provider's Responsibility 10-13-03

It is the provider's responsibility to be alert to the possibility of third party sources and to make every effort to obtain third party insurance information. The provider should also inquire about liability coverage in accident cases and pursue this or notify Medicaid. It is the responsibility of the provider to file a claim with the third party source and to report the third party payment to the Medicaid Program. If a provider is aware that a Medicaid recipient has other insurance that is not reflected by the system, the insurance information should be faxed to the DMS Third Party Liability Unit. **View or print Third Party Liability Unit contact information.**

All Medicaid claims, including claims that involve third party liability, are filed on an assignment basis. In no case may the recipient be billed for charges above the Medicaid allowable on paid claims. A claim is considered paid even though the actual Medicaid payment has been reduced to zero by the amount of third party liability. This applies whether the third party payment was reported on the original claim or was refunded by way of an adjustment or by personal check. All paid services that are limited by the Medicaid Program count toward the patient's benefit limits even when the amount of Medicaid payment is reduced to zero by the amount of third party liability, except for Medicare crossover claims with no secondary payer other than Medicaid.

The system provides fields to capture any third party liability (TPL) information the provider may obtain. The provider is required to record TPL for each claim submitted.

When a user enters an electronic claim for services to a recipient who has other insurance coverage for the service and enters a TPL paid amount of $0.00, the software prompts the user

to enter the date of the denial HIPAA Explanation of Benefits (HEOB) or the date of the HEOB showing that the allowed amount was applied to the insurance deductible.

350.000 REFERENCE BOOKS 10-13-03

351.000 Diagnosis Code Reference 10-13-03

The Arkansas Medicaid Program uses the current version of the *International Classification of Diseases* as a reference for coding primary and secondary diagnoses for all providers required to file claims with diagnosis codes completed.

Providers can order the current *ICD.* **View or print *ICD* ordering information.**

352.000 HCPCS Procedure Code Reference 10-13-03

The State of Arkansas uses the HCFA Common Procedure Coding System (HCPCS). HCPCS is composed of Level I-CPT codes, Level II-HCPCS national codes and Level III-HCPCS local codes. If applicable, the state-assigned codes are listed in the Billing Procedures section of this manual. *The Current Procedural Terminology (CPT)* is the professional component of the Healthcare Common Procedure Coding System (HCPCS). The *CPT* book and the HCPCS-Level II book also include modifiers, which are used in conjunction with some procedure codes. Revenue codes, which are used for institutional claims, can be found in the CMS-1450 data specifications manual.

Providers can order the *CPT*. **View or print *CPT* ordering information.**

CPT is a systematic listing of medical terms and identifying codes for reporting medical services provided by physicians. Each procedure or service is identified with a 5-digit code. The use of CPT codes simplifies the reporting of services.