Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us
Telephone (501) 682-8292 TDD (501) 682-6789 or 1-877-708-8191
FAX (501) 682-1197

TO: **All Arkansas Medicaid Health Care Providers**

DATE: **February 1, 2005**

SUBJECT: **Section III Provider Manual Update Transmittal**

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REMOVE

Section	**Date**
302.400	10-13-03
332.300	10-13-03

INSERT

Section	**Date**
302.400	2-1-05
332.300	2-1-05

Explanation of Updates

Section 302.400 is included to clarify the timely filing deadline for pseudo claims.

Section 332.300 is included to correct an error about filing adjustments electronically.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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

302.400 Claims With Retroactive Eligibility 2-1-05

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.

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 provided 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 timely filed claim as a clean claim denied because of agency 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.

To submit a claim for services provided 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.

Providers have 12 months from the approval date of the patient's Medicaid eligibility to resubmit a clean claim after filing a pseudo claim. After the 12-month filing deadline (12 months from the Medicaid approval date) claims will be denied for timely filing and will not be paid. It is the responsibility of the provider to verify the eligibility approval date.

332.300 Adjustments by Medicare 2-1-05

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 must 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.