Arkansas Department Of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers - Visual Care**

DATE: **March 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #66**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	7-1-05	201.000	3-1-06
201.100	7-1-05	201.100	3-1-06
202.000	10-13-03	202.000	3-1-06
216.230	2-1-05	216.230	3-1-06
—	—	216.240	3-1-06
—	—	221.100	3-1-06
222.000	10-13-03	222.000	3-1-06

Explanation of Updates

Sections 201.000 and 201.100 are included to add new participation and enrollment requirements for Visual Care providers.

Section 202.000 is included to add additional information concerning documentation that Visual Care providers are required to keep to comply with the Medicaid Fairness Act of 2005.

Section 216.230 is included to rename the section, Administrative Reconsideration of Extension of Benefits Denial and to update the information to comply with the Medicaid Fairness Act of 2005.

Section 216.240 is a new section titled, “Appealing an Adverse Action”. It explains that information about the appeals process can be referenced to Section I of the manual. This section is being added to comply with the Medicaid Fairness Act of 2005.

Section 221.100 is a new section titled, “AFMC Extension of Benefits Review Process”. It is included to comply with the Medicaid Fairness Act of 2005.

Section 222.000 is included to make a minor wording change.

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 will be automatically incorporated.

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.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

SECTION II - VISUAL CARE

CONTENTS

200.000 VISUAL CARE GENERAL INFORMATION 10-13-03

201.000 Arkansas Medicaid Participation Requirements for Visual Care Providers 3-1-06

Visual Care Program providers meeting the following criteria are eligible for participation in the Arkansas Medicaid Program:

A. Provider must be licensed by the State Board of Optometry to practice in his or her state. A current copy of the optometrist's license must be submitted with the provider application for participation. Subsequent licensure must be provided when issued.

1. Subsequent license renewal must be forwarded to Provider Enrollment within 30 days of issue. If the renewal documents have not been received within the 30-day deadline, the provider will have an additional and final 30 days to comply.

2. Failure to ensure that current licensure is on file with Provider Enrollment will result in termination from the Arkansas Medicaid Program.

B. Provider must be enrolled in the Title XVIII (Medicare) Program.

C. Provider 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). **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).**

D. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

Visual Care Providers in Arkansas and Bordering States

Visual Care Program providers in Arkansas and the bordering states of Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas will be enrolled as routine services providers.

Routine Services Providers

A. Provider will be enrolled in the program as a regular provider of routine services.

B. Reimbursement will be available for all visual care services covered in the Arkansas Medicaid Program.

C. Claims must be filed according to Section 240.000 of this manual. This includes assignment of ICD-9-CM and HCPCS codes for all services rendered.

Visual Care Providers in Non-Bordering States

All Visual Care Program providers in non-bordering states may be enrolled only as limited services providers.

Limited Services Providers

A. Providers will be enrolled in the program to provide prior authorized or emergency services only.

"Emergency services" are defined as inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.
Source: 42 U.S. Code of Federal Regulations §422.2 and §424.101.

"Prior authorized services" are those that are medically necessary and not available in Arkansas. Each request for these services must be made in writing, forwarded to the Utilization Review Section and approved before the service is provided. An Arkansas Medicaid Provider Contract must be signed before reimbursement can be made. A provider number will be assigned upon receipt and approval of the provider application and Medicaid contract. **View or print the Division of Medical Services, Utilization Review Section contact information**.

B. Limited Services provider claims will be manually reviewed prior to processing to ensure that only emergency or prior authorized services are approved for payment. These claims should be mailed to the Arkansas Division of Medical Services, Program Communications Unit. **View or print the Division of Medical Services, Program Communications Unit contact information.**

201.100 Group Providers of Visual Care Services 3-1-06

Group providers of visual care services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

In situations where an optometrist is a member of a group, each individual optometrist and the group must both enroll according to the following criteria:

A. Each individual optometrist in the group must enroll following the criteria established in Section 201.000.

B. The group must complete a provider application and Medicaid contract as an Arkansas Medicaid provider of visual care services. See Section I of this manual. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

All group providers are "pay to" providers only. The service must be performed and billed by a licensed and enrolled optometrist with the group.

202.000 Visual Care Records Providers are Required to Keep 3-1-06

Visual care providers are required to keep the following records and, upon request, must immediately furnish the records to authorized representatives of the Division of Medical Services, the state Medicaid Fraud Control Unit, representatives of the Department of Health and Human Services and the Centers for Medicare and Medicaid Services:

A. History and visual care examination on initial visit.

B. Chief complaint on each visit.

C. Tests and results.

D. Diagnosis.

E. Treatment, including prescriptions.

F. Signature or initials of visual care provider after each visit.

G. Copies of hospital and/or emergency room records that are available to disclose services.

1. All records must be kept for five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish these records upon request may result in sanctions being imposed.

2. All documentation must be immediately made available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. When a recoupment is necessary, no more than thirty (30) days will be allowed after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30 days allowed after recoupment.

3. Visual Care providers furnishing any Medicaid-covered good or service for which a prescription is required by law, by Medicaid rule, or both, must have a copy of the prescription for such good or service. The Visual Care provider must obtain a copy of the prescription within five (5) business days of the date the prescription is written.

4. The Visual Care provider must maintain a copy of each relevant prescription in the Medicaid beneficiary's records and follow all prescriptions and care plans.

5. The Visual Care provider must adhere to all applicable professional standards of care and conduct.

216.230 Administrative Reconsideration of Extensions of Benefits Denial 3-1-06

A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation pursuant to section 221.100.

The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days gives rise to a rebuttable presumption that it is not timely.

216.240 Appealing an Adverse Action 3-1-06

Please see section 190.000 et al for information regarding administrative appeals.

221.100 AFMC Extension of Benefits Review Process 3-1-06

The following is a step-by-step outline of AFMC's extension of benefits review process:

A. Requests received via mail are screened for completeness and researched to verify the beneficiary's eligibility for Medicaid when the service was provided and to determine whether the claim has already been paid.

B. The documentation submitted is reviewed by a nurse. If, in the judgment of the nurse the documentation supports medical necessity, he or she may approve the request. An approval letter is computer generated and mailed to the provider the following day.

C. If the nurse reviewer determines the documentation does not justify the service or it appears that the service is not medically necessary, he or she will refer the case to the appropriate physician advisor for a decision.

D. The physician reviewer's rationale for approval or denial is entered into the computer review system and the appropriate notification is created. If services are denied for medical necessity, the physician reviewer's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.

E. Providers may request administrative reconsideration of an adverse decision or they can appeal as provided in section 190.003 of this manual.

F. If the denial is because of incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the nurse may approve the extension of benefits without referral to a physician advisor.

G. If the denial is because there is no proof of medical necessity or the documentation does not allow for approval by the nurse, the original documentation, reason for denial and new information submitted will be referred to a different physician advisor for reconsideration.

H. All parties will be notified in writing of the outcome of the reconsideration.

222.000 Duration of Authorization 3-1-06

Medical assistance prior authorizations are valid for 180 days from date of approval, provided the patient remains eligible for services. Prior authorization does not guarantee payment unless the patient remains eligible.

The doctor's office will be responsible for verifying eligibility for the dates in which services are provided. The patient is responsible for telling the doctor that he or she is a Medicaid beneficiary when making the first appointment.

The doctor should always keep a copy of the services authorized with the prior authorization control number and a copy of each claim submitted. If the treatment has not been completed in this period of time, send a new request for authorization for the portion of the plan not completed. A new prior authorization control number may be issued under prevailing policies.