Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers**

DATE: **March 1, 2006**

SUBJECT: **PROPOSED - Section I Provider Manual Update Transmittal**

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REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
100.000 – 169.000	varies	100.000 – 169.000	varies
171.400	7-1-05	171.400	3-1-06
173.100	7-1-05	173.100	3-1-06
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Explanation of Updates

Sections 100.000 through 169.000 contain minor grammatical corrections and style revisions as well as policy revisions which are outlined in the explanations below.

Section 105.180 has been deleted – respite waiver services were terminated October 31, 2005. All children and youth served have been transitioned to a respite program funded by Title V.

Section 106.000 has been revised to include current policy related to record keeping and the availability of provider records.

Section 106.100 has been revised to comply with Act 1758 of 2005.

Section 106.200 has been revised to comply with Act 1758 of 2005.

Section 123.300 has been revised to comply with Act 2227 of 2005.

Section 123.400 has been revised to comply with Act 2227 of 2005.

Section 133.500 adds information about Arkansas Medicaid's visual care policy requiring co-payment for eyeglasses.

Section 141.000 contains updated policy regarding provider enrollment.

Section 142.300 has been revised to outline current policy regarding record keeping and the availability of provider records.

Section 151.000 has been revised to outline current policy governing grounds for sanctioning providers.

Section 152.000 has been revised to comply with Act 1758 of 2005.

Section 153.000 now contains rules governing the imposition and extent of sanctions. This policy section was formerly found at 154.000.

Section 154.000 contains policy formerly found at 161.000. This section has been revised to comply with Act 1758 of 2005.

Section 155.000 contains policy formerly found at 153.000.

Section 156.000 contains policy formerly found at 161.100 and has been revised to comply with Act 1758 of 2005.

Section 160.000 has been assigned a new title “Administrative Reconsideration and Appeals”

Sections 161.000 and 161.100 have been deleted—the information located in the sections have been revised and relocated to sections 154.000 and 156.000, respectively.

Section 161.200 has been assigned a new title “Administrative Reconsideration” and includes revisions to what was formerly known as “informal reconsideration”.

Section 161.300 has been assigned a new title “Administrative Appeals” and includes revisions to bring it into compliance with Act 1758 of 2005.

Section 167.000 has been revised to include a list of good cause reasons for reopening a hearing in the event that a party fails to appear.

Sections 171.400, 173.100, 173.610 and 173.620 contain minor revisions.

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.

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 I - GENERAL POLICY

CONTENTS

100.000 GENERAL INFORMATION

100.100 Introduction 3-1-06

Section I imparts general program information about the Arkansas Medicaid Program. It includes information about beneficiary 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. Beneficiary eligibility - This area contains information about Medicaid beneficiary aid categories, beneficiaries' eligibility for benefits, and an explanation of the Medicaid identification card, the beneficiaries' responsibilities and other beneficiary 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 3-1-06

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 Procedure 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 3-1-06

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 3-1-06". Text that appears underlined and 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 3-1-06

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, updated and issued twice a year, display the issue date in the footer on the left. Official notices and RAs issued during the previous quarter are also incorporated into this CD. 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.

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 are assigned sequential identification numbers, 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 3-1-06

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 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 3-1-06

Titles XIX and XXI of the Social Security Act created a joint federal-state medical assistance program commonly referred to as Medicaid. Ark. Code Ann. § 20-77-107 authorizes the Department of Health and Human Services to establish a Medicaid Program in Arkansas.

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 (DMS) administers the program. Within the Division, the Office of Long Term Care (OLTC) is responsible for nursing home policy and procedures.

103.000 Scope of Program 3-1-06

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 3-1-06

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

Program	Coverage
Targeted Case Management for Beneficiaries of Children's Medical Services (CMS)	Under Age 21
Targeted Case Management for Pregnant Women	Women Ages 14 to 44
Targeted Case Management for Beneficiaries Age 22 and Older with a Developmental Disability	Age 22 or Older
Targeted Case Management for Beneficiaries Age 60 and Older	Age 60 or Older
Targeted Case Management for Beneficiaries in the Division of Children and Family Services	Under Age 21
Targeted Case Management for Beneficiaries in the Division of Youth Services	Under Age 21
Targeted Case Management for Beneficiaries in the Child Health Services (EPSDT) Program	Under Age 21
Targeted Case Management for Beneficiaries under Age 21 with a Developmental Disability	Under Age 21
Targeted Case Management for SSI Beneficiaries and TEFRA Waiver Beneficiaries	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 3-1-06

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

105.100 Alternatives for Adults with Physical Disabilities 3-1-06

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) 3-1-06

In ConnectCare, a Medicaid beneficiary selects and enrolls with a primary care physician (PCP) that has contracted with DMS 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.

A PCP contracts with DMS to provide primary care, health education and case management for a self-limited number of Medicaid enrollees. DMS pays the PCP a monthly per-enrollee case management fee in addition to the 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, a PCP is 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 so that the PCP can coordinate care and monitor an enrollee's status, progress and outcomes.

Most Medicaid-eligible individuals, as well as children participating in ARKids First-B, must enroll with a PCP 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) 3-1-06

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 services

B. ACS Respite care

C. ACS Supportive living

D. Community experiences

E. Consultation services

F. ACS Waiver coordination

G. ACS Non-medical transportation

H. Supported employment services

I. Adaptive equipment

J. Environment modifications

K. ACS specialized medical supplies

L. Supplemental support services

M. Crisis intervention services

N. 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 3-1-06

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) 3-1-06

Medicaid non-emergency transportation (NET) services for Medicaid beneficiaries are furnished, under the authority of a capitated selective contract waiver, by twelve regional brokers. Medicaid beneficiaries 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**.

105.190 Women's Health (Family Planning) 3-1-06

The Arkansas Department of Health and Human Services implemented the Family Planning Demonstration Waiver Program in September of 1997. The demonstration was renamed the Women's Health Demonstration Program in 2002. 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. Beneficiaries may use the participating and willing provider of their choice.

106.000 Utilization Review (UR) 3-1-06

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

The tasks of the Utilization Review Section are mandated by federal regulations. The nature of these reviews is to review documentation for services provided and evaluate the medical necessity of the delivered services. Review analysts may request additional information regarding the provider's medical practice.

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 selected for an on-site audit will not be notified in advance.

Each Medicaid provider is required to contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with its delivery of medical assistance to any Medicaid beneficiary. Pertinent records concerning the provision of Medicaid covered health care services are to be made available upon request during regular business hours to DMS, its contractors and designees and the Medicaid Fraud Control Unit.

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 made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

The UR section is also responsible for researching all inquiries from beneficiaries in response to the Explanation of Medicaid Benefits (EOMB) and for reviewing requests for procedures and services requiring prior authorization.

106.100 Utilization Review Recoupment Process 3-1-06

The Utilization Review Section is responsible for the recoupment of Medicaid funds from providers. 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 a provider has been assessed a monetary penalty for failure to follow a corrective action plan which was developed to correct a pattern of non-compliance as provided in section 190.005

When a recoupment decision is made, UR will forward a Notice of Decision/Action to the provider. This notice must comply with section 190.006 of this manual and must include the name(s) of the patient(s), date(s) of service, date(s) of payment and the reason(s) for the recoupment decision.

Upon receipt of this notice, the provider has thirty (30) calendar days in which to pursue one of the following actions:

1. forward a check for the indicated recoupment amount

2. request administrative reconsideration
3. appeal

See sections 160.000 through 169.000 for rules and procedures related to administrative reconsideration and appeals.

110.000 SOURCES OF INFORMATION

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 3-1-06

Customer Assistance, a section of the Division of County Operations, handles beneficiary inquiries regarding Medicaid eligibility and the 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 3-1-06

This unit responds to Medicaid beneficiary inquiries regarding Medicaid coverage and benefits, assists out-of-state providers with claim filing procedures, verifies beneficiary eligibility and maintains beneficiary 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 BENEFICIARY ELIGIBILITY

121.000 Introduction 3-1-06

Eligibility is based on many factors that vary depending on the beneficiary'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 3-1-06

The Department of Health and Human Services (DHHS) local county offices or district Social Security offices determine beneficiary 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 Health and Human Services County Offices 3-1-06

Family Support Specialists in the DHHS 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 DHHS 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 Division of Health 3-1-06

Within the DHHS office, the Division of Health determines presumptive eligibility for category 62, titled Pregnant Women-Presumptive Eligibility. The Division of Health is the designated application point for Breast and Cervical Cancer Prevention and Treatment and for Tuberculosis aid categories; however, the Division of County Operations makes the final eligibility determination.

123.000 Medicaid Eligibility 3-1-06

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 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 3-1-06

Beneficiary 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 3-1-06

Medicaid beneficiaries 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 DHHS county offices establish retroactive eligibility.

123.300 Beneficiary Notification of a Denied Medicaid Claim 3-1-06

DMS must notify a Medicaid beneficiary when a claim for Medicaid payment is denied, in whole or in part, or is not acted upon with reasonable promptness. The notice must comply with section 191.002 of this manual and it must include the following:

A. the beneficiary's name

B. provider's name

C. date of service

D. description of the service

E. reason for denial

F. and an indication of whether the beneficiary is responsible for payment of the denied claim

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

When a beneficiary disagrees with the Medicaid claim denial, he or she may appeal. See sections 191.000 – 191.006 for a complete explanation of beneficiary due process.

123.400 Beneficiary Lock-In 3-1-06

The beneficiary lock-in rule enables physicians and pharmacists to provide quality care and assures that the Medicaid Program does not unintentionally facilitate drug abuse or injury from overmedication or drug interaction.

If a beneficiary has utilized pharmacy services at a frequency or amount that is not medically necessary, as determined by a computerized algorithm and clinical review process, DMS can "lock-in" the beneficiary by requiring him or her to choose a single provider of pharmacy services. After lock-in, DMS will deny claims for pharmacy services submitted by any provider other than the selected provider. The selected provider will be notified prior to lock-in, so that adequate time is allowed for selection of another pharmacy if the selected provider cannot provide the needed services.

If a beneficiary fails or refuses to choose one provider, a list of providers used by the beneficiary will be reviewed and a provider will be chosen at random. DMS will ensure that the beneficiary has reasonable access, taking into account geographic location and reasonable travel time, to pharmacy services of adequate quality.

Before imposing lock-in, DMS or its agent will mail a notice to the beneficiary in accordance with the beneficiary due process rules found in section 191.000 of this manual. The notice will also inform the beneficiary of his or her right to request administrative reconsideration and outline that process. If the beneficiary does not appeal or request reconsideration, he must choose a pharmacy using the selection form enclosed with the notice.

When a beneficiary has been locked-in, eligibility verification transactions will reflect "lock-in to other provider." The restriction will be removed after demonstration by the beneficiary 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 beneficiary.

Any provider who believes that a particular beneficiary should be considered for beneficiary 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 Beneficiary Aid Categories 3-1-06

The following is the full list of beneficiary aid categories. Some categories provide a full range of benefits while others may offer limited benefits or may require cost sharing by a beneficiary. 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 I	FR, AC
11 AABD	AABD	FR

Category	Description	Code
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
18 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

Category	Description	Code
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.

124.100 Beneficiary Aid Categories with Limited Benefits 3-1-06

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 3-1-06

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 beneficiaries, 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) 3-1-06

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 beneficiary 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 Health and Human Services (DHHS) 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) 3-1-06

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 Health and Human Services (DHHS) county office.

124.180 Tuberculosis (TB) 3-1-06

The TB aid category is for low-income individuals of all ages who are infected or who are suspected to be infected with TB. Application may be made through the Division of Health by contacting the local county health unit.

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 Beneficiary Aid Categories with Additional Cost Sharing 3-1-06

Certain programs require beneficiaries to share the cost for Medicaid services received. These programs are discussed below.

124.210 ARKids First-B 3-1-06

Covered services provided to ARKids First-B participants are within the same scope of services provided to Arkansas Medicaid beneficiaries, 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 3-1-06

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 by 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 3-1-06

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. Individuals who are ages 16 through 64 and who are disabled according to Supplemental Security Income (SSI) criteria are eligible in this category.

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.

Beneficiaries 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".

Beneficiaries 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

Program Services	New Co-Payment*
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

Program Services	New Co-Payment*
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 beneficiaries (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 3-1-06

125.100 Explanation of Medicaid Identification Card 3-1-06

Medicaid beneficiaries 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 beneficiary. Children under the age of five, ARKids-B, nursing home and home and community-based waiver beneficiaries are not pictured. New beneficiaries 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 beneficiaries.

THE MEDICAID IDENTIFICATION CARD DOES NOT GUARANTEE ELIGIBILITY FOR A BENEFICIARY. Payment is subject to verification of beneficiary eligibility at the time services are provided. See section 123.000 for verification of beneficiary 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 beneficiary by the Arkansas Division of County Operations.

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

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

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

E. Signature - This is the signature of the beneficiary 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 Beneficiary 3-1-06

When beneficiaries report non-receipt or loss of a Medicaid card, refer them to the local DHHS 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 BENEFICIARY RESPONSIBILITIES

131.000 Charges that Are Not the Responsibility of the Beneficiary 3-1-06

Subject to cost-sharing responsibilities outlined in sections 133.000 – 135.000, a beneficiary is not liable for the following:

A. a claim or portion of a claim denied for lack of medical necessity

B. charges in excess of the Medicaid maximum allowable rate

C. a claim or portion of a claim denied due to provider error

D. a claim or portion of a claim denied due to errors made by DMS or EDS

E. a claim or portion of a claim denied due to changes in state or federal mandates

F. a claim or portion of a claim denied because a provider failed to obtain prior, concurrent or mandatory authorization for a service

G. the difference between the beneficiary Medicaid cost sharing responsibility, if any, and the Medicare deductible and co-insurance

The beneficiary is not responsible for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

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 the covered service(s). If it is agreeable with the individual, these funds may be credited against unpaid non-covered services that are the responsibility of the beneficiary.

The beneficiary may not be billed for the completion and submission of a Medicaid claim form.

132.000 Charges that are the Responsibility of the Beneficiary 3-1-06

A beneficiary is responsible for:

A. charges incurred during a time of ineligibility

B. charges for non-covered services, including services received in excess of Medicaid benefit limitations, if the beneficiary has chosen to receive and agreed to pay for those non-covered services

C. charges for services which the beneficiary has chosen to receive and agreed to pay for as a private pay patient

D. spend down liability on the first day of spend down eligibility

The beneficiary is also responsible for any applicable cost-sharing amounts such as enrollment fees, premiums, deductibles, coinsurance, or co-payments imposed by the Medicaid Program pursuant to 42 C.F.R. §§ 447.50 – 447.60 (2004). These cost-sharing responsibilities are outlined in sections 133.000 – 135.000 of this manual.

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 Beneficiaries 3-1-06

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

Example:

A Medicaid beneficiary 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 beneficiary 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 Beneficiaries 3-1-06

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

Example:

An ARKids First-B beneficiary 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 beneficiary 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 Beneficiaries 3-1-06

The coinsurance charge per admission for Medicaid beneficiaries, 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 3-1-06

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

Medicaid Maximum Amount	Beneficiary Co-pay
$10.00 or less	$0.50
$10.01 to $25.00	$1.00

Medicaid Maximum Amount	Beneficiary Co-pay
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

133.500 Co-Payment of Eyeglasses for Recipients Age 21 and Older 3-1-06

Arkansas Medicaid has a recipient co-payment policy in the visual care program. Medicaid –eligible recipients who are 21 years or age and older must pay a $2.00 co-payment to the visual care provider for prescription services. Nursing home residents are excluded from this co-pay.

134.000 Exclusions from Cost Sharing Policy 3-1-06

As required by 42 C.F.R. § 447.53(b), the following services are excluded from the beneficiary cost sharing (coinsurance/co-payment) policy:

A. Services provided to individuals under 18 years of age, except:

1. ARKids First-B beneficiaries (see the ARKids Manual for more information about this program)
2. Working Disabled 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 beneficiary is a resident of a nursing facility does not on its own exclude the Medicaid services provided to the beneficiary from the cost sharing policy. Unless a Medicaid beneficiary 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 beneficiary, 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 beneficiary's medical record that substantiates the exclusion from the beneficiary cost sharing policy.

135.000 Collection of Coinsurance/Co-payment 3-1-06

The method of collecting the coinsurance/co-payment amount from the beneficiary 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 beneficiary 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 beneficiary's inability to pay the coinsurance/co-payment amount will not alter the Medicaid reimbursement amount for the claim. Unless the beneficiary 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 3-1-06

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 by:

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

141.000 Provider Enrollment 3-1-06

Any provider of services must be enrolled in the Arkansas Medicaid Program before reimbursement may be made for any services provided to Arkansas Medicaid beneficiaries. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Agreement. 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.

The Division of Medical Services has contracted with EDS to provide enrollment services for new providers and changes to current provider enrollment files. However, the unit will still be known as the Medicaid Provider Enrollment Unit.

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). **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).**

A potential provider may complete the necessary forms for enrollment and submit them via the Internet by connecting to the Arkansas Medicaid web site at **www.medicaid.state.ar.us** or they may return the printed forms to the Medicaid Provider Enrollment Unit. **View or print the Medicaid Provider Enrollment Unit contact information.**

Section II of all provider manuals contains information relative to provider participation requirements.

Upon receipt and approval of the above information by the Medicaid 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 one year from the date the provider agreement is approved, the effective date of the provider's license or certification or the date a service became available through 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 incorporated by reference into the Medicaid contract and providers must comply with its terms and conditions in order to participate in the Arkansas Medicaid Program.

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 3-1-06

Providers enrolled in the Arkansas Medicaid Program must agree to and meet the conditions of participation contained in sections 142.000 through 142.700.

Failure to comply with the requirements contained in Sections 142.000 through 142.700 may result in termination from the Medicaid Program and/or recovery of money paid for services by the Division of Medical Services.

Nothing in the conditions of participation is a limitation on the ability of DMS 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 General Conditions 3-1-06

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 DMS and to abide by the rules and regulations specified in the manual.

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

E. Services will be provided to qualified beneficiaries 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.

F. Each provider must notify the Medicaid Provider Enrollment Unit 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 Federal Employer Identification Number (FEIN)
5. Retirement or death of provider
6. Change of ownership

G. Except for Medicaid covered services and other professional services furnished in exchange for the provider's usual and customary charges, a Medicaid provider may not knowingly give, offer, furnish, provide or transfer money, services or any thing of value for less than fair market value to any Medicaid beneficiary, to anyone related to any Medicaid beneficiary within the third degree or any person residing in the household of a beneficiary.

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.

142.200 Conditions Related to Billing for Medicaid Services 3-1-06

A. 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.

B. 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.

C. 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 DMS.

D. 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).

E. 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 beneficiary for these services.

F. Medicaid providers may not charge beneficiaries for the completion and submission of a Medicaid claim form. If the provider agrees to accept the patient as a Medicaid beneficiary and agrees to bill Medicaid for the services rendered, the beneficiary may not be charged for this billing procedure.

G. Claims for services provided to eligible Medicaid beneficiaries must be submitted to the Medicaid fiscal agent within twelve months from the date of service.

142.300 Conditions Related to Record Keeping 3-1-06

A. 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 and for eligible beneficiaries. The delivery of all goods and services billed to Medicaid must be documented in the beneficiary's medical record.

B. 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 DMS and its agents and designees.

C. 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.

D. Upon request, each provider must 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 of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services, or their designated agents. The request may be made in writing or in person. No advance notice is required for an in-person request. 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 made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

E. 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.

142.400 Conditions Related to Disclosure 12-01-03

142.410 Disclosures of Ownership and Control 12-01-03

A. The Division of Medical Services (DMS) requires that providers disclose the following information regarding ownership and control.

1. The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent or more.
2. In compliance with information shown above, the provider must also disclose if any person named above is related to another as a spouse, parent, child or sibling.
3. The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:

   a. Keep copies of all these requests and the responses to them;

   b. Make them available to representatives of the Secretary of Health and Human Services or to the Division of Medical Services upon request, and

   c. Advise DMS when there is no response to a request.

B. Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified above to representatives of an Arkansas survey agency at the time of a survey. The survey agency must promptly furnish the information to the Secretary of Health and Human Services and to the Division of Medical Services.

C. Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified above to the Secretary of Health and Human Services within the prior twelve month period, must submit the information to the Division of Medical Services before entering into a contract or agreement to participate in the program.

142.420 Disclosures of Business Transactions 12-01-03

A provider must submit, within 35 days of the date of a request by representatives of the Secretary of Health and Human Services or the Division of Medical Services, full and complete information about:

The ownership of any subcontractor with whom the provider has business transactions totaling more than $25,000 during the 12-month request, and

Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

142.430 Disclosures of Information Regarding Personnel Convicted of Crime 12-01-03

Before the Division of Medical Services enters into or renews a provider agreement, or at any time upon written request by DMS, the provider must disclose to DMS the identity of any person who:

Has ownership or control interest in the provider, or is an agent or managing employee of the provider and

Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services programs since the inception of those programs.

142.500 Conditions Related to Fraud and Abuse 3-1-06

A. 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.

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

C. 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 the following:

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

142.600 Conditions Related to Provider Refunds to DMS 12-1-03

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.

142.700 Mandatory Assignment of Claims for "Physician" Services 12-1-03

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 ("QMB-plus"), *including qualified Medicare beneficiaries (QMBs not eligible for benefits covered by Medicaid and not covered by Medicare)*, may only be made on an assignment-related basis.

150.000 ADMINISTRATIVE REMEDIES AND SANCTIONS

151.000 Grounds for Sanctioning Providers 3-1-06

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

A. Non-compliance with any provision of federal laws and rules contained in or related to Title XIX or XXI of the Social Security Act, federal regulations promulgated there under, state medical assistance (Medicaid) law and rules or any applicable Medicaid provider manual

B. Any act or omission that is inconsistent with sound fiscal, business or medical practices and results in unnecessary cost to the Arkansas Medicaid Program, or in reimbursement

for services that are not medically necessary or that fails to meet professionally recognized standards for health care

C. Accepting beneficiaries for whom all prescribed and medically necessary care and services cannot be provided at the time of acceptance, unless otherwise required by the Emergency Medical Treatment and Active Labor Act (EMTLA). There is no violation if it appears, based upon information available at the time of admission, that the provider can meet the patient's needs

D. Engaging in conduct that defrauds or abuses the Medicaid program, regardless of whether the conduct is successful

E. Failure to submit an acceptable corrective action plan when requested to do so by the department or its agents in a written statement which complies with section 190.006 of this manual

F. Failure to comply with any remedy imposed under 42 U.S.C. §1320a-7(a) and implementing federal regulations, 42 U.S.C. §1320a-7(b) and implementing federal regulations, and state Medicaid law and rules, including, without limitation, this manual.

152.000 Sanctions 3-1-06

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 – subject to the requirements of sections 190.000 through 190.014 of this manual

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 Health and Human Services (DHHS) Policy 1088, titled DHHS Participant Exclusion Rule

153.000 Rules Governing the Imposition and Extent of Sanctions 3-1-06

A. Imposition of Sanction

1. The Director of the Division of Medical Services shall determine the sanction(s) to be imposed according to the following factors:
   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 DHHS Policy 1088, titled DHHS Participant Exclusion Rule
2. 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 Health and 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 DHHS 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 DHHS 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 DHHS Policy 1088, shall be suspended, terminated or excluded from participation.

154.000 Notice of Violation 3-1-06

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 in writing. The written notification shall comply with section 190.006 of this manual.

Unless a timely and complete request for administrative reconsideration or appeal is received by the Department of Health and Human Services, the findings of DHHS as set forth in the notice shall be considered a final and binding administrative determination.

155.000 Notice of Provider Sanction 3-1-06

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

When a provider's participation in the Medicaid Program has been suspended or terminated, the Department of Health and Human Services shall notify the beneficiaries 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.

156.000 Withholding of Medicaid Payments 3-1-06

Upon receipt of reliable evidence that the circumstances involve fraud, willful misrepresentation or both, DMS may withhold Medicaid payments, in whole or in part, without first notifying the provider of its intention to withhold.

Within five days of taking the action, the Division of Medical Services will send a Notice of Non-Compliance (form DMS-635) that explains the reasons for withholding payment and the

provider's right to administrative reconsideration or appeal as provided in sections 160.000 through 169.000 and section 190.003.

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

A. DMS 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

160.000 ADMINISTRATIVE RECONSIDERATION AND APPEALS

161.200 Administrative Reconsideration 3-1-06

A. Within 30 calendar days after notice of an adverse decision/action, as defined in section 190.002, the provider may request administrative reconsideration. Requests must be in writing and include:

1. A copy of the letter or notice of adverse decision/action
2. Additional documentation that supports medical necessity

Administrative reconsideration does not postpone any adverse action that may be imposed pending appeal. Requests for reconsideration must be submitted as follows:

B. In situations where the adverse decision/action has been taken by a reviewing agent, the request must be directed to that reviewing agent. Contact information for the department's reviewing agents can be found in Section V of this manual. Reviewing agents and the administrative reconsideration processes that those agents have established are program-specific and are outlined in Section II of this manual.

C. In situations where the adverse decision/action has been taken by the Utilization Review Section (UR), the request must be directed to UR. View or print the UR contact information. Within 20 calendar days of receiving a timely and complete request for administrative reconsideration, the Director of the Division of Medical Services will designate a reviewer who did not participate in the determination leading to the adverse decision/action and who is knowledgeable in the subject matter of the administrative reconsideration to review the reconsideration request and associated documents. The reviewer shall recommend to the director that the adverse decision/action be sustained, reversed or modified. The director may adopt or reject the recommendation in whole or in part.

All deadlines outlined in this section shall comply with sections 190.012 and 190.013 of this manual. A request received within 35 calendar days of the written notice will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis. The request must be mailed or delivered by hand. Faxed or emailed requests will not be accepted.

No administrative reconsideration is allowed if the adverse decision/action is due to loss of licensure, accreditation or certification.

161.300 Administrative Appeals 3-1-06

Within 30 calendar days of receiving notice of adverse decision/action, or 10 calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision/action, whichever is later, the provider may appeal. See sections 190.003 and 190.004 for additional information about administrative appeals.

A notice of appeal must be in writing and state with particularity all findings, determinations, and adverse decisions/actions that the provider alleges are not supported by applicable laws

(including state and federal laws and rules and applicable professional standards) or both. The appeal should be mailed or delivered to the Office of Appeals and Hearings, P.O. Box 1437, Slot N401, Little Rock, AR 72203-1437. The deadline for receipt of an appeal will be enforced pursuant to sections 190.012 and 190.013 of this manual.

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

162.000 Notice of the Administrative Appeal Hearing 3-1-06

When an appeal hearing is scheduled, the Office of Hearings and Appeals 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 3-1-06

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 Health and Human Services shall notify the provider in writing of the name and telephone number of its representative.

163.000 Form of Papers 3-1-06

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 and the docket number, if any.

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

163.100 Notice, Service and Proof of Service 3-1-06

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

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 an 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. Service by mail is presumptively complete upon mailing. When service is permitted upon an attorney, such service may be effected by electronic transmission, provided that the attorney being served has facilities within his office to receive and reproduce verbatim electronic transmissions.

164.000 Witnesses 10-13-03

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

165.000 Amendments 3-1-06

At any time prior to the completion of the hearing, amendments to the adverse decision/action, the provider's notice of appeal, or both, may be allowed on just and reasonable terms to add or discontinue any party, change the allegations or defenses, or add new causes of action or 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 154.000, "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, "Administrative Reconsideration," and section 162.000, "Notice of the Administrative 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 Additional Hearings."

166.000 Continuances or Additional Hearings 3-1-06

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

B. When 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 one or both parties 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 additional hearing shall be given, except that when a continuance or additional hearing is ordered during a hearing, oral notice may be given to each party present.

167.000 Failure to Appear 3-1-06

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. The hearing officer may, upon motion, set aside the decision and reopen the hearing for mistake, inadvertence, surprise, excusable neglect, fraud, or misrepresentation.

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 Procedure Act.

169.000 Decision 3-1-06

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 and conclusions of law, separately stated, 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 Procedure 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.

171.400 PCP Referrals 3-1-06

A. Referrals may be only for medically necessary services, supplies or equipment.

B. In order for a PCP to refer an enrollee to a specific provider by name, he or she must allow the enrollee free choice by naming two or more providers of the same type or specialty.

C. PCPs are not required to make retroactive referrals.

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

E. 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. (This requirement varies somewhat in some programs; applicable regulations are clearly set forth in the appropriate Arkansas Medicaid Provider Manuals.)

F. 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 (with exceptions as noted in part E, above).

G. An enrollee's PCP determines whether it is necessary to see the enrollee before making or renewing a referral.

H. Medicaid beneficiaries and ARKids First-B participants are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in section 172.100.

173.100 PCP Selection and Enrollment at Local County DHHS Offices 3-1-06

A. Medicaid applicants receive from DHHS county office staff, a description and explanation of *ConnectCare*.

1. By means of form DCO-2609, "Primary Care Physician Selection and Change Form", an applicant indicates the first, second and third choice for PCPs of each family member included in the Medicaid case.
2. Individuals applying for ARKids First A and B indicate their PCP preferences on the mail-in application, form DCO-995.
3. Family members may choose the same PCP whenever there is a PCP available that can serve all eligible family members.

B. When eligibility is determined, a DHHS worker uses a Web-based program or a telephonic voice response system to complete the PCP enrollment, beginning with each beneficiary/participant's first choice.

1. If the first choice has a full caseload, the worker tries the second choice and so on.
2. The county office forwards confirmation of PCP enrollment to each new enrollee.

173.610 PCP Transfers by Enrollee Request 3-1-06

ConnectCare enrollees may transfer their PCP enrollment at any time, for any stated reason.

A. Enrollees are encouraged to use the *ConnectCare HelpLine* when transferring their enrollment from one PCP to another, unless the enrollee is a child in foster care, in which case the PCP enrollment transfer must be done by the local DHHS county office in the child's county of residence.

B. PCP transfer for any reason may be done at the local DHHS county office in the enrollee's county of residence, but the enrollee or the enrollee's parent or guardian must request the transfer in person and in writing by means of form DCO-2609.

173.620 PCP Transfers by PCP Request 3-1-06

A PCP may request that an individual transfer his or her PCP enrollment to another PCP because the arrangement with that individual is not acceptable to the PCP.

A. Examples of unacceptable arrangements include, but are not limited to the following.

1. The enrollee fails to appear for 2 or more appointments without contacting the PCP before the scheduled appointment time.
2. The enrollee is abusive to the PCP.
3. The enrollee does not comply with the PCP's medical instruction.

B. At least 30 days in advance of the effective date of the termination, the PCP must give the enrollee written notice to transfer his or her enrollment to another PCP.

1. The notice must state that the enrollee has 30 days in which to enroll with a different PCP.
2. The PCP must forward a copy to the enrollee and to the local DHHS office in the enrollee's county of residence.

C. The PCP continues as the enrollee's primary care physician during the 30 days or until the individual transfers to another PCP, whichever comes first.