Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – Hearing Services**

DATE: **September 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #63**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	4-1-05	201.000	9-1-06
202.000	4-1-05	202.000	9-1-06
202.100	4-1-05	202.100	9-1-06
203.000	10-13-03	203.000	9-1-06
—	—	203.100	9-1-06
205.000	10-13-03	205.000	9-1-06

Explanation of Updates

Section 201.000: The Medicaid provider participation requirements have been updated.

Section 202.000: The Medicaid provider participation requirements have been updated.

Section 202.100: The Medicaid provider participation requirements have been updated.

Section 203.000: The information in this section has been divided up to make two sections. Also, the section heading has been renamed **Providers in Arkansas and Bordering States**.

Section 203.100: This is a new section titled **Providers in States Not Bordering Arkansas** that explains the enrollment and reimbursement process for providers in non-bordering states.

Section 205.000: The record keeping and documentation requirements have been updated.

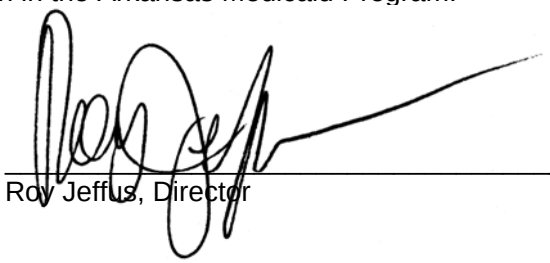
Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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 (TDD only).

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.



Roy Jeffus, Director

SECTION II HEARING SERVICES

CONTENTS

201.000 Arkansas Medicaid Participation Requirements for Hearing Aid Dealers 9-1-06

Hearing aid dealers must meet the following criteria to participate in the Arkansas Medicaid Program.

A. Hearing aid dealers, physicians and audiologists in Arkansas must be licensed as Hearing Aid dealers. Audiologists licensed in Arkansas may provide both audiology service and the dispensing of hearing aids with their audiologist license. Hearing aid dealers, physicians and audiologists outside of Arkansas must be licensed by their states as hearing aid dealers. A current copy of the applicable license must accompany the provider application and Medicaid contract.

1. A copy of subsequent state licensure renewal must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and final 30 days to comply.

2. Failure to timely submit verification of license renewal will result in termination of enrollment in the Arkansas Medicaid Program.

B. The provider must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).

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

D. The provider must adhere to all applicable professional standards of care and conduct.

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

202.000 Participation Requirements for Individual Audiologists 9-1-06

Audiologists must meet the following criteria to participate in the Arkansas Medicaid Program:

A. The provider must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

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

C. Audiologists must be licensed in their states as audiologists. Audiologists with an Arkansas license may also dispense hearing aids as per Arkansas Act 1171 of 1991.

1. A copy of the current state license must accompany the provider application and Medicaid contract.

2. A copy of subsequent state licensure renewal must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s)

have not been received within this timeframe, the provider will have an additional and final 30 days to comply.

3. Failure to timely submit verification of license renewal will result in termination of enrollment in the Arkansas Medicaid Program.

D. The provider must adhere to all applicable professional standards of care and conduct.

NOTE: An audiologist licensed outside the state of Arkansas who has a Hearing Aid Dealer license and an Audiology license must enroll under both programs. A provider application and Medicaid contract must be completed for each program, and two (2) separate Medicaid provider numbers will be assigned.

202.100 Group Providers of Audiology Services in Arkansas and Bordering States 9-1-06

Group providers of Audiology Services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program.

A. In order for a group of audiologists to receive Arkansas Medicaid reimbursement, the group and each individual audiologist must enroll in Arkansas Medicaid.

1. Each audiologist member of the group who intends to treat Medicaid beneficiaries must enroll in accordance with the requirements in section 202.000.

2. The group must also enroll in the Arkansas Medicaid Program by completing and submitting to the Medicaid Provider Enrollment Unit 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 a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

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

B. All group providers are “pay to” providers only. The service must be performed and billed by the performing licensed and enrolled audiologist with the group.

NOTE: An audiologist licensed outside the state of Arkansas who has a Hearing Aid Dealer License and an Audiology License must enroll under both programs. A provider application and Medicaid contract must be completed for each program, and two (2) separate Medicaid provider numbers will be assigned.

203.000 Providers in Arkansas and Bordering States 9-1-06

Hearing Services providers in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) will be enrolled as routine services providers.

Routine Services Provider

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

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

C. Paper claims must be filed according to Section 240.000 of this manual. Information regarding electronic claim filing is available in Section III of this manual.

203.100 Providers in States Not Bordering Arkansas 9-1-06

A. Providers in states not bordering Arkansas may enroll as closed-end providers after they have furnished services to an Arkansas Medicaid beneficiary and have a claim to file with Arkansas Medicaid. **View or print Provider Enrollment Unit contact information.**

A non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, **www.medicaid.state.ar.us/InternetSolution/Provider/Provider.aspx**, and then submit its application and claim to the Medicaid Provider Enrollment Unit.

B. Closed-end providers remain enrolled for one year.

1. If a closed-end provider treats another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.

2. During the enrollment period, the provider may file any subsequent claims directly to the Arkansas Medicaid fiscal agent.

3. Closed-end providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

205.000 Record Keeping Requirements 9-1-06

DHHS requires retention of all records for five (5) years. All medical records shall be completed promptly, filed and retained for a minimum of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish records upon request may result in sanctions being imposed.

A. The provider must 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.

B. Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the aforementioned prescription, care plan or order within five (5) business days of the date it is written. Providers also must maintain a copy of each prescription, care plan or order in the beneficiary's medical record and follow all prescriptions, care plans, and orders as required by law, by Medicaid rule, or both.

C. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary.

1. All documentation must be available at the provider's place of business.

2. When records are stored off-premise or are in active use, the provider may certify, in writing, that the records in question are in active use or in 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.

3. If an audit determines that recoupment is necessary, there will be no more than thirty (30) days after the date of recoupment notice in which additional documentation will be accepted.