Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – Medicare/Medicaid Crossover Only**

DATE: **November 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #46**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	10-13-03	201.000	11-1-06
202.000	10-13-03	202.000	11-1-06
—	—	202.100	11-1-06
211.000	10-13-03	211.000	11-1-06
212.000	10-13-03	212.000	11-1-06
213.000	10-13-03	213.000	11-1-06
214.000	10-13-03	214.000	11-1-06
215.000	10-13-03	215.000	11-1-06
215.100	10-13-03	215.100	11-1-06
215.200	10-13-03	215.200	11-1-06
215.300	10-13-03	215.300	11-1-06
231.000	10-13-03	231.000	11-1-06
241.000	10-13-03	241.000	11-1-06
241.100	10-13-03	241.100	11-1-06

Explanation of Updates

Section 201.000 is included to update the provider participation and enrollment procedures.

Section 202.000 has been renamed as **Providers in Arkansas and Bordering States.** The information in this section has been rewritten. Clarification has been added that explains the enrollment and reimbursement process for providers in Arkansas and bordering states.

Section 202.100 is a new section titled **Providers in States Not Bordering Arkansas.** This section explains the enrollment and reimbursement process for providers in non-bordering states.

Section 211.000 is included to make a minor correction to clarify information within the section.

Section 212.000 is included to change the word **recipient** to **beneficiary** throughout the section.

Section 213.000: This section is included to clarify information within the section.

Section 214.000 is included because the agency name has been corrected to the **Department of Health and Human Services.**

Sections 215.000 and 215.100 have been included to correct the name of the services to Medicare/Medicaid Crossover Only.

Section 215.200 is included to change the name of the section to "Documentation in Beneficiary Files" and to inform providers about new documentation requirements to be utilized in maintaining beneficiary files.

Section 215.300 has been revised to update information regarding record keeping requirements.

Section 231.000 is included to correct the agency's name to the Department of Health and Human Services and to change the agency's acronym to DHHS.

Sections 241.000 and 241.100 have been revised to include a minor text change.

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

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Roy Jeffus, Director

TOC required

201.000 Arkansas Medicaid Participation Requirements for Medicare/Medicaid Crossover Only Providers Located in the State of Arkansas 11-1-06

Providers of Title XVIII (Medicare) covered services who are interested in participating in the Title XIX (Medicaid) Program for the payment of Medicare coinsurance and deductible amounts for services not covered by Medicaid and/or do not meet the enrollment criteria for other Medicaid programs must meet the following criteria:

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). **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a 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. Provider must be enrolled in the appropriate Title XVIII (Medicare) Program.

202.000 Providers in Arkansas and Bordering States 11-1-06

Providers of Title XVIII (Medicare) covered services in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as routine services providers if they meet the participation and enrollment criteria as specified in section 201.000.

Routine Services Provider

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

B. Reimbursement will only be for cost share for paid Medicare-covered services.

C. Claims must be filed according to the specifications in this manual.

202.100 Providers in States Not Bordering Arkansas 11-1-06

A. Providers in states not bordering Arkansas may enroll as Medicare/Medicaid Crossover Only closed-end providers after they have furnished services to an Arkansas Medicaid QMB and have a claim for Medicare cost share 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 Medicare/Medicaid Crossover Only provider treats another Arkansas Medicaid/Medicare dually eligible beneficiary during the year of enrollment and bills Medicaid, either manually, electronically or by automated crossover, 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 manual claims directly to the Arkansas Medicaid fiscal agent.

3. Closed-end providers with the necessary capability (see section 241.000) 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.

211.000 Scope 11-1-06

The Arkansas Medicaid Program covers certain services provided to persons eligible for Medicaid through the Qualified Medicare Beneficiary (QMB) Program.

The QMB program was created by the Medicare Catastrophic Coverage Act and uses Medicaid funds to assist low income Medicare beneficiaries. If a person is eligible for the QMB program, Medicaid will pay the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance on other medical services not to exceed the Medicaid maximum allowable amount. Medicaid will also pay the Medicare Part A premium, the Medicare Part A hospital deductible and the Medicare Part A coinsurance.

Persons eligible through the QMB program do not receive the full range of Medicaid benefits. For a QMB eligible, Medicaid covers only those benefits listed above on Medicare-covered services. If the service provided to a QMB-eligible is not a Medicare-covered service, such as personal care or ambulance transportation to a doctor's office, Medicaid does not cover the service for that individual.

212.000 Medicaid Payment of Medicare Coinsurance/Deductible 11-1-06

The Medicaid payment toward the Medicare Part A and Part B deductible and/or coinsurance will equal the full amount submitted to Medicaid by Medicare.

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.

Physician services furnished to an individual enrolled under Medicare who is also eligible for Medicaid, including Qualified Medicare Beneficiaries may only be reimbursed on an assignment related basis.

If the provider does not accept Medicare assignment but has agreed to treat the patient as a QMB, the provider must file a hard copy claim with Medicaid for the deductible/coinsurance coverage. The provider is responsible for obtaining from the QMB a copy of the Medicare EOMB and attaching it to the hard copy claim submitted to Medicaid. The beneficiary may be billed for the difference between the actual billed amount and the Medicare allowed amount if the provider has not agreed to accept Medicare assignment. The following is a Medicare non-assigned claim example:

Amount Billed	**Medicare Allowable**	**Medicare Payment**
$150.00	$100.00	$80.00

Medicaid Payment	**Beneficiary Liability**
$20.00	$50.00

If the provider has agreed to accept Medicare assignment, the beneficiary is not responsible for the difference between the billed charges and the Medicare allowable amount. The following is a Medicare assigned claim example:

Amount Billed	Medicare Allowable	Medicare Payment
$200.00	$150.00	$120.00

Medicaid Payment	Beneficiary Liability
$30.00	$0.00

213.000 QMB Medicaid ID Card 11-1-06

QMB eligibles receive a Medicaid ID after a determination that they are eligible for the program. Providers must verify eligibility and category by one of the various electronic means available. The category of service for a QMB is QMB-AA, QMB-AB or QMB-AD. Additionally, the electronic verification includes the statement "Limited to cost sharing of Medicare services."

214.000 Eligibility Criteria for QMB Program 11-1-06

This program has been designed to assist low income elderly and disabled persons who are covered by Medicare Part A. The person must be 65 or older, blind or disabled and eligible for or enrolled in Medicare Part A.

Persons interested in applying for the QMB Program should contact their local county Department of Health and Human Services office. The applicant should call the county office to inquire about the eligibility criteria, what documents are needed to determine eligibility and whether an appointment is necessary.

215.000 Documentation Requirements 11-1-06

Providers of Medicare-Medicaid Crossover Only services must keep and properly maintain written records. At a minimum, the following records must be included in the provider's files.

215.100 General Records 11-1-06

Medicare-Medicaid Crossover Only providers must maintain a copy of the Arkansas Medicaid contract (form DMS-653) for participation in the Arkansas Medicaid Program.

215.200 Documentation in Beneficiary Files 11-1-06

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. All entries in a beneficiary's file must be signed and dated by the individual who provided the service, along with the individual's title. The documentation must be kept in the beneficiary's case file, along with the beneficiary's name, Medicaid identification number, and the date the service was provided.

215.300 Record Keeping Requirements 11-1-06

A. All records must be completed promptly, filed and retained for a period 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.

B. 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. 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.

C. All documentation must be made available to representatives of the Division of Medical Services at the time of an audit conducted by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the thirty-day period.

Failure to furnish records upon request may result in sanctions being imposed.

231.000 Rate Appeal Process 11-1-06

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the assistant director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the assistant director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

When the provider disagrees with the decision of the Assistant Director, Division of Medical Services, the provider may appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) management staff, who will serve as chairperson.

The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

241.000 Claim Filing Procedures 11-1-06

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

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

When the Medicare intermediary or carrier completes the processing of the claim, the information is forwarded to EDS on computer tape. EDS processes it in the next weekend cycle for payment of coinsurance and deductible. The transaction will usually appear on the Medicaid RA within 3 weeks of payment by Medicare. If it does not appear within that time, the provider must request payment according to the instructions below.

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

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

EDS provides software with which to electronically bill Medicaid for Professional Crossover claims that do not cross to Medicaid. Institutional providers and those without electronic billing capability must mail a copy of the claim payment information from the Medicare Payment Report to EDS Claims Department. **View or print EDS Claims Department contact information.**

On the Medicare Payment Report:

A. Circle the provider name.

Write or type, within the circle, the Medicaid pay-to provider number to which Medicaid will write the check.

B. Circle the single claim that is being submitted for payment.

1. Within the circle, write or type the beneficiary's Medicaid identification number, effective for the claim dates of service.
2. When requesting payment for two or more claims appearing on the same page, send a separate copy for each claim, with only one claim circled on each copy and all other requested information present.

EDS staff must be able to locate and read the Medicare payment date and the Medicare claim's internal control number. Those items must be present and readable.

241.100 Billing Instructions 11-1-06

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

A. Insurance Policies

1. Private health
2. Group health
3. Liability
4. Automobile and/or medical insurance
5. Family health insurance carried by an absent parent
6. Medicare supplements ("Medi-Gap")

B. Worker's Compensation

C. Veteran's Administration

D. CHAMPUS

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

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