ARKANSAS REGISTER

Transmittal Sheet

Charlie Daniels
Secretary of State
State Capitol Room 026
Little Rock, Arkansas 72201-1094
(501) 682-3527

For Office Use Only: Effective Date _____ Code Number _____

Name of Agency Department of Health and Human Services.

Department Division of Medical Services.

Contact Lisa Smith E-mail lisa.smith.dms@arkansas.gov Phone 683-5776.

Statutory Authority for Promulgating Rule _____.

Rule Title: Sections I & III of all Medicaid Provider Manuals

Intended Effective Date

☐ Emergency

☐ 10 Days After Filing

☒ Other June 1, 2008

Date

Legal Notice Published..... 03/19/08 – 03/21/08.

Final Date for Public Comment..... 04/17/08.

Reviewed by Legislative Council.....

Adopted by State Agency..... 06/01/08.

☒ Electronic Copy of Rule Provided (per Act 1478 of 2003)

☒ Electronic Copy of Rule to be e-mailed from: Becky Murphy (Contact Person) becky.Murphy@arkansas.gov (Email Address)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended

Roy Jeffus
Signature

(501) 682-8292
Phone Number

roy.jeffus@arkansas.gov
E-mail Address

Director
Title

May 2, 2008
Date

FILED
AR. REGISTER
08 MAY -1 PM 3:45
CHARLIE DANIELS
SECRETARY OF STATE
STATE OF ARKANSAS
BY:

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Randy Helms
TELEPHONE NO. 682-1857 **FAX NO.** 682-3889 EMAIL: randy.helms@medicaid.state.ar.us

To comply with Act 1104 of 1995, please complete the following Financial Impact statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Section I & III – All Arkansas Medicaid Provider Manuals

1. **Does this proposed, amended, or repealed rule or regulation have a financial impact?**
   Yes____ No X

2. **If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.**

3. **If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation. Please indicate if the cost provided is the cost of the program.**

Current Fiscal Year	Next Fiscal Year
General Revenue_____	General Revenue _____
Federal Funds_____	Federal Funds _____
Cash Funds_____	Cash Funds_____
Special Revenue_____	Special Revenue _____
Other (Identify) _____	Other (Identify) _____
Total _____	Total _____

4. **What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation? Identify the party subject to the proposed regulation, and explain how they are affected.**

Current Fiscal Year	Next Fiscal Year

5. **What is the total estimated cost by fiscal year to the agency to implement this regulation?**

Current Fiscal Year	Next Fiscal Year
None	None

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480 · TDD: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers**

DATE: **June 1, 2008**

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

Provider Manual	Transmittal Number
Alternatives for Adults with Physical Disabilities Waiver	66
Ambulatory Surgical Center	99
ARKids First-B	68
Certified Nurse-Midwife	101
Child Health Management Services	101
Child Health Services/Early and Periodic Screening, Diagnosis and Treatment	106
Children's Services Targeted Case Management	48
Chiropractic	93
DDS Alternative Community Services Waiver	92
Dental	118
Developmental Day Treatment Clinic Services	103
Developmental Rehabilitation Services	48
Division of Youth Services and Division of Children and Family Services Targeted Case Management	40
Domiciliary Care	76
ElderChoices Home and Community-Based 2176 Waiver	92
Federally Qualified Health Center	87
Hearing Services	90
Home Health	110
Hospice	81
Hospital/End-Stage Renal Disease	132
Hyperalimentation	106
Inpatient Psychiatric Services for Under Age 21	98
Licensed Mental Health Practitioners	80
Living Choices Assisted Living	47
Medicare/Medicaid Crossover Only	73
Nurse Practitioner	99
Occupational, Physical, Speech Therapy Services	93
Personal Care	103
Pharmacy	117

REMOVE Section	Date	INSERT Section	Date
100.100	4-1-06	100.100	6-1-08
101.000	4-1-06	101.000	6-1-08
101.200	10-13-03	101.200	6-1-08
101.300	4-1-06	101.300	6-1-08
102.000	3-1-06	102.000	6-1-08
103.100	10-13-03	103.100	6-1-08
103.200	2-1-06	103.200	6-1-08
105.100	3-1-06	105.100	6-1-08
105.110	10-13-03	105.110	6-1-08
105.120	3-1-06	105.120	6-1-08
105.130	4-1-06	105.130	6-1-08
105.140	10-13-03	105.140	6-1-08
105.170	3-1-06	105.170	6-1-08
—	—	105.180	6-1-08
105.190	3-1-06	105.190	6-1-08
110.100	10-13-03	110.100	6-1-08
110.400	10-13-03	110.400	6-1-08
110.500	3-1-06	110.500	6-1-08
121.000	3-1-06	121.000	6-1-08
122.000	3-1-06	122.000	6-1-08
122.100	3-1-06	122.100	6-1-08

Section 124.180 is revised to improve readability.

Section 124.190 is revised to improve readability.

Section 124.200 is revised to improve readability.

Section 124.210 is revised to improve readability.

Section 124.230 is revised to improve readability and to clarify cost sharing requirements for the Working Disabled benefit category.

Section 125.100 is revised to improve readability.

Section 125.200 is revised to improve readability.

Section 131.000 is revised to improve readability and to explain the process of cost sharing for Medicaid beneficiaries

Section 132.000 is revised to site federal and state regulations for cost sharing.

Section 133.000 is revised to improve readability and to reference federal regulations and the manual sections which cover cost sharing.

Section 133.100 is revised to improve readability and reference the manual sections for Working Disabled cost sharing requirements as they apply to Inpatient Hospital coinsurance.

Section 133.200 is revised to improve readability.

Section 133.300 is revised to improve readability.

Section 133.400 is revised to improve readability and to reference the co-payment on Prescription Drugs for the working disabled and ARKids-First B manuals.

Section 133.500 is revised to improve readability.

Section 134.000 is revised to improve readability.

Section 135.000 is revised to improve readability.

Section 136.000 is revised to improve readability.

Section 141.000 is revised to improve readability and update the Provider Enrollment section about the National Provider Identifier (NPI).

Section 142.700 is revised to improve readability and to clarify circumstances for mandatory assignment of claims for provider services.

Section 171.100 is revised to improve readability.

Section 171.110 is revised to clarify PCP enrollment exclusions.

Section 171.170 is added section to define PCP for Out of State Services.

Section 172.100 is revised to add hospital and non-emergency or outpatient clinic services on the effective date or the day after the effective date of PCP enrollment as not requiring a PCP referral.

Section 172.200 is revised to add the Tuberculosis and Family planning aid categories as Medicaid-Eligible individuals that may not enroll with a PCP.

Section 173.610 is included to change the name of the agency from the Department of Health and Human Services to the Department of Human Services.

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

REMOVE Section	Date	INSERT Section	Date
122.300	3-1-06	122.300	6-1-08
123.000	3-1-06	123.000	6-1-08
123.100	3-1-06	123.100	6-1-08
123.200	3-1-06	123.200	6-1-08
124.110	3-1-06	124.110	6-1-08
124.120	10-13-03	124.120	6-1-08
124.130	10-13-03	124.130	6-1-08
124.140	10-13-03	124.140	6-1-08
124.150	4-1-06	124.150	6-1-08
124.160	10-13-03	124.160	6-1-08
124.170	4-1-06	124.170	6-1-08
124.180	4-1-06	124.180	6-1-08
124.190	10-13-03	124.190	6-1-08
124.200	4-1-06	124.200	6-1-08
124.210	4-1-06	124.210	6-1-08
124.230	4-1-06	124.230	6-1-08
125.100	4-1-06	125.100	6-1-08
125.200	4-1-06	125.200	6-1-08
131.000	4-1-06	131.000	6-1-08
132.000	4-1-06	132.000	6-1-08
133.000	10-13-03	133.000	6-1-08
133.100	4-1-06	133.100	6-1-08
133.200	4-1-06	133.200	6-1-08
133.300	4-1-06	133.300	6-1-08
133.400	4-1-06	133.400	6-1-08
133.500	4-1-06	133.500	6-1-08
134.000	4-1-06	134.000	6-1-08
135.000	4-1-06	135.000	6-1-08
136.000	4-1-06	136.000	6-1-08
141.000	4-1-06	141.000	6-1-08
142.700	12-1-03	142.700	6-1-08
171.100	6-1-06	171.100	6-1-08
171.110	7-1-05	171.110	6-1-08
—	—	171.170	6-1-08
172.100	7-1-05	172.100	6-1-08
172.200	7-1-05	172.200	6-1-08
173.610	4-1-06	173.610	6-1-08

Explanation of Updates

Section 100.100 is revised to improve readability.

Section 101.000 is revised to improve readability.

Section 101.200 is revised to improve readability.

Section 101.300 is revised to improve readability.

Section 102.000 is revised to improve readability and change the name of the agency from Department of Health and Human Services to Department of Human Services.

Section 103.100 is revised to update program information for Federally Mandated Services.

Section 103.200 is revised to update program information for Optional Services.

Section 105.100 is revised to improve readability.

Section 105.110 is revised to improve readability.

Section 105.120 is revised to improve readability.

Section 105.130 is revised to improve readability.

Section 105.140 is revised to add the service "Adult Companion Services" to the ElderChoices program description.

Section 105.170 is revised to improve readability and provide clarification to the NET Transportation services descriptions by adding subsection I excluding periods of retroactive eligibility as covered.

Section 105.180 is a new section added to describe TEFRA waiver services.

Section 105.190 is revised to improve readability.

Section 110.100 is revised to improve readability.

Section 110.400 is revised to provide a detailed list of services provided by the Arkansas Foundation for Medical Care, Inc.

Section 110.500 is revised to improve readability.

Section 121.000 is revised to improve readability.

Section 122.000 is revised to include information.

Section 122.100 is included to change the name of the agency from Department of Health and Human Services to Department of Human Services.

Section 122.300 is included to clarify presumptive eligibility for the pregnant women category.

Section 123.000 is revised to remind providers to print and retain eligibility documentation in the beneficiary record for all services provided.

Section 123.100 is revised to clarify the description and process of PES eligibility.

Section 123.200 is revised to provide clarification to the description and process of retroactive eligibility.

Section 124.110 is revised to improve readability.

Section 124.120 is revised to improve readability.

Section 124.130 is revised to clarify the benefit differences between the SOBRA pregnant women and pregnant women unborn child category.

Section 124.140 is revised to clarify the definition of Pregnant Women Presumptive Eligibility.

Section 124.150 is revised to clarify the description for the Qualified Medicare Beneficiaries and to change the name of the agency from the Department of Health and Human Services to the Department of Human Services.

Section 124.160 is revised to improve readability.

Section 124.170 is revised to improve readability.

TOC required

100.100 Introduction 6-1-08

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. The intent of Section I is to provide users with an understanding of Medicaid Program objectives and regulations. Additionally it contains details providers may need to answer questions often asked about the Medicaid Program. Six 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 administered 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 additional 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 section defines the scope of the Primary Care Case Management Program (PCCM) and regulations regarding provider and enrollee participation. It lists the categories of eligibility that are exempt from primary care physician (PCP) referral requirements and it itemizes the services that do not require PCP referral. PCP enrollment and enrollment transfer procedures are explained, as are PCP referral requirements and procedures.

E. Administrative Remedies and Sanctions-This area describes the rules for imposing sanctions.

F. Provider Due Process-This area describes how a provider may request an administrative reconsideration of an adverse decision/action within 30 calendar days after the notice of the decision/action.

101.000 Provider Manuals 6-1-08

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, are 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 completing paper claims.

Obtain provider manuals from 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 are asked whether 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.

101.200 Updates 6-1-08

Provider manuals are amended ("updated") in accordance with new, repealed or revised federal and state legislative and legal clarifications, Changes in DMS medical policy, new administrative or billing procedures and numerous other requirements, are implemented 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.

Provider manual pages are updated automatically on the Arkansas Medicaid Web site; providers are notified via e-mail or mail when an applicable manual update transmittal, official notice or RA message is issued. Providers must give Provider Enrollment an e-mail address to receive e-mail notification of the supplementary material.

Providers receiving paper copies of manual update transmittals, official notices and RAs must maintain the paper supplements as they are received. Only the revised sections 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 help providers quickly review changes. Minor wording changes (usually corrected spelling, punctuation or grammar) are not highlighted. An update transmittal memorandum accompanies updated provider manual sections. Provider manual update transmittals are assigned sequential identification numbers, e.g., Update Transmittal #1. The transmittal memo identifies any new sections being added and the sections being replaced, deleted or amended. It provides brief explanations of the revisions... Provider manual update transmittals are recorded on the update log located in Appendix A of the manual.

For persons maintaining a printed provider 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 transmittal memo effective date should be entered on the update log opposite the appropriate update transmittal number. Transmittal memos should be filed immediately following the update log in descending numerical order by transmittal number. Immediately following the transmittal memos 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.

101.300 Obtaining Provider Manuals 6-1-08

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 without charge 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 transmittals, 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 the fiscal agent.

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.

Send orders for CDs and printed manuals to EDS, Technical Publications. Include with your order a check made to EDS for the appropriate amount. **View or print the EDS manual order contact information.**

102.000 Legal Basis of the Medicaid Program 6-1-08

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 Human Services to establish a Medicaid Program in Arkansas. The Medicaid Program provides necessary medical services to eligible persons who would not be able to pay for such services.

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 assistance:

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

In Arkansas, the Division of Medical Services (DMS) administers the Medicaid Program. Within the Division, the Office of Long Term Care (OLTC) is responsible for nursing home policy and procedures.

103.100 Federally Mandated Services 6-1-08

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

Program	Coverage
Laboratory and X-Ray	All Ages
Certified Nurse-Midwife	All Ages
Medical and Surgical Services of a Dentist	All Ages
Nurse Practitioner (Pediatric, Family, Obstetric-Gynecologic and Gerontological)	All Ages
Nursing Facility	Age 21 or Older
Outpatient Hospital	All Ages
Physician	All Ages
Rural Health Clinic	All Ages

103.200 Optional Services 6-1-08

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 Older
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
Licensed Mental Health Practitioner	Under Age 21
Medical Supplies	All Ages
Nursing Facility	Under Age 21

Program	Coverage
Occupational, Physical and Speech Therapy	Under Age 21
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
Rehabilitative Services for Youth and Children	Under Age 21
Respiratory Care	Under Age 21
School Based Mental Health Services	Under Age 21
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 Participants	Under Age 17
Transportation Services (Ambulance, Non-Emergency)	All Ages
Ventilator Equipment	All Ages
Visual Care	All Ages

105.100 Alternatives for Adults with Physical Disbilities 6-1-08

The Alternatives for Adults with Physical Disabilities (APD) waiver program is for disabled individuals age 21 through 64 who receive Supplemental Security Income (SSI) or that are Medicaid eligible by virtue of their disability and without the services provided by the waiver program 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 that the beneficiary may choose either home and community-based services or 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. Detailed information is found in the APD provider manual.

105.110 ARKids First-B 6-1-08

ARKids First-B incorporates uninsured children age 18 and under into the health care system. ARKids First-B benefits are comparable to those of the state employees and teachers insurance programs. 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 aged 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 deemed uninsured. E. Children who do not have primary comprehensive health insurance, whose insurance is inaccessible or have non-employer sponsored insurance are considered 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) 6-1-08

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 (specified by the PCP of Medicaid and ARKids First-B.

A PCP contracts with DMS to provide primary care, health education and case management for his or her 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, therefore; he or she is responsible 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-beneficiaries, and children participating in ARKids First-B, must enroll with a PCP to receive Medicaid-covered or ARKids First-B services. Some individuals are not required to enroll with a PCP. A few services are covered without PCP referral. See Sections 170.000 through 173.000 for details regarding ConnectCare.

105.130 DDS Alternative Community Services (ACS) 6-1-08

The Developmental Disability Services Alternative Community Services (DDS ACS) waiver program is for beneficiaries who, without the waiver's services, would require institutionalization. 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 advising the beneficiary that he or she may freely choose between waiver's 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

Detailed information may be found in the DDS ACS Waiver provider manual.

105.140 ElderChoices 6-1-08

ElderChoices is designed for beneficiaries aged 65 and older, who, without the waiver's services, would require an intermediate level of care in a nursing home. The services listed below are designed to maintain beneficiaries at home and 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

I. Adult Companion Services

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 notifying the beneficiary that he or she may freely choose between waiver services and institutional services.

More detailed information may be found in the ElderChoices provider manual.

105.170 Non-Emergency Transportation Services (NET) **6-1-08**

Medicaid non-emergency transportation (NET) services for Medicaid beneficiaries are furnished, under the authority of a capitated selective contract waiver, by 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) when Medicaid pays only the Medicare premium, deductible and co pay.

D. Special Low Income Qualified Medicare Beneficiaries (SMB)

E. Qualifying Individual-1 (QI-1 eligible)

F. ARKids First-B participants

G. Women's Health (Family Planning) FP-W category eligible

H. Tuberculosis (TB) category eligible

I. Periods of Retroactive eligibility

Detailed information may be found the Transportation provider manual and on the Arkansas Medicaid Web site at **www.medicaid.state.ar.us**.

105.180 TEFRA 6-1-08

The Arkansas Department of Human Services implemented the TEFRA waiver effective January 1, 2003. The TEFRA waiver covers beneficiaries 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. of 2005 TEFRA children, aid category 49, receive the full range of Medicaid services. However, a premium may be required, based on parental income. See Section 124.220 for the premium chart.

105.190 Women's Health (Family Planning) 6-1-08

The Arkansas Department of Health and the Arkansas Department of 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 is women aged 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. (FPL, which changes every October 1).

Participants are not required to have a photo Medicaid identification card. Their Medicaid eligibility entitles them to most but not all Medicaid covered family planning services. Beneficiaries may use the participating and willing provider of their choice.

110.100 Provider Enrollment Contractor 6-1-08

EDS, a contractor, performs provider enrollment functions for Medicaid. Any questions regarding provider enrollment participation requirements or contracts should be directed to the EDS Provider Enrollment unit. **View or print the Provider Enrollment contact information.**

110.400 Arkansas Foundation for Medical Care, Inc. (AFMC) 6-1-08

A. Arkansas Foundation for Medical Care, Inc., (AFMC) performs most medical and surgical prior authorizations. **View or print the AFMC contact information.**

B. AFMC administers the Medicaid Utilization Management Program (MUMP).

C. AFMC is Arkansas Medicaid's Quality Improvement Organization.

D. Medicaid Managed Care Services (MMCS) and the NET Helpline are divisions of AFMC.

110.500 Customer Assistance 6-1-08

Customer Assistance, of the Division of County Operations, handles beneficiary inquiries regarding Medicaid eligibility, the Medicaid identification card and Medicaid coverage and benefits.. **View or print the Division of County Operations Customer Assistance Section contact information.**

121.000 Introduction 6-1-08

Medicaid eligibility determinants are such things as income (individual or household), resources, and medical needs with charges exceeding one's ability to pay, age or

disability, current residency in Arkansas and other factors. The full range of criteria is beyond the scope of this provider manual. Eligibility inquires should be made to the local DHS office in the needy individual's county of residence.

122.000 Agencies Responsible for Determining Eligibility 6-1-08

The Department of Human Services (DHS) 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 pregnant women in the SOBRA Pregnant Women, Infants and Children aid category.

District Social Security offices determine Supplemental Security Income (SSI) eligibility, which automatically confers Medicaid eligibility.

122.100 Department of Human Services County Offices 6-1-08

Family Support Specialists in the DHS 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 and determination, the DHS 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.

122.300 Department of Health 6-1-08

The Department determines presumptive eligibility for category 62, Pregnant Women-Presumptive Eligibility. The Department 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 6-1-08

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. Providers should print and retain eligibility documentation in the beneficiary's record each time services are provided or to document retroactive eligibility.

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 6-1-08

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. A PES electronic eligibility

verification inquiry and positive response (i.e. the beneficiary is eligible on the date of service) guarantees that a claim for service on that date will not deny for ineligibility.

123.200 Retroactive Medicaid Eligibility 6-1-08

Medicaid beneficiaries may be found eligible for Medicaid benefits for the three-month period before the application date, if eligibility requirements for the three-month period are met. The DHS county offices establish retroactive eligibility. Initial SSI eligibility is usually retroactive.

124.110 ARKids First-B 6-1-08

Act 407 of 1997 established the ARKids First Program. The ARKids First-B Program incorporates uninsured children into the health care system. ARKids First-B benefits are comparable to the Arkansas state employees and teachers insurance program.

Covered services provided to ARKids First-B participants are within the same scope of services provided to Arkansas Medicaid (ARKids First-A and other full-benefit) 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 6-1-08

The medically needy category helps provide medical care for those individuals who are medically eligible for benefits, but while their income and/or resources exceed the Medicaid's limits for other types of assistance they are but are insufficient to pay for all or part of necessary medical care.

Individuals in such circumstances are frequently eligible for the full range of Medicaid benefits except 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 6-1-08

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 SOBRA pregnant women (PW-PL) receive only services related to the pregnancy and services that if not provided to PW-PLs could complicate the pregnancy. Generally, PW-PL eligible's are covered for postpartum follow-up services and family planning services; however it is important to note that their PW-PL eligibility ends on the last day of the month in which the 60th postpartum day occurs, PW-Unborn Child group (covered through the State Child Health Insurance program, which is authorized by Section 4901 of the Balanced Budget Act of 1997) does not cover sterilization or any other family planning services. Therefore providers need to verify eligibility to determine if the pregnant women is PW-PL or PW "Unborn Child (when providers check eligibility the system will reflect: PW Unborn CH-no Ster cov" for the Unborn Child group).

A pregnant woman whose unborn child will be a US citizen (PW-Unborn Child) receives the same pregnancy services as those in the PW-PL category;however after delivery, no family planning services (including sterilization) are covered.

124.140 Pregnant Women Presumptive Eligibility 6-1-08

Covered services are outpatient services related to the pregnancy and services for conditions that, if not treated could complicate the pregnancy. Services are further limited to ambulatory prenatal care (hospitalization is not covered).

124.150 Qualified Medicare Beneficiaries (QMB) 6-1-08

The Qualified Medicare Beneficiary (QMB) group was created by the Medicare Catastrophic Coverage Act and uses Medicaid funds to assist low-income Medicare beneficiaries. QMBs do not receive the full range of Medicaid benefits. For example, QMBs do not receive prescription drug benefits from Medicaid or drugs not covered under Medicare Part D. If a person is eligible for QMB, Medicaid pays the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance, less any Medicaid cost sharing, for Medicare covered medical services. Medicaid also pays the Medicare Part A hospital deductible and the Medicare Part A co insurance, less any Medicaid cost sharing. Medicaid pays the the Medicare Part A premium for QMBs whose employment history is insufficient for Title XVIII to pay it. Certain QMBs may be eligible for other limited Medicaid services. Only Medicare/Medicaid dual eligilbes qualify for coverage of Medicaid services that Medicare does not cover.

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 may not exceed 100% of the Federal Poverty Level (FPL). Countable resources may be equal to but not 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 simultaneously. However, some QMBs may simultaneously receive assistance in the medically needy categories, SOBRA pregnant women (61 and 62), Family Planning (69) and TB (08). QMBsgenerally do not have Medicaid coverage for any service that is not covered under Medicare; with the exception of the above listed categories.

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.

Most providers are not federally mandated to accept Medicare assignment (See Section 142.700). However, if a physician or non-physician (by Medicare's definition) provider desires Medicaid reimbursement for coinsurance or deductible on a Medicare claim, he or she must accept Medicare assignment on that claim (see Section 142.200 D) and enter the information required by Medicare on assigned claims. When a provider accepts Medicare according to section 142.200 D the beneficiary is not responsible for the difference between the billed charges and the Medicare allowed amount. Medicaid will pay a QMB's or Medicare/Medicaid dual eligible's Medicare cost sharing (less any applicable Medicaid cost sharing) for Medicare covered services.

Interested individuals may be directed to apply for the QMB program at their local Department of Human Services (DHS) county office.

124.160 Qualifying Individuals-1 (QI-1) 6-1-08

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 do not receive a Medicaid card. Additionally, unlike QMBs and SMBs, they 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 must choose which coverage they want 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 payment 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 fiscal year) Federal Poverty Level.

Countable resources may equal but not exceed twice the current SSI resource limitations.

124.170 Specified Low-Income Medicare Beneficiaries (SMB) 6-1-08

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 only for Medicaid 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 those for QMB program. The individuals must be aged 65 or older, blind or disabled and entitled to receive Medicare Part A hospital insurance and Medicare Part B 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 not exceed twice the current SSI resource limitations.

Interested individuals may apply for SMB eligibility at their local Department of Human Services (DHS) county office.

124.180 Tuberculosis (TB) 6-1-08

The TB aid category is for low-income individuals of all ages who are infected or who are suspected to be infected with Tuberculosis (TB). Application may be made through the Arkansas Department 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 for individuals in 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) 6-1-08

Women in aid category 69 (FP-W) are eligible for most family planning services, subject to the benefit limits listed in the appropriate provider manual.

124.200 Beneficiary Aid Categories with Additional Cost Sharing 6-1-08

Certain programs require additional cost sharing for Medicaid services. These programs are discussed in sections 124.210 through 124.230.

124.210 ARKids First-B 6-1-08

Covered services provided to ARKids First-B participants are (with only a few exceptions) 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.

124.230 Working Disabled 6-1-08

The Working Disabled category is an employment initiative designed to enable people with disabilities to gain employment without losing medical benefits. Individuals who are aged 16 through 64; disabled as defined by Supplemental Security Income (SSI) criteria; and who meet the income and resource criteria may be 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.

Beneficiaries with gross income below 100% of the Federal Poverty Level (FPL) are responsible for the regular Medicaid cost sharing (pharmacy; inpatient hospital; and prescription services for eyeglasses). They are designated in the system as "WD RegCO".

B. New cost sharing requirements.

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 are 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
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 aged 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

Program Services	New Co-Payment*
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 facility's Medicaid per diem for the first Medicaid-covered day
Outpatient 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 aged 21 and older)	None
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 the first covered day's Medicaid in-patient per diem.
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
VisualCare	$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. Coverage requires prior approval except in emergencies.

*** **Exception:** This service is NOT covered for individuals in the Occupational, Physical and Speech Therapy Program for individuals aged 21 and older.

NOTE: Providers should consult the appropriate provider manual to determine coverage and benefits.

125.100 Explanation of Medicaid Identification Card 6-1-08

Medicaid beneficiaries are issued a magnetic identification card similar to a credit card. Each identification card displays a hologram, and for many Medicaid categories, a picture of the beneficiary. Children under the age of five, ARKids First-B participants, nursing home patients and home and community-based waiver beneficiaries are not pictured. New participants in the Women's Health Program (Family Planning Wavier Category 69) and ARKids First -A are not pictured unless their current certification is under an existing case number and they 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 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 look different from a Medicaid identification card. See the ARKids First-B Provider Manual for more information.

125.200 Non-Receipt or Loss of Card by Beneficiary 6-1-08

When beneficiaries report non-receipt or loss of a Medicaid card, refer them to the local DHS County Office or the Division of County Operations, Customer Assistance. **View or print the Division of County Operations, Customer Assistance contact information.**

131.000 Charges that Are Not the Responsibility of the Beneficiary 6-1-08

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

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 because of errors made by DMS or EDS .

E. A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed.

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

G. Medicaid pays the difference, if any, between the Medicaid maximum allowable fee and the total of all payments previously received by the provider for the same service. Medicaid recipients are not responsible for deductibles, copayments or co-insurance amounts to the extent that such payments, when added to the amounts paid by third parties, exceed the Medicaid maximum for that service. The beneficiary is responsible for paying applicable Medicaid cost share amounts.

H. 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 and Medicaid cost-sharing amounts 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 6-1-08

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

E. The beneficiary is also responsible for any applicable cost-sharing amounts such as 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 124.210 -124.230 and 133.000 –135.000 of this manual.

133.000 Cost Sharing 6-1-08

There are four forms of cost sharing in the Medicaid Program: co-insurance, co-payment, deductibles and premiums. Each is in the following sections 133.100 through 133.500

133.100 Inpatient Hospital Coinsurance Charge for Medicaid Beneficiaries Without Medicare. 6-1-08

For inpatient admissions, the Medicaid coinsurance charge per admission for non-exempt Medicaid beneficiaries aged 18 and older is **10%** of the hospital's interim Medicaid per diem, applied on the first Medicaid covered day. (See section 124.230 for Working Disabled cost-sharing requirements.)

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 6-1-08

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

Example:

An ARKids First-B beneficiary is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem 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 6-1-08

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 Medicare 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 the 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 current (federal fiscal year) Medicare 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. Medicaid's payment is the current (federal fiscal year) Medicare Medicare Part A deductible minus $50.00 Medicaid coinsurance.

If, on a subsequent admission, Medicare Part A assesses coinsurance Medicaid will deduct from the Medicaid payment, an amount equal to 10% of the hospital's Medicaid per diem for one day. The patient will be responsible for the amount deducted from the Medicaid payment.

133.400 Co-payment on Prescription Drugs 6-1-08

Arkansas Medicaid has a beneficiary co-payment requirement in the Pharmacy Program. The payment is applied per prescription. Non-exempt beneficiaries aged 18 and older are responsible for paying the provider a co-payment amount based on the following table: (See section 124.230 for Working Disabled cost-sharing requirements. See ARKids First B manual for ARKids-First B cost-sharing requirements.)

Medicaid Maximum Amount	Beneficiary Co-pay
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

133.500 Co-Payment of Eyeglasses for Beneficiaries Aged 21 and Older 6-1-08

Arkansas Medicaid has a beneficiary co-payment requirement in the Visual Care Program. Medicaid Beneficiaries 21 years of age and older must pay a $2.00 co-payment for Visual Care prescription services. Nursing home residents are exempt from the co-pay requirement.

134.000 Exclusions from Cost Sharing Policy 6-1-08

As required by 42 C.F.R. § 447.53(b), the following services are excluded from the beneficiary cost sharing requirement:

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

1. Services for ARKids First-B beneficiaries (see the ARKids Manual for more information about this program)
2. Services for individuals under age 18 in the Working Disabled category.

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 (for personal needs) of his or her income 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 requirement. Unless a Medicaid beneficiary has been found eligible for long term care assistance through the Arkansas Medicaid Program, and Medicaid is making a vendor payment to the nursing facility (NF or ICF/MR) for the beneficiary, the beneficiary is not exempt from the cost sharing requirement.

E. Family planning services and supplies .

The provider must maintain sufficient documentation in the beneficiary's medical record to substantiate any exemption from the beneficiary cost sharing requirement.

135.000 Collection of Coinsurance/Co-payment 6-1-08

The method of collecting the coinsurance/co-payment amount from the beneficiary is the provider's responsibility. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing (coinsurance or co-payment) from the beneficiary remains the provider's responsibility.

The provider may not deny services to a Medicaid beneficiary because of the individual's inability to pay the coinsurance or co-payment. However, the individual's inability to pay does not eliminate his or her liability for the coinsurance or co-payment charge.

The beneficiary's inability to pay the coinsurance or co-payment does not alter the Medicaid reimbursement for the claim. Unless the beneficiary or the service is exempt from cost-sharing requirements as listed in section 134.000.Medicaid reimbursement is made in accordance with the current reimbursement methodology and when applicable cost sharing amounts are deducted from the maximum allowable fee before payment.

136.000 Patient Self Determination Act 6-1-08

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 employ the following procedures:

A. Provide all adult (aged 18 and older) patients (not just Medicaid beneficiaries) 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 furnished to Medicaid beneficiaries by the following provider types and in accordance with the listed procedures.

   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 a beneficiary's 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. Additionally providers must also document whether patients have signed an advance directive and record the terms of the advance directive.

E. Not discriminate against a beneficiary 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.**

141.000 Provider Enrollment 6-1-08

Any provider of health care services must be enrolled in the Arkansas Medicaid Program before Medicaid will cover 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 each program's provider manual contains provider type-specific participation requirements.

Upon receipt and approval of required documentation and a Medicaid contract the Medicaid Provider Enrollment Unit, will assign a unique Medicaid number to the provider. The assigned provider number is linked to the provider's tax identification number (either a Social Security number of a federal Employer Identification Number) and to the provider's National Provider Identifier (NPI) unless the provider is an atypical provider not required to have an NPI. Provider eligibility is retroactive one year from the date the provider agreement is approved, the effective date of the provider's license or certification or the date Medicaid implemented the provider's program or , whichever date is the most recent.

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 provider's authorized representative may sign the contract for a group practice, hospital, agency or other institution.

142.700 Mandatory Assignment of Claims for "Physician" Service 1216s and Medicaid's Mandatory Assignment of Claims for Provider Services 6-1-08

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, reimbursement for "physician" services furnished to an individual enrolled under Medicare who is also eligible for Medicaid, *including qualified Medicare beneficiaries* may only be made on an assignment related basis. Not all providers are federally mandated to accept Medicare assignment (See Section 142.200). However , if a physician or Medicaid enrolled non-physician desires Medicaid reimbursement for the insured's cost share on a Medicare claim, he or she must accept assignment on that claim (See Section 142.200D) and enter the information required by Medicare on assigned claims. The beneficiary is not responsible for the difference between the billed charges and the Medicare allowed amount.

Item 1-C of the Contract to participate in the Arkansas Medical Assistance Program (**View or print Form DMS-653 Section V of the Provider Manual**) requires enrollment and acceptance of assignment under Title XIX (Medicaid) for any applicable deductible or coinsurance that may be due and payable under Medicaid.

When a beneficiary is dually eligible for Medicare and Medicaid, including those eligible as qualified Medicare beneficiaries (QMBs) and is provided services that are covered by Medicare, Medicaid will not reimburse for applicable deductible or coinsurance that may be due and payable under Medicare if Medicare has not been billed and made payment prior to billing Medicaid. The beneficiary cannot be billed the difference in Medicare and Medicaid payment or billed chares on assigned claims.

Claims properly filed directly to the original Medicare plan intermediary by Arkansas Medicaid enrolled providers should automatically cross to Medicare's Coordination of Benefits Assignment (COBA) process then to Arkansas Medicaid, once Medicare processing and payment has been completed. The cross over claim should process in the next weekend cycle for Medicaid payment of applicable coinsurance and deductibles (usually within four to six weeks of Medicare payment).However, claims for Medicare beneficiaries entitled under the Railroad Retirement Act or Medicare Advantage will not automatically cross to Arkansas Medicaid for payment and must be filed directly with Arkansas Medicaid after Medicare payment has been received by the provider. See Section -330.000 of this Provider Manual for further information.

NOTE: A Provider enrolled to participate in the Title XVIII Medicare Program must notify the Provider Enrollment Unit of their National Provider Identifier (NPI). View or print form DMS-683, NPI Reporting Form. View or print Medicaid Provider Enrollment Unit contact information.

171.100 PCP-Qualified Physicians and Single-Entity Providers 6-1-08

A. Obstetricians and gynecologists may choose whether to be PCPs.

B. All other PCP-qualified physicians and clinics must enroll as PCPs, except for physicians who certify in writing that they are employed exclusively by an Area Health Education Center (AHEC), a Federally Qualified Health Center (FQHC), a Medical College Physicians Group, or a hospital (i.e., they are "hospitalists" and they practice exclusively in a hospital).

C. PCP-qualified physicians are those whose sole or primary specialty is

1. Family Practice
2. General Practice
3. Internal Medicine
4. Obstetrics and gynecology

5. Pediatrics and Adolescent Medicine

D. Physicians with multiple specialties may elect to enroll as PCPs if a secondary or tertiary specialty in their Medicaid provider file is listed in part C above.

E. PCP-qualified clinics and health centers (single-entity PCPs) are

1. AHECs
2. FQHCs
3. The family practice and internal medicine clinics at the University of Arkansas for Medical Sciences

171.110 Exclusions 6-1-08

A. Physicians whose only specialty is emergency care or who practice exclusively in hospital emergency departments may not enroll as PCPs.

B. Physician group practices (except the family practice and internal medicine clinics at UAMS) may not be PCPs.

C. Rural Health Clinics (RHCs) may not be PCPs but PCP-qualified physicians affiliated with RHCs must be PCPs.

D. Physicians excluded in section 171.100 part B.

171.170 PCP for Out of State Services 6-1-08

Services that require PCP referral or PCP enrollment within Arkansas require PCP referral or PCP enrollment as applicable, when furnished outside of Arkansas.

172.100 Services not Requiring a PCP Referral 6-1-08

The services listed in this section do not require a PCP referral.

A. Alternatives for Adults with Physical Disabilities (Alternatives Program) waiver services

B. Anesthesia services, excluding outpatient pain management

C. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists The physician and facility assessment services do not require a PCP referral if the Medicaid beneficiary or ARKids First-B participant is enrolled with a PCP.

D. Dental services

E. DDS Alternative Community Services (ACS) Waiver services

F. Developmental Day Treatment Clinic Services (DDTCS) core services

G. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS.

H. Domiciliary Care

I. ElderChoices waiver services

J. Emergency services in an acute care hospital emergency department, including emergency physician services

K. Family Planning services

L. Gynecological care

M. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment

N. Mental health services, as follows:

1. Psychiatry
2. Rehabilitative services for persons with mental illness (RSPMI Program) who are aged 21 and older
3. Rehabilitative Services for Youth and Children (RSYC) Program

O. Obstetric (antepartum, delivery and postpartum) services.

1. Only obstetric-gynecologic services are exempt from the PCP referral requirement.
2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications
3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider.

P. Nursing facility services and intermediate care facility for mentally retarded (ICF/MR) services.

Q. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye

R. Optometry services

S. Pharmacy services.

T. Physician services for inpatients in an acute care hospital. This includes

1. Direct patient care (initial and subsequent evaluation and management services, surgery, etc.) and
2. Indirect care (pathology, interpretation of X-rays etc.).

U. Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment.

V. Physician visits (except consultations) in the outpatient departments of acute care hospitals

1. Medicaid will cover these services without a PCP referral only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations.
2. Consultations require PCP referral.

W. Professional components of diagnostic laboratory, radiology and machine tests in the outpatient departments of acute care hospitals. Medicaid covers these services without a PCP referral only

1. If the Medicaid beneficiary is enrolled with a PCP and
2. The services are within applicable benefit limitations.

X. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services

Y. Transportation (emergency and non-emergency) to Medicaid-covered services

Z. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity, or would create unnecessary hardship.

172.200 Medicaid-Eligible Individuals that may not Enroll with a PCP 6-1-08

All Medicaid-eligible individuals and ARKids First-B participants must enroll with a PCP unless they:

A. Have Medicare as their primary insurance.

B. Are in a long term care aid category and a resident of a nursing facility.

C. Reside in an intermediate care facility for the mentally retarded (ICF/MR).

D. Are in a Medically Needy-Spend Down eligibility category.

E. Only have a retroactive eligibility period.

1. Medicaid does not require PCP enrollment for the period between the beginning of the retroactive eligibility segment and the fourth day (inclusive) following the eligibility authorization date.
2. If eligibility extends beyond the fourth day following the authorization date, Medicaid requires PCP enrollment unless the beneficiary is otherwise exempt from PCCM requirements.

F. Are in the Tuberculosis aid category.

G. Are in the Family Planning aid category.

173.610 PCP Transfers by Enrollee Request 6-1-08

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 DHS county office in the child's county of residence.

B. PCP transfer for any reason may be done at the local DHS 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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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Program Planning & Development
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TO: **Arkansas Medicaid Health Care Providers**

DATE: **June 1, 2008**

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

Provider Manual	Transmittal Number
Alternatives for Adults with Physical Disabilities Waiver	65
Ambulatory Surgical Center	98
ARKids First-B	67
Certified Nurse-Midwife	100
Child Health Management Services	100
Child Health Services/Early and Periodic Screening, Diagnosis and Treatment	105
Children's Services Targeted Case Management	47
Chiropractic	92
DDS Alternative Community Services Waiver	91
Dental	117
Developmental Day Treatment Clinic Services	102
Developmental Rehabilitation Services	47
Division of Youth Services and Division of Children and Family Services Targeted Case Management	39
Domiciliary Care	75
ElderChoices Home and Community-Based 2176 Waiver	91
Federally Qualified Health Center	86
Hearing Services	89
Home Health	109
Hospice	80
Hospital/End-Stage Renal Disease	131
Hyperalimentation	105
Inpatient Psychiatric Services for Under Age 21	97
Licensed Mental Health Practitioners	79
Living Choices Assisted Living	46
Medicare/Medicaid Crossover Only	72
Nurse Practitioner	98
Occupational, Physical, Speech Therapy	92
Personal Care	102
Pharmacy	116
Physician/Independent Lab/CRNA/Radiation Therapy Center	147

Provider Manual	Transmittal Number
Podiatrist	94
Portable X-Ray Services	83
Private Duty Nursing Services	96
Program of All-Inclusive Care for the Elderly	24
Prosthetics	111
Rehabilitative Hospital	94
Rehabilitative Services for Persons with Mental Illness	95
Rehabilitative Services for Persons with Physical Disabilities	68
Rehabilitative Services for Youth and Children	48
Rural Health Clinic Services	85
School-Based Mental Health Services	54
Targeted Case Management	86
Transportation	105
Ventilator Equipment	86
Visual Care	106

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
332.100	10-13-03	332.100	6-1-08
332.200	10-13-03	332.200	6-1-08
332.300	4-1-07	332.300	6-1-08

Explanation of Updates

Section 332.100 is revised to clarify Medicare-Medicaid crossover claims filing.

Section 332.200 is revised to clarify claims filing procedures when Medicare denies a claim.

Section 332.300 is revised to clarify the instructions for filing a claim when a Medicare adjustment has occurred.

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) 682-8323 or (501) 682-6789 (TDD only). In-State Toll Free at 800-482-1141 or Out-of State Toll Free at 800-482-5850. The Toll-Free lines are voice 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

TOC not required

332.100 Medicare-Medicaid Crossover Claim Filing Procedures 6-1-08

If medical services are provided to a patient who is entitled to and is enrolled with coverage within the original Medicare plan under the Social Security Act and also to Medicaid benefits, it is necessary to file a claim only with the original Medicare plan. The claim must be filed according to Medicare's instructions and sent to the Medicare intermediary. The claim should automatically cross to Medicaid if the provider is properly enrolled with Arkansas Medicaid and indicates the beneficiary's dual eligibility on the Medicare claim form. According to the terms of the Medicaid provider contract, a provider must "accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any appropriate deductible or coinsurance which may be due and payable under Title XIX (Medicaid)." See Section I – 142.700 for further information regarding Medicare/Medicaid mandatory acceptance of assignment for providers.

When the original Medicare plan intermediary completes the processing of the claim, the payment information is automatically crossed to Medicare's Coordination of Benefits Agreement (COBA) process and from there crossed to Arkansas Medicaid and the claim is processed in the next weekend cycle for Medicaid payment of applicable coinsurance and deductible. The transaction will usually appear on the provider's Medicaid RA within four (4) to six (6) weeks of payment by Medicare. If it does not appear within that time, payment should be requested according to the instructions below.

Claims for Medicare beneficiaries entitled under the Railroad Retirement Act **do not** cross to Medicaid. The provider of services must request payment of co-insurance and deductible amounts through Medicaid according to the instructions below, after Railroad Retirement Act Medicare pays the claim.

Medicare Advantage/Medigap Plans (like HMOs and PPOs) are health plan options that are available to beneficiaries, approved by Medicare, but run by private companies. These companies' bill Medicare and pay directly through the private company for benefits that are a part of the Medicare Program, as well as offering enhanced coverage provisions to enrollees. Since these claims are paid through private companies and not through the original Medicare plan directly, these claims **do not** automatically cross to Medicaid and the provider must request payment of Medicare covered services co-insurance and deductible amounts through Medicaid according to the instructions below, after the Medicare Advantage/Medigap plan pays the claim.

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.

Instructions: EDS provides software and Web-based technology with which to electronically bill Medicaid for crossover claims that do not cross to Medicaid. Additional information regarding electronic billing can be located in this Section – Subsections 301.000 through 301.200. Providers are strongly encouraged to submit claims electronically or through the Arkansas Medicaid website. Front-end processing of electronically and web-based submitted claims ensures prompt adjudication and facilitates reimbursement.

Providers without electronic billing capability must mail a red-ink original claim of the appropriate crossover invoice to the address on the top of the form (see examples of red-ink original forms in Section V of this manual). To order copies of the appropriate Medicare-Medicaid crossover invoice, please use the Medicaid Form Request (EDS-MFR-001). **View or print form EDS-MFR-001.** Indicate the quantity of each form required and send the request to the Provider Assistance Center (PAC). **View or print PAC contact information.** Instructions for filling out the invoice are included with the ordered forms.

When you complete the appropriate red-lined Medicare-Medicaid crossover form, sign and date the form and mail it to the address printed at the top of the form.

332.200 Denial of Claim by Medicare 6-1-08

Any charges denied by either the original Medicare plan, a Medicare Advantage/Medigap plan, or Railroad Retirement, will not be automatically forwarded to Medicaid for reimbursement. An appropriate Medicaid claim form must be completed and a copy of the Medicare denial statement attached. Claims under these circumstances must be forwarded to the Provider Assistance Center (PAC) for processing. **View or print PAC contact information.**

332.300 Adjustments by Medicare 6-1-08

Any adjustment made by the original Medicare plan, a Medicare Advantage/Medigap plan, or Medicare Railroad Retirement, **will not** be automatically forwarded to Medicaid. If either Medicare payment source makes an adjustment that results in an overpayment or underpayment by Medicaid, the provider must submit an Adjustment Request Form – Medicaid XIX (**View or print Adjustment Request Form-Medicaid XIX EDS-AR-004**), available in Section V of this manual, an appropriate red-lined Medicare-Medicaid crossover form, completed with the **corrected** crossover billing information, and a copy of the Medicare EOMB reflecting Medicare's adjustment. Enter the provider identification number and the patient's Medicaid identification number on the face of the Medicare EOMB and mail all documents to the address located on the Adjustment Request Form (EDS-AR-004).