ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – ALL**

DATE: **October 8, 2010**

SUBJECT: **Provider Manual Update Transmittal #SecI-1-10**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
141.000	9-15-09	141.000	10-8-10
142.100	9-15-09	142.100	10-8-10
171.210	1-01-10	171.210	10-8-10
173.200	9-15-09	173.200	10-8-10

Explanation of Updates

Section 141.000 is updated to include the acceptance of a provider's approved electronic signature.

Section 142.100 is updated to include the acceptance of a provider's approved electronic signature.

Section 171.210 is updated to delete verbiage regarding original signature.

Section 173.200 is updated to delete verbiage regarding original signature and to correct verbiage in the link to the Provider Relations Representative contact information.

The paper version of this update transmittal includes revised pages that may be filed 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 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

If you have questions regarding this transmittal, please contact the HP Enterprise Services 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.

Eugene I. Gessow, Director

TOC not required

141.000 Provider Enrollment 10-8-10

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 new Medicaid provider is conditioned upon approval of a completed provider enrollment and contract package (AppMaterial), 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.

The provider enrollment functions for the Medicaid program are performed by an independent contractor. The contractor is responsible for provider enrollment services for new providers and changes to current provider enrollment files. New providers must complete all appropriate portions of a provider enrollment and contract package (AppMaterial) and submit a copy of all certifications and licenses verifying compliance with enrollment criteria for the discipline to be practiced. All subsequent state license and certification renewals must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and FINAL 30 days to comply. Failure to timely submit verification of license or certification renewals will result in cancellation of enrollment in the Arkansas Medicaid Program. **View or print the provider enrollment and contract package (AppMaterial).**

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.**

In addition to the information in Section 140.000, Section II of each program's provider manual contains provider type-specific participation requirements and program guidelines where applicable.

All providers must sign an Arkansas Medicaid Provider Contract. The signature must be an original signature or an approved electronic signature of the individual provider. The provider's authorized representative may sign the contract for a group practice, hospital, agency or other institution.

Upon receipt and approval of the provider application, 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 or 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.

142.100 General Conditions 10-8-10

A. Each provider must be licensed, certified or both, as required by law, to furnish all goods or services that may be reimbursed by the Arkansas Medicaid Program.

B. Providers must adhere to all applicable standards for professional conduct and quality care.

C. It is the responsibility of each provider to read the complete Arkansas Medicaid provider manual provided by DMS and to abide by the rules and regulations specified in the manual.

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

E. Services will be provided to qualified beneficiaries without regard to race, color, national origin or disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

F. Each provider must notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract, such as:

1. Change of address (**View or print form DMS-673 – Address Change Form.**)
2. Change in members of group, professional association or affiliations*
3. Change in practice or specialty*
4. Change in Federal Employer Identification Number (FEIN)*
5. Retirement or death of provider*
6. Complete change of ownership (**View or print form DMS-0688 – Provider Change of Ownership Information Form.**)
7. Change in Ownership Control (5% or more) or Conviction of Crime (**View or print form DMS-675 – Ownership and Conviction Disclosure.**)
8. Disclosure of Significant Business Transactions (**View or print form DMS-689 – Disclosure of Significant Business Transactions**.)

Changes in items two (2) through five (5) above may be properly addressed through a letter of explanation with the provider's original signature or an approved electronic signature and the appropriately corrected pages of the provider application document (**View or print form DMS-652 – Provider Application Form**).

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

This rule does not apply to:

1. Pharmaceutical samples provided to a physician at no cost or to other comparable circumstances where the provider obtains the sample at no cost and distributes the samples without regard to Medicaid eligibility.
2. Provider actions taken under the express authority of state or federal Medicaid laws or rules or the provider's agreement to participate in the Medicaid Program.

171.210 ConnectCare Caseload Maximum and PCP Caseload Limits 10-8-10

A. Each PCP may establish an upper limit to his or her Medicaid caseload, up to the default maximum of 2500.

1. The state may permit higher maximum caseloads in areas the federal government has designated as medically underserved.
2. The state may permit higher maximum caseloads for PCPs who state in writing that the default maximum will create a hardship for them, their patients and/or the community they serve.

B. The state will not require any PCP to accept a caseload greater than the PCP's requested caseload maximum.

C. At any time, a PCP may increase or decrease his or her maximum desired caseload by any amount, up to the default maximum by submitting a signed request to his or her Provider Relations Representative, or on-line through the Medicaid Website (**www.medicaid.state.ar.us/**), Provider Enrollment Information, and Access to the Provider Information Portal.

D. To request an increase in a PCP caseload above the default maximum, the PCP must submit a written request to the Provider Relations Representative. **View or print Provider Relations Representative contact information.**

E. Prior to making the request for an increase of a caseload that is already at the default maximum, PCPs are encouraged to review their caseload for inactive patients to determine if those patients should be removed from their caseload. To do so, PCPs may use the Arkansas Medicaid Information Interchange (AMII) web portal. If it is determined that the inactive patients should be removed from his or her caseload, the PCP must:

1. Contact the patient in writing at least 30 days in advance of the effective date of the termination to give the patient the option of making a visit to the PCP to remain an active patient. If the patient does not choose to make a visit to the PCP, the termination can be effective at the end of 30 calendar days.
2. With approval from his or her Provider Relations Representative, the PCP may add and see new patients during the 30 calendar day notification process of inactive patients.
3. The notice must state that the enrollee has 30 calendar days in which to enroll with a different PCP.
4. The PCP must forward a copy of the notice to the enrollee and to the local DHS office in the enrollee's county of residence.

173.200 PCP Selection and Enrollment at PCP Offices and Clinics 10-8-10

Physician and single-entity PCPs may enroll Medicaid beneficiaries and ARKids First-B participants by means of the telephonic voice response system (VRS.)

A. Enrollees must document their PCP choice on a Primary Care Physician Selection and Change form (DMS 2609 or DCO-2609.)

1. The form must be completed, dated and signed by the enrollee.
2. The enrollee may request and receive a copy of the form.
3. The PCP office must retain a copy of the form in the enrollee's file.

B. Enrolling the beneficiary is performed by accessing the VRS and following the instructions. **View or print Voice Response System (VRS) contact information.**

C. When a PCP wants to add a new enrollee but the PCP's Medicaid caseload is full or when a PCP wants to increase or decrease his or her caseload limit:

1. The PCP may increase or decrease his or her maximum desired caseload by any amount, at any time, up to the default maximum by submitting a signed request to their Medicaid Managed Care Services (MMCS) Provider Relations Representative or, on-line through the Medicaid Website **www.medicaid.state.ar.us/** Provider Enrollment Information, Access to the Provider Information Portal.

2. Prior to making the request for an increase of a caseload that is already at maximum, the PCP is encouraged to review their caseload using the AMII (Arkansas Medicaid Information Interchange) web portal for inactive patients, to determine if those patients should be removed from their caseload. An increase in PCP caseload above the default maximum requires a written request to the Provider Relations Representative. **View or print Provider Relations Representative contact information**.

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SUBJECT: **Provider Manual Update Transmittal #SecIV-1-10**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
400.000	2-1-08	400.000	10-8-10

Explanation of Updates

Section 400.000 is updated to include the term and definition of an electronic signature.

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Eugene I. Gessow, Director

SECTION IV - GLOSSARY

400.000 **10-8-10**

AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ABESPA	Arkansas Board of Examiners in Speech-Language Pathology and Audiology
ACD	Augmentative Communication Device
ACIP	Advisory Committee on Immunization Practices
ACES	Arkansas Client Eligibility System
ACS	Alternative Community Services
ADE	Arkansas Department of Education
ADH	Arkansas Department of Health
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children (cash assistance program replaced by the Transitional Employment Assistance (TEA) program)
AFMC	Arkansas Foundation for Medical Care, Inc.
AHEC	Area Health Education Centers
ALF	Assisted Living Facilities
ALS	Advance Life Support
ALTE	Apparent Life Threatening Events
AMA	American Medical Association
APD	Adults with Physical Disabilities
ARS	Arkansas Rehabilitation Services
ASC	Ambulatory Surgical Centers
ASHA	American Speech-Language-Hearing Association
BIPA	Benefits Improvement and Protection Act
BLS	Basic Life Support
CARF	Commission on Accreditation of Rehabilitation Facilities
CCRC	Children's Case Review Committee
CFA	One Counseling and Fiscal Agent
CFR	Code of Federal Regulations
CHMS	Child Health Management Services
CLIA	Clinical Laboratory Improvement Amendments
CME	Continuing Medical Education
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COA	Council on Accreditation
CON	Certification of Need

CPT	Physicians' Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CSHCN	Children with Special Health Care Needs
CSWE	Council on Social Work Education
D&E	Diagnosis and Evaluation
DAAS	Division of Aging and Adult Services
DBS	Division of Blind Services (currently named Division of Services for the Blind)
DCFS	Division of Children and Family Services
DCO	Division of County Operations
DD	Developmentally Disabled
DDS	Developmental Disabilities Services
DDTCS	Developmental Day Treatment Clinic Services
DHS	Department of Human Services
DLS	Daily Living Skills
DME	Durable Medical Equipment
DMHS	Division of Mental Health Services
DMS	Division of Medical Services (Medicaid)
DOS	Date of Service
DRG	Diagnosis Related Group
DRS	Developmental Rehabilitative Services
DSB	Division of Services for the Blind (formerly Division of Blind Services)
DSH	Disproportionate Share Hospital
DURC	Drug Utilization Review Committees
DYS	Division of Youth Services
EAC	Estimated Acquisition Cost
EFT	Electronic Funds Transfer
EIN	Employer Identification Number
EOB	Explanation of Benefits
EOMB	Explanation of Medicaid Benefits. EOMB may also refer to Explanation of Medicare Benefits.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ESC	Education Services Cooperative
FEIN	Federal Employee Identification Number
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
GUL	Generic Upper Limit
HCBS	Home and Community Based Services

HCPCS	Healthcare Common Procedure Coding System
HDC	Human Development Center
HHS	The Federal Department of Health and Human Services
HIC Number	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HP	Hewlett Packard
IADL	Instrumental Activities of Daily Living
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification
ICF/MR	Intermediate Care Facility/Mental Retardation
ICN	Internal Control Number
IDEA	Individuals with Disabilities Education Act
IDG	Interdisciplinary Group
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IMD	Institution for Mental Diseases
IPP	Individual Program Plan
IUD	Intrauterine Devices
JCAHO	Joint Commission on Accreditation of Healthcare Organization
LAC	Licensed Associate Counselor
LCSW	Licensed Certified Social Worker
LEA	Local Education Agencies
LMFT	Licensed Marriage and Family Therapist
LMHP	Licensed Mental Health Practitioner
LPC	Licensed Professional Counselor
LPE	Licensed Psychological Examiner
LSPS	Licensed School Psychology Specialist
LTC	Long Term Care
MAC	Maximum Allowable Cost
MAPS	Multi-agency Plan of Services
MART	Medicaid Agency Review Team
MEI	Medicare Economic Index
MMIS	Medicaid Management Information System
MNIL	Medically Needy Income Limit
MPPPP	Medicaid Prudent Pharmaceutical Purchasing Program
MSA	Metropolitan Statistical Area
MUMP	Medicaid Utilization Management Program
NBCOT	National Board for Certification of Occupational Therapy

NCATE	North Central Accreditation for Teacher Education
NDC	National Drug Code
NET	Non-Emergency Transportation Services
NF	Nursing Facility
NPI	National Provider Identifier
OBRA	Omnibus Budget Reconciliation Act
OHCDS	Organized Health Care Delivery System
OTC	Over the Counter
PA	Prior Authorization
PAC	Provider Assistance Center
PCP	Primary Care Physician
PERS	Personal Emergency Response Systems
PES	Provider Electronic Solutions
PHS	Public Health Services
PIM	Provider Information Memorandum
PL	Public Law
POC	Plan of Care
POS	Place of Service
PPS	Prospective Payment System
PRN	Pro Re Nata or “As Needed”
PRO	Professional Review Organization
ProDUR	Prospective Drug Utilization Review
QMB	Qualified Medicare Beneficiary
QMRP	Qualified Mental Retardation Professional
RA	Remittance Advice. Also called Remittance and Status Report
RFP	Request for Proposal
RHC	Rural Health Clinic
RID	Recipient Identification Number
RSPD	Rehabilitative Services for Persons with Physical Disabilities
RSPMI	Rehabilitation Services for Persons with Mental Illness
RSYC	Rehabilitative Services for Youth and Children
RTC	Residential Treatment Centers
RTP	Return to Provider
RTU	Residential Treatment Units
SBMH	School-Based Mental Health Services
SD	Spend Down
SFY	State Fiscal Year
SMB	Special Low Income Qualified Medicare Beneficiaries

SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SURS	Surveillance and Utilization Review Subsystem
TCM	Targeted Case Management
TEA	Transitional Employment Assistance
TEFRA	Tax Equity and Fiscal Responsibility Act
TOS	Type of Service
TPL	Third Party Liability
UPL	Upper Payment Limit
UR	Utilization Review
VFC	Vaccines for Children
VRS	Voice Response System
Accommodation	A type of hospital room, e.g., private, semiprivate, ward, etc.
Activities of Daily Living (ADL)	Personal tasks that are ordinarily performed on a daily basis and include eating, mobility/transfer, dressing, bathing, toileting and grooming
Adjudicate	To determine whether a claim is to be paid or denied
Adjustments	Transactions to correct claims paid in error or to adjust payments from a retroactive change
Admission	Actual entry and continuous stay of the beneficiary as an inpatient to an institutional facility
Affiliates	Persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another
Agency	The Division of Medical Services
Aid Category	A designation within SSI or state regulations under which a person may be eligible for public assistance
Aid to Families with Dependent Children (AFDC)	A Medicaid eligibility category
Allowed Amount	The maximum amount Medicaid will pay for a service as billed before applying beneficiary coinsurance or co-pay, previous TPL payment, spend down liability or other deducted charges
American Medical Association (AMA)	National association of physicians
Ancillary Services	Services available to a patient other than room and board. For example: pharmacy, X-ray, lab and central supplies
Arkansas Client Eligibility System (ACES)	A state computer system in which data is entered to update assistance eligibility information and beneficiary files
Arkansas Foundation for Medical Care, Inc. (AFMC)	State professional review organization

Attending Physician	*See Performing Physician*.
Automated Eligibility Verification Claims Submission (AEVCS)	On-line system for providers to verify eligibility of beneficiaries and submit claims to fiscal agent
Base Charge	A set amount allowed for a participating provider according to specialty
Beneficiary	Person who meets the Medicaid eligibility requirements, receives an ID card and is eligible for Medicaid services (formerly recipient)
Benefits	Services available under the Arkansas Medicaid Program
Billed Amount	The amount billed to Medicaid for a rendered service
Buy-In	A process whereby the state enters into an agreement with the Medicaid/Medicare and the Social Security Administration to obtain Medicare Part B (and part A when needed) for Medicaid beneficiaries who are also eligible for Medicare. The state pays the monthly Medicare premium(s) on behalf of the beneficiary.
Care Plan	*See Plan of Care (POC).*
Casehead	An adult responsible for an AFDC or Medicaid child
Categorically Needy	All individuals receiving financial assistance under the state's approved plan under Title I, IV-A, X, XIV and XVI of the Social Security Act or in need under the state's standards for financial eligibility in such a plan
Centers for Medicare and Medicaid Services	Federal agency that administers federal Medicaid funding
Child Health Services	Arkansas Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program
Children's Services	A Title V Children with Special Health Care Needs Program administered by the Arkansas Division of Developmental Disabilities Services to provide medical care and service coordination to chronically and disabled children
Claim	A request for payment for services rendered
Claim Detail	*See Line Item*.
Clinic	(1) A facility for diagnosis and treatment of outpatients. (2) A group practice in which several physicians work together
Closed-end Provider Agreement	An agreement for a specific period of time not to exceed 12 months, which must be renewed in order for the provider to continue to participate in the Title XIX Program.
Coinsurance	The portion of allowed charges the patient is responsible for under Medicare. This may be covered by other insurance, such as Medi-Pak or Medicaid (if entitled). This also refers to the portion of a Medicaid covered inpatient hospital stay for which the beneficiary is responsible.
Contract	Written agreement between a provider of medical services and the Arkansas Division of Medical Services. A contract must be signed by each provider of services participating in the Medicaid Program.
Co-pay	The portion of the maximum allowable (either that of Medicaid or a third-party payer) that the insured or beneficiary must pay
Cosmetic Surgery	Any surgical procedure directed at improving appearance but not medically necessary

Covered Service	Service which is within the scope of the Arkansas Medicaid Program
Current Procedural Terminology	A listing published annually by AMA consisting of current medical terms and the corresponding procedure codes used for reporting medical services and procedures performed by physicians
Credit Claim	A claim transaction which has a negative effect on a previously processed claim.
Crossover Claim	A claim for which both Titles XVIII (Medicare) and XIX (Medicaid) are liable for reimbursement of services provided to a beneficiary entitled to benefits under both programs
Date of Service	Date or dates on which a beneficiary receives a covered service. Documentation of services and units received must be in the beneficiary's record for each date of service.
Deductible	The amount the Medicare beneficiary must pay toward covered benefits before Medicare or insurance payment can be made for additional benefits. Medicare Part A and Part B deductibles are paid by Medicaid within the program limits.
Debit Claim	A claim transaction which has a positive effect on a previously processed claim
Denial	A claim for which payment is disallowed
Department of Health and Human Services (HHS)	Federal health and human services agency
Department of Human Services (DHS)	State human services agency
Dependent	A spouse or child of the individual who is entitled to benefits under the Medicaid Program
Diagnosis	The identity of a condition, cause or disease
Diagnostic Admission	Admission to a hospital primarily for the purpose of diagnosis
Disallow	To subtract a portion of a billed charge that exceeds the Medicaid maximum or to deny an entire charge because Medicaid pays Medicare Part A and B deductibles subject to program limitations for eligible beneficiaries
Discounts	A discount is defined as the lowest available price charged by a provider to a client or third-party payer, including any discount, for a specific service during a specific period by an individual provider. If a Medicaid provider offers a professional or volume discount to any customer, claims submitted to Medicaid must reflect the same discount. Example: If a laboratory provider charges a private physician or clinic a discounted rate for services, the charge submitted to Medicaid for the same service must not exceed the discounted price charged to the physician or clinic. Medicaid must be given the benefit of discounts and price concessions the lab gives any one of its customers.
Duplicate Claim	A claim that has been submitted or paid previously or a claim that is identical to a claim in process
Durable Medical Equipment	Equipment that (1) can withstand repeated use and (2) is used to serve a medical purpose. Examples include a wheelchair or hospital bed.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally mandated Medicaid program for eligible individuals under the age of 21. *See Child Health Services*.
Education Accreditation	When an individual is required to possess a bachelor's degree, master's degree, or a Ph.D. degree in a specific profession. The degree must be from a program accredited by an organization that is approved by the Council for Higher Education Accreditation (CHEA).
Electronic Signature	An electronic or digital method executed or adopted by a party with the intent to be bound by or to authenticate a record, which is: (a) Unique to the person using it; (b) Capable of verification; (c) Under the sole control of the person using it; and (d) Linked to data in such a manner that if the data are changed the electronic signature is invalidated. An Electronic Signature method must be approved by the DHS Chief Information Officer or his designee before it will be accepted. A list of approved electronic signature methods will be posted on the state Medicaid website.
Eligible	(1) To be qualified for Medicaid benefits. (2) One who is qualified for benefits
Eligibility File	A file containing individual records for all persons who are eligible or have been eligible for Medicaid
Emergency Services	Inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services. Source: 42 U.S. Code of Federal Regulations (42 CFR) and §424.101.
Error Code	A numeric code indicating the type of error found in processing a claim; also known as an "Explanation of Benefits (EOB) code" or a "HIPAA Explanation of Benefits (HEOB) code"
Estimated Acquisition Cost	The estimated amount a pharmacy actually pays to obtain a drug
Experimental Surgery	Any surgical procedure considered experimental in nature
Explanation of Medicaid Benefits (EOMB)	A statement mailed once per month to selected beneficiaries to allow them to confirm the Medicaid service which they received
Family Planning Services	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician, nurse practitioner, certified nurse-midwife, pharmacy, hospital, family planning clinic, rural health clinic (RHC), Federally Qualified Health Center (FQHC) or the Department of Health to individuals of child-bearing age for purposes of enabling such individuals freedom to determine the number and spacing of their children.
Field Audit	An activity performed whereby a provider's facilities, procedures, records and books are audited for compliance with Medicaid regulations and standards. A field audit may be conducted on a routine basis, or on a special basis announced or unannounced.
Fiscal Agent	An organization authorized by the State of Arkansas to process Medicaid claims

Fiscal Agent Intermediary	A private business firm which has entered into a contract with the Arkansas Department of Human Services to process Medicaid claims
Fiscal Year	The twelve-month period between settlements of financial accounts
Generic Upper Limit (GUL)	The maximum drug cost that may be used to compute reimbursement for specified multiple-source drugs unless the provisions for a Generic Upper Limit override have been met. The Generic Upper Limit may be established or revised by the Centers for Medicare and Medicaid Services (CMS) or by the State Medicaid Agency.
Group	Two or more persons. If a service is a "group" therapy or other group service, there must be two or more persons present and receiving the service.
Group Practice	A medical practice in which several practitioners render and bill for services under a single pay-to provider identification number
Healthcare Common Procedure Coding System (HCPCS)	Federally defined procedure codes
Health Insurance Claim Number	Number assigned to Medicare beneficiaries and individuals eligible for SSI
Hospital	An institution that meets the following qualifications: • Provides diagnostic and rehabilitation services to inpatients • Maintains clinical records on all patients • Has by-laws with respect to its staff of physicians • Requires each patient to be under the care of a physician, dentist or certified nurse-midwife • Provides 24-hour nursing service • Has a hospital utilization review plan in effect • Is licensed by the State • Meets other health and safety requirements set by the Secretary of Health and Human Services
Hospital-Based Physician	A physician who is a hospital employee and is paid for services by the hospital
HP Enterprise Services	Current fiscal agent for the state Medicaid program
ID Card	An identification card issued to Medicaid beneficiaries and ARKids First-B participants containing encoded data that permits a provider to access the card-holder's eligibility information
Individual	A single person as distinguished from a group. If a service is an "individual" therapy or service, there may be only one person present who is receiving the service.
Inpatient	A patient, admitted to a hospital or skilled nursing facility, who occupies a bed and receives inpatient services.
In-Process Claim (Pending Claim)	A claim that suspends during system processing for suspected error conditions such as: all processing requirements appear not to be met. These conditions must be reviewed by HP ENTERPRISE SERVICES or DMS and resolved before processing of the claim can be completed. *See Suspended Claim*.
Inquiry	A request for information

Institutional Care	Care in an authorized private, non-profit, public or state institution or facility. Such facilities include schools for the deaf, and/or blind and institutions for the handicapped.
Instrumental Activities of Daily Living (IADL)	Tasks which are ordinarily performed on a daily or weekly basis and include meal preparation, housework, laundry, shopping, taking medications and travel/transportation
Intensive Care	Isolated and constant observation care to patients critically ill or injured
Interim Billing	A claim for less than the full length of an inpatient hospital stay. Also, a claim that is billed for services provided to a particular date even though services continue beyond that date. It may or may not be the final bill for a particular beneficiary's services.
Internal Control Number (ICN)	The unique 13-digit claim number that appears on a Remittance Advice
International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9CM)	A diagnosis coding system used by medical providers to identify a patient's diagnosis and/or diagnoses on medical records and claims
Investigational Product	Any product that is considered investigational or experimental and that is not approved by the Food and Drug Administration. The Arkansas Medicaid Program does not cover investigational products.
Julian Date	Chronological date of the year, 001 through 365 or 366, preceded on a claims number (ICN) by a two-digit-year designation. Claim number example: 03231 (August 19, 2003).
Length Of Stay	Period of time a patient is in the hospital. Also, the number of days covered by Medicaid within a single inpatient stay.
Line Item	A service provided to a beneficiary. A claim may be made up of one or more line items for the same beneficiary. Also called a claim detail.
Long Term Care (LTC)	An office within the Arkansas Division of Medical Services responsible for nursing facilities
Long Term Care Facility	A nursing facility
Maximum Allowable Cost (MAC)	The maximum drug cost which may be reimbursed for specified multi-source drugs. This term is interchangeable with generic upper limit.
Medicaid Provider Number	A unique identifying number assigned to each provider of services in the Arkansas Medicaid Program, required for identification purposes
Medicaid Management Information System (MMIS)	The automated system utilized to process Medicaid claims
Medical Assistance Section	A section within the Arkansas Division of Medical Services responsible for administering the Arkansas Medical Assistance Program
Medically Needy	Individuals whose income and resources exceed the levels for assistance established under a state or federal plan for categorically needy, but are insufficient to meet costs of health and medical services

Medical Necessity	All Medicaid benefits are based upon medical necessity. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or (where appropriate) no treatment at all. The determination of medical necessity may be made by the Medical Director for the Medicaid Program or by the Medicaid Program Quality Improvement Organization (QIO). Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental inappropriate or ineffective using unless objective clinical evidence demonstrates circumstances making the service necessary.
Mis-Utilization	Any usage of the Medicaid Program by any of its providers and/or beneficiaries which is not in conformance with both State and Federal regulations and laws (includes fraud, abuse and defects in level and quality of care)
National Drug Code	The unique 11-digit number assigned to drugs which identifies the manufacturer, drug, strength and package size of each drug
National Provider Identifier (NPI)	A standardized unique health identifier for health care providers for use in the health care system in connection with standard transactions for all covered entities. Established by the Centers for Medicare & Medicaid Services, HHS, in compliance with HIPAA Administrative Simplification – 45 CFR Part 162.
Non-Covered Services	Services not medically necessary, services provided for the personal convenience of the patient or services not covered under the Medicaid Program
Nonpatient	An individual who receives services, such as laboratory tests, performed by a hospital, but who is not a patient of the hospital
Nurse Practitioner	A professional nurse with credentials that meet the requirements for licensure as a nurse practitioner in the State of Arkansas
Outpatient	A patient receiving medical services, but not admitted as an inpatient to a hospital
Over-Utilization	Any over usage of the Medicaid Program by any of its providers and/or beneficiaries not in conformance with professional judgment and both State and Federal regulations and laws (includes fraud and abuse)
Participant	A provider of services who: (1) provides the service, (2) submits the claim and (3) accepts Medicaid's reimbursement for the services provided as payment in full
Patient	A person under the treatment or care of a physician or surgeon, or in a hospital
Payment	Reimbursement to the provider of services for rendering a Medicaid-covered benefit
Pay-to Provider	A person, organization or institution authorized to receive payment for services provided to Medicaid beneficiaries by a person or persons who are a part of the entity

Pay-to Provider Number	A unique identifying number assigned to each pay-to provider of services (Clinic/Group/Facility) in the Arkansas Medicaid Program or the pay-to provider group's assigned National Provider Identifier (NPI). Medicaid reports provider payments to the Internal Revenue Service under the Employer Identification Number "Tax ID" linked in the Medicaid Provider File to the pay-to provider identification number.
Per Diem	A daily rate paid to institutional providers
Performing Physician	The physician providing, supervising, or both, a medical service and claiming primary responsibility for ensuring that services are delivered as billed
Person	Any natural person, company, firm, association, corporation or other legal entity
Place of Service (POS)	A nationally approved two-digit numeric code denoting the location of the patient receiving services
Plan of Care	A document utilized by a provider to plan, direct or deliver care to a patient to meet specific measurable goals; also called care plan, service plan or treatment plan
Postpayment Utilization Review	The review of services, documentation and practice after payment
Practitioner	An individual who practices in a health or medical service profession
Prepayment Utilization Review	The review of services, documentation and practice patterns before payment
Prescription	A health care professional's legal order for a drug which, in accordance with federal and/or state statutes, may not be obtained otherwise; also an order for a particular Medicaid covered service
Prescription Drug (RX)	A drug which, in accordance with federal and/or state statutes, may not be obtained without a valid prescription
Primary Care Physician (PCP)	A physician responsible for the management of a beneficiary's total medical care. Selected by the beneficiary to provide primary care services and health education. The PCP will monitor on an ongoing basis the beneficiary's condition, health care needs and service delivery be responsible for locating, coordinating and monitoring medical and rehabilitation services on behalf of the beneficiary and refer the beneficiary for most specialty services, hospital care and other services.
Prior Approval	The approval for coverage and reimbursement of specific services prior to furnishing services for a specified beneficiary of Medicaid. The request for prior approval must be made to the Medical Director of the Division of Medical Services for review of required documentation and justification for provision of service.
Prior Authorization (PA)	The approval by the Arkansas Division of Medical Services, or a designee of the Division of Medical Services, for specified services for a specified beneficiary to a specified provider before the requested services may be performed and before payment will be made. **Prior authorization does not guarantee reimbursement.**
Procedure Code	A five-digit numeric or alpha numeric code to identify medical services and procedures on medical claims
Professional Component	A physician's interpretation or supervision and interpretation of laboratory, X-ray or machine test procedures

Profile	A detailed view of an individual provider's charges to Medicaid for health care services or a detailed view of a beneficiary's usage of health care services
Provider	A person, organization or institution enrolled to provide and be reimbursed for health or medical care services authorized under the State Title XIX Medicaid Program
Provider Identification Number	A unique identifying number assigned to each provider of services in the Arkansas Medicaid Program or the provider's assigned National Provider Identifier (NPI), when applicable, that is required for identification purposes
Provider Relations	The activity within the Medicaid Program which handles all relationships with Medicaid providers
Quality Assurance	Determination of quality and appropriateness of services rendered
Quality Improvement Organization	A Quality Improvement Organization (QIO) is a federally mandated review organization required of each state's Title XIX (Medicaid) program. Arkansas Medicaid has contracted with the Arkansas Foundation for Medical Care, Inc. (AFMC) to be its QIO. The QIO monitors hospital and physician services billed to the state's Medicare intermediary and the Medicaid program to assure high quality, medical necessity and appropriate care for each patient's needs.
Railroad Claim Number	The number issued by the Railroad Retirement Board to control payments of annuities and pensions under the Railroad Retirement Act. The claim number begins with a one- to three-letter alphabetic prefix denoting the type of payment, followed by six or nine numeric digits.
Referral	An authorization from a Medicaid enrolled provider to a second Medicaid enrolled provider. The receiving provider is expected to exercise independent professional judgment and discretion, to the extent permitted by laws and rules governing the practice of the receiving practitioner, and to develop and deliver medically necessary services covered by the Medicaid program. The provider making the referral may be a physician or another qualified practitioner acting within the scope of practice permitted by laws or rules. Medicaid requires documentation of the referral in the beneficiary's medical record, regardless of the means the referring provider makes the referral. Medicaid requires the receiving provider to document the referral also, and to correspond with the referring provider regarding the case when appropriate and when the referring provider so requests.
Reimbursement	The amount of money remitted to a provider
Rejected Claim	A claim for which payment is refused
Relative Value	A weighting scale used to relate the worth of one surgical procedure to any other. This evaluation, expressed in units, is based upon the skill, time and the experience of the physician in its performance.
Remittance	A remittance advice
Remittance Advice (RA)	A notice sent to providers advising the status of claims received, including paid, denied, in-process and adjusted claims. It includes year-to-date payment summaries and other financial information.
Reported Charge	The total amount submitted in a claim detail by a provider of services for reimbursement
Retroactive Medicaid Eligibility	Medicaid eligibility which may begin up to three (3) months prior to the date of application provided all eligibility factors are met in those months

Returned Claim	A claim which is returned by the Medicaid Program to the provider for correction or change to allow it to be processed properly
Sanction	Any corrective action taken against a provider
Screening	The use of quick, simple medical procedures carried out among large groups of people to sort out apparently well persons from those who may have a disease or abnormality and to identify those in need of more definitive examination or treatment
Signature	The person's original signature or initials. The person's signature or initials may also be recorded by an electronic or digital method, executed or adopted by the person with the intent to be bound by or to authenticate a record. An electronic signature must comply with Arkansas Code Annotated § 25-31-101-105, including verification through an electronic signature verification company and data links invalidating the electronic signature if the data is changed.
Single State Agency	The state agency authorized to administer or supervise the administration of the Medicaid Program on a statewide basis
Skilled Nursing Facility (SNF)	A nursing home, or a distinct part of a facility, licensed by the Office of Long Term Care as meeting the Skilled Nursing Facility Federal/State licensure and certification regulations. A health facility which provides skilled nursing care and supportive care on a 24-hour basis to residents whose primary need is for availability of skilled nursing care on an extended basis.
Social Security Administration (SSA)	A federal agency which makes disability and blindness determinations for the Secretary of the HHS
Social Security Claim Number	The account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is the Social Security Account Number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (e.g., wife, widow, child, etc.).
Source of Care	A hospital, clinic, physician or other facility which provides services to a beneficiary under the Medicaid Program
Specialty	The specialized area of practice of a physician or dentist
Spend Down (SD)	The amount of money a beneficiary must pay toward medical expenses when income exceeds the Medicaid financial guidelines. A component of the medically needy program allows an individual or family whose income is over the medically needy income limit (MNIL) to use medical bills to spend excess income down to the MNIL. The individual(s) will have a spend down liability. The spend down column of the remittance advice indicates the amount which the provider may bill the beneficiary. The spend down liability occurs only on the first day of Medicaid eligibility.
Status Report	A remittance advice
Supplemental Security Income (SSI)	A program administered by the Social Security Administration. This program replaced previous state administered programs for aged, blind or disabled beneficiaries (except in Guam, Puerto Rico and the Virgin Islands). This term may also refer to the Bureau of Supplemental Security Income within SSA which administers the program.
Suspended Claim	An "In-Process Claim" which must be reviewed and resolved
Suspension from Participation	An exclusion from participation for a specified period of time

Suspension of Payments	The withholding of all payments due to a provider until the resolution of a matter in dispute between the provider and the state agency
Termination from Participation	A permanent exclusion from participation in the Title XIX Program
Third Party Liability (TPL)	A condition whereby a person or an organization, other than the beneficiary or the state agency, is responsible for all or some portion of the costs for health or medical services incurred by the Medicaid beneficiary (e.g., a health insurance company, a casualty insurance company or another person in the case of an accident, etc.).
Utilization Review (UR)	The section of the Arkansas Division of Medical Services which performs the monitoring and controlling of the quantity and quality of health care services delivered under the Medicaid Program
Void	A transaction which deletes
Voice Response System (VRS)	Voice-activated system to request prior authorization for prescription drugs and for PCP assignment and change
Ward	An accommodation of five or more beds
Withholding of Payments	A reduction or adjustment of the amounts paid to a provider on pending and subsequently due payments
Worker's Compensation	A type of Third Party Liability for medical services rendered as the result of an on-the-job accident or injury to a beneficiary for which the employer's insurance company may be obligated under the Worker's Compensation Act

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – ALL**

DATE: **October 8, 2010**

SUBJECT: **Provider Manual Update Transmittal #SecV-4-10**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
DMS-652	07/09	DMS-652	10/10

Explanation of Updates

Form DMS-652 is updated to include the acceptance of an approved electronic signature.

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Eugene I. Gessow, Director

DIVISION OF MEDICAL SERVICES
MEDICAL ASSISTANCE PROGRAM
PROVIDER APPLICATION

As a condition for entering into or renewing a provider agreement, all applicants must complete this provider application. A true, accurate and complete disclosure of all requested information is required by the Federal and State Regulations that govern the Medical Assistance Program. Failure of an applicant to submit the requested information or the submission of inaccurate or incomplete information may result in refusal by the Medical Assistance program to enter into, renew or continue a provider agreement with the applicant. Furthermore, the applicant is required by Federal and State Regulations to update the information submitted on the Provider Application.

Whenever changes in this information occur, please submit the change in writing to:

Medicaid Provider Enrollment Unit
HP Enterprise Services
P. O. Box 8105
Little Rock, AR 72203-8105

All dates, except where otherwise specified, should be written in the month/day/year (MMDDYY) format. Please print all information.

This information is divided into sections. The following describes which sections are to be completed by the applicant:

Section I	-	All providers
Section II	-	Facilities Only
Section III	-	Pharmacists/Registered Respiratory Therapist Only
Section IV	-	Provider Group Affiliations
Electronic Fund Transfer	-	All Providers (optional)
Managed Care Agreement	-	Primary Care Physician
W-9 Tax Form	-	All Providers
Contract	-	All Providers
Ownership and Conviction Disclosure	-	All Providers
Disclosure of Significant Business Transactions	-	All Providers

FOR OFFICE USE ONLY

Provider ID Number _____ Pending _____
Taxonomy Code _____
Specialty Code _____ Computer _____
Provider Type _____ OK to Key _____
Keyed _____
Effective Date _____ Maintenance Checked _____

SECTION I: ALL PROVIDERS

This section **MUST** be completed by all providers.

(1) **Date of Application:** Enter the current date in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(2) **Last Name, First Name, Middle Initial, and Title:** Enter the legal name of the applicant. The title spaces are reserved for designations such as MD, DDS, CRNA or OD. If the space is insufficient, please abbreviate.

If entering any other name such as an organization, corporation or facility, enter the full name of the entity in item 3. NOTE: Item 2 or 3 must be completed, <u>BUT NOT BOTH</u>.

_____ _____ ____ _____
Last Name First Name M. I. Title

(3) **Group, Organization or Facility Name:** Enter full name of the entity.
Examples: John R. Doe, PA; Adam B. Corn, Inc.; Arkansas Emer. Phys. Group; Pulaski County Hospital; John Thompson, M. D., DBA Thompson Clinic

_____
Corporation Name

_____
Fictitious Name (Doing Business As)

Must submit documentation that the above fictitious name is registered with the appropriate board within your state, (i.e., Secretary of State's, County Clerk) of the county in which the corporation's registered office is located.

(4) **Application Type:** Circle one of the following codes which coincide with fields 2 or 3:

0 = Individual Practitioner (i.e., physician, dentist, a licensed, registered or certified practitioner)
1 = Sole Proprietorship (This includes individually owned businesses.)
2 = Government Owned
3 = Business Corporation, for profit
4 = Business Corporation, non-profit **<u>* copy of Tax Form 501 (c) (3) must accompany this application</u>**
5 = Private, for profit
6 = Private, non-profit **<u>* copy of Tax Form 501 (c) (3) must accompany this application</u>**
7 = Partnership
8 = Trust
9 = Chain

<u>* NOTE: IF THE TAX FORM IS NOT ATTACHED THE APPLICATION WILL BE DENIED</u>

(5) **SSN/FEIN Number:** Enter the Social Security Number of the applicant or the Federal Employer Identification Number of the applicant. **IF ENROLLING AN INDIVIDUAL APPLICANT THIS FIELD MUST REFLECT A SOCIAL SECURITY NUMBER.**

____ _____ _____ - _____ _____ - _____ _____ _____ _____
Social Security Number

NOTE: If an individual has a Federal Employee Identification Number, you will need to complete two (2) applications and two (2) contracts. One (1) as an individual and one (1) as an organization.

____ _____ - _____ _____ _____ _____ _____ _____ _____
Federal Employee Identification Number

(6) **National Provider Identification Number (NPI) and Taxonomy Code:** Enter the National Provider Identification Number and the taxonomy code of the applicant.

_____
National Provider Identification Number

_____
Taxonomy Code

(7) **Place of Service - Street Address**

(A) Enter the applicant's service location address, include suite number if applicable. THIS FIELD IS MANDATORY.

_____

(B) Enter any additional street address. (MAY REFLECT POST OFFICE BOX IF UNDELIVERABLE TO A STREET ADDRESS)

_____

(C) City, State, Zip+4 Code - enter the applicant's city, state and zip+4 code. Use the Post Office's two letter abbreviation for State. Enter the complete nine digit zip code.

_____ _____ _____
City State Zip Code+4

(D) Telephone Number - enter the area code and telephone number of the location in which the services are provided.

_____ _____
Area Code Telephone Number

(E) Fax Number – enter the area code and fax number of the location in which the services are provided.

_____ _____
Area Code Fax Number

(8a) **Billing Street Address:** This is the billing address where your Medicaid checks, Remittance Statements (RA) and information will be sent. Use the same format as the place of service address, P. O. Box may be entered in billing address.

_____

_____ _____ _____
City State Zip Code+4

_____ _____
Area Code Telephone Number

_____ _____
Area Code Fax Number

(8b) **Provider Manuals and Updates:** Please review Section I sub-section 101.000; 101.200; 101.300 in your Arkansas Medicaid provider manual regarding provider manuals and updates. Choose the format in which you would like to receive manuals, manual updates, and official notices. The Arkansas Medicaid website (www.medicaid.state.ar.us) is updated weekly and the Arkansas Medicaid Provider Reference CD will be distributed quarterly. Providers selecting "Internet only" or "CD with e-mail notification" will receive e-mails notifying them of applicable manual updates, official notices, and remittance advice (RA) messages available at the website; these choices require an e-mail address and Internet access. Providers selecting "CD with paper supplements" will receive the Arkansas Medicaid Provider Reference CD and applicable manual updates and official notices in the mail; these providers can find RA messages with their RAs or at the Arkansas Medicaid website. Providers selecting "paper" will receive a paper copy of the manual and receive supplementary materials on paper to maintain their manual.

_____ Internet only* _____ CD with e-mail notification*

_____ CD with paper supplements _____ Paper

* Selection requires an e-mail address and Internet access.

E-mail address: _____

Please make sure your e-mail address will accept e-mail from hp.com. You may need to instruct your network administrator or e-mail provider to accept e-mails from hp.com. Arkansas Medicaid sends e-mail in bulk, and some e-mail services may block bulk e-mail unless instructed otherwise.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

MEDICARE VERIFICATION FORM

Before we can enroll a provider as an Arkansas Medicaid provider, we must have verification of **CURRENT** Medicare enrollment. **If you have documentation, i.e., EOMB, Medicare letter that is not over 6 months old and reflects the Medicare number and name of the enrolling provider,** please attach a copy of the information to the application. If you do not have documentation, please submit this form to your Medicare intermediary and instruct them to complete the information requested below. After Medicare has completed the requested information and returned this form to you, you must then return this form with your completed Medicaid application. **If your application is not returned with Medicare verification, enrollment in the Arkansas Medicaid Program will be denied.**

Provider's Name _____

(l) _____ _____ _____
Provider ID Number Effective Date End Date

(2) _____ _____
Social Security Number Tax I.D. Number

(3) _____
Specialty of Practice or Taxonomy Code

This inquiry was completed by:

Name of Medicare Intermediary _____

Address _____

Telephone # _____

Signature of Medicare Representative _____

_____
(Typed or Printed Name)

Date _____

(9) **County:** From the following list of codes, indicate the county that coincides with the place of service. If the services are provided in a bordering or out-of-state location, please use the county codes designated at the end of the code list.

County	County Code	County	County Code	County	County Code
Arkansas	01	Garland	26	Newton	51
Ashley	02	Grant	27	Ouachita	52
Baxter	03	Greene	28	Perry	53
Benton	04	Hempstead	29	Phillips	54
Boone	05	Hot Spring	30	Pike	55
Bradley	06	Howard	31	Poinsett	56
Calhoun	07	Independence	32	Polk	57
Carroll	08	Izard	33	Pope	58
Chicot	09	Jackson	34	Prairie	59
Clark	10	Jefferson	35	Pulaski	60
Clay	11	Johnson	36	Randolph	61
Cleburne	12	Lafayette	37	Saline	62
Cleveland	13	Lawrence	38	Scott	63
Columbia	14	Lee	39	Searcy	64
Conway	15	Lincoln	40	Sebastian	65
Craighead	16	Little River	41	Sevier	66
Crawford	17	Logan	42	Sharp	67
Crittenden	18	Lonoke	43	St. Francis	68
Cross	19	Madison	44	Stone	69
Dallas	20	Marion	45	Union	70
Desha	21	Miller	46	Van Buren	71
Drew	22	Mississippi	47	Washington	72
Faulkner	23	Monroe	48	White	73
Franklin	24	Montgomery	49	Woodruff	74
Fulton	25	Nevada	50	Yell	75

State	County Code	State	County Code	State	County Code
Louisiana	91	Oklahoma	94	Texas	96
Missouri	92	Tennessee	95	All other states	97
Mississippi	93				

(10) **Provider Category (A-C)**

Enter the two-digit **highlighted** code, from the following list, which identifies the services the applicant will be providing.

A) _____ B) _____ C) _____

Code	Category Description
N3	Advanced Practice Nurse – Pediatrics
N4	Advanced Practice Nurse – Women's Health
N6	Advanced Practice Nurse – Family
N7	Advanced Practice Nurse – Adult/Gerontological
N8	Advanced Practice Nurse – Psychiatric Mental Health
N9	Advanced Practice Nurse – Acute Care
N0	Advanced Practice Nurse– Nurse Practitioner - Other
03	Allergy/Immunology
A8	Alternatives for Adults with Physical Disabilities (Alternative) - Environmental Adaptations
A9	Alternatives for Adults with Physical Disabilities (Alternative) - Attendant Care Services
A4	Ambulatory Surgical Center
AA	Adolescent Medicine
05	Anesthesiology
AH	Living Choices Assisted Living Agency
AL	Living Choices Assisted Living Facility—Direct Services Provider
AP	Living Choices Assisted Living Pharmacist Consultant
64	Audiologist
C1	Cancer Screen (Health Dept. Only)
C2	Cancer Treatment (Health Dept. Only)
06	Cardiovascular Disease
C4	Child Health Management Services
CF	Child Health Management Services – Foster Care
35	Chiropractor
C8	Communicable Diseases (Health Dept. Only)
C3	CRNA
HA	DDS ACS Waiver Physical Adaptations
HB	DDS ACS Waiver Specialized Medical Supplies
HC	DDS ACS Waiver Case Management Services
HE	DDS ACS Waiver Supported Employment
H7	DDS ACS Waiver Supportive Living
H8	DDS ACS Waiver Crisis Abatement Services
HG	DDS ACS Waiver Crisis Center – Intervention Services
H9	DDS ACS Waiver Consultation Services
IC	DDS ACS Waiver IndependentChoices
HF	DDS ACS Waiver Organized HealthCare
N5	DDS Non-Medicaid
V2	Dental
V1	Dental Clinic (Health Dept. Only)
X5	Dental - Oral Surgeon
V6	Dental - Orthodontia
07	Dermatology
V3	Developmental Day Treatment Center
DR	Developmental Rehabilitation Services
V5	Domiciliary Care
CN	DYS/TCM Group
CO	DYS/TCM Performing
E4	ElderChoices H&CB 2176 Waiver - Chore services
E5	ElderChoices H&CB 2176 Waiver - Adult Family Homes
E6	ElderChoices H&CB 2176 Waiver - Home maker
E7	ElderChoices H&CB 2176 Waiver - Home delivered hot meals
EC	ElderChoices H&CB 2176 Waiver - Home delivered frozen meals
E8	ElderChoices H&CB 2176 Waiver - Personal emergency response systems
E9	ElderChoices H&CB 2176 Waiver - Adult day care
EA	ElderChoices H&CB 2176 Waiver - Adult day health care
EB	ElderChoices H&CB 2176 Waiver - Respite care
E1	Emergency Medicine
E2	Endocrinology
E3	Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
F1	Family Planning

(10) Provider Category (Continued)

Code	Category Description
08	Family Practice
F2	Federally Qualified Health Center
10	Gastroenterology
01	General Practice
38	Geriatrics
16	Gynecology - Obstetrics
H1	Hearing Aid Dealer
H2	Hematology
H5	Hemodialysis
H3	Home Health
H6	Hospice
A5	Hospital - AR State Operating Teaching Hospital
W6	Hospital – Inpatient
W7	Hospital - Outpatient
CH	Hospital – Critical Access
IH	Hospital – Indian Health Services
IS	Hospital – Indian Health Services Freestanding
P7	Hospital - Pediatric Inpatient
P8	Hospital - Pediatric Outpatient
R7	Hospital - Rural Inpatient
HN	Hyperalimentation Enteral Nutrition – Sole Source
H4	Hyperalimentation Parenteral Nutrition – Sole Source
V8	Immunization (Health Dept. Only)
69	Independent Lab
55	Infectious Diseases
W3	Inpatient Psychiatric - under 21
WA	Inpatient Psychiatric - Residential Treatment Unit within Inpatient Psychiatric Hospital
WB	Inpatient Psychiatric - Residential Treatment Center
WC	Inpatient Psychiatric - Sexual Offenders Program
W4	Intermediate Care Facility
W9	Intermediate Care Facility – Infant Infirmaries
W5	Intermediate Care Facility - Mentally Retarded
11	Internal Medicine
L1	Laryngology
M1	Maternity Clinic (Health Dept. Only)
M4	Medicare/Medicaid Crossover Only
WI	Mental Health Practitioner – Licensed Certified Social Worker
W2	Mental Health Practitioner – Licensed Professional Counselor
R5	Mental Health Practitioner – Licensed Marriage and Family Therapist
62	Mental Health Practitioner - Psychologist
N1	Neonatology
39	Nephrology
13	Neurology
NI	Nuclear Medicine
N2	Nurse Midwife
N3	Nurse Practitioner – Pediatric
N4	Nurse Practitioner - OB/GYN
N6	Nurse Practitioner – Family Practice
N7	Nurse Practitioner - Gerontological
RK	Offsite Intervention Service - Outpatient Mental and Behavioral Health (ARKids ONLY)
X1	Oncology
18	Ophthalmology
X2	Optical Dispensing Contractor
X4	Optometrist
X6	Orthopedic
12	Osteopathy - Manipulative Therapy
X7	Osteopathy - Radiation Therapy
X8	Otology
X9	Otorhinolaryngology

(10) Provider Category (Continued)

Code	Category Description
22	Pathology
37	Pediatrics
P1	Personal Care Services
PA	Personal Care Services / Area Agency on Aging
PD	Personal Care Services / Developmental Disability Services
PE	Personal Care Services / Week-end
PG	Personal Care Services / Level I Assisted Living Facility
PH	Personal Care Services / Level II Assisted Living Facility
R3	Personal Care Services / Residential Care Facility
PS	Personal Care Services: Public School or Education Service Cooperative
P2	Pharmacy Independent
PC	Pharmacy – Chain
PM	Pharmacy – Compounding
PN	Pharmacy – Home Infusion
PR	Pharmacy – Long Term Care / Closed Door
PV	Pharmacy – Administrated Vaccines
P3	Physical Medicine
48	Podiatrist
63	Portable X-ray Equipment
P6	Private Duty Nursing
PF	Private Duty Nursing: Public School or Education Service Cooperative
28	Proctology
P4	Prosthetic Devices
V4	Prosthetic - Durable Medical Equipment/Oxygen
Z1	Prosthetic - Orthotic Appliances
26	Psychiatry
P5	Psychiatry - Child
29	Pulmonary Diseases
R9	Radiation Therapy - Complete
RA	Radiation Therapy - Technical
30	Radiology - Diagnostic
31	Radiology - Therapeutic
R6	Rehabilitative Services for Persons with Mental Illness
RC	Rehabilitative Services for Persons with Physical Disabilities
R1	Rehabilitative Hospital
RJ	Rehabilitative Services for Youth and Children DCFS
RL	Rehabilitative Services for Youth and Children DYS
CR	Respite Care – Children's Medical Services
R4	Rheumatology
R2	Rural Health Clinic - Provider Based
R8	Rural Health Clinic - Independent Freestanding
S7	School Based Health Clinic - Child Health Services
S8	School Based Health Clinic - Hearing Screener
S9	School Based Health Clinic - Vision Screener
SA	School Based Health clinic - Vision & Hearing Screener
VV	School Based Mental Health Clinic
SO	School District Outreach for ARKids
S5	Skilled Nursing Facility
W8	Skilled Nursing Facility – Special Services
S6	SNF Hospital Distinct Part Bed
S1	Surgery - Cardio
S2	Surgery - Colon & Rectal
O2	Surgery - General
14	Surgery - Neurological
20	Surgery - Orthopedic
53	Surgery - Pediatric
54	Surgery - Oncology

(10) Provider Category (Continued)

Code	Category Description
24	Surgery - Plastic & Reconstructive
33	Surgery - Thoracic
S4	Surgery - Vascular
C5	Targeted Case Management - Ages 60 and Older
C6	Targeted Case Management - Ages 00 - 20
C7	Targeted Case Management - Ages 21 – 59
CM	Targeted Case Management – Developmental Disabilities Certification – Ages 00 - 20
T6	Therapy - Occupational
T1	Therapy - Physical
T2	Therapy - Speech Pathologist
TO	Therapy - Occupational Assistant
TP	Therapy - Physical Assistant
TS	Therapy - Speech Pathologist Assistant
A1	Transportation - Ambulance, Emergency
A2	Transportation - Ambulance, Non-emergency
A6	Transportation - Advanced Life Support with EKG
A7	Transportation - Advanced Life Support without EKG
TA	Transportation - Air Ambulance/Helicopter
TB	Transportation - Air Ambulance/Fixed Wing
TD	Transportation - Broker
TC	Transportation - Non-Emergency
TH	Tuberculosis (Health Dept. Only)
34	Urology
V7	Ventilator Equipment

(11) **Certification Code:** This code identifies the type of provider the certification number in field 12 defines. If an entry is made in this field (11), an entry **MUST** be made in field 12 and 13 unless the entry is a 5. Please check the appropriate code.

0 = Mental Health []
1 = Home Health []
2 = CRNA []
3 = Nursing Home []
4 = Other []
5 = Non-applicable []

(12) **Certification Number:** If applicable, enter the certification number assigned to the applicant by the appropriate certification board/agency.

A CURRENT COPY OF THIS CERTIFICATION MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(13) **End Date:** Enter the expiration date of the applicant's current certification number in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(14) **Fiscal Year:** Enter the date of the applicant's fiscal year end. This date is in month/day format.

____ ____/____ ____
MM DD

(15) **DEA Number:** If applicable, enter the number assigned to the applicant by the Federal Drug Enforcement Agency. Pharmacies must submit this information to be enrolled.

Required for Pharmacies only
A CURRENT COPY OF THIS CERTIFICATE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____

(16) **End Date:** Enter the expiration date of the current DEA Number in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(17) **License Number:** If applicable, enter the license number assigned to the applicant by the appropriate state licensure board. If the license issued is a temporary license enter **TEMP**. If the license number is smaller than the fields allowed, leave the last spaces blank.

A CURRENT COPY OF THIS LICENSE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(18) **End Date:** Enter the expiration date of the applicant's current license in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(19) **CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA):** If applicable, enter the CLIA number assigned to the applicant. **A copy of the CLIA certificate is required in order to have your laboratory test paid**.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

FOR OFFICE USE ONLY

Provider ID Number _____ Pending _____
Taxonomy Code _____ Computer _____
Provider Name _____ OK to Key _____
Keyed _____
Maintenance Checked _____

SECTION II: FACILITIES ONLY

(20) **Special Facility Program:** Check the appropriate value to depict if the applicant's facility is indigent care, teaching facility/university or UR plan. Special facility program values include:

*A	=	indigent care only	[]
**B	=	teaching facility/university only	[]
***C	=	UR plan only	[]
D	=	A/B	[]
E	=	A/C	[]
F	=	B/C	[]
G	=	A/B/C	[]
N	=	No special program	[]

* Indigent Care - Indicate whether the facility is qualified for the indigent care allowance.

NOTE: Facilities which serve a disproportionate number of indigent patients (defined as exceeding 20% Medicaid days as compared to a total patient day) may qualify for an indigent care allowance. If the facility meets the above criteria, please send the appropriate excerpt from the most current cost report that reflects total Medicaid days and total patient days.

** Teaching/University Facility - Indicate whether the facility is designated as a teaching/university affiliated institution and participates in three or more residency training programs.

*** Utilization Review Plan - Does the facility have a Utilization Review Plan applicable to all Medicaid patients?

(21) **Total Beds:** Enter the total number of beds in the facility.

_____
# of Beds

FOR OFFICE USE ONLY

Provider ID Number ______________________________
Taxonomy Code ______________________________
Provider Name ______________________________

Pending ____________________
Computer ____________________
OK to Key ____________________
Keyed ____________________
Maintenance Checked ____________________

SECTION III: PHARMACIST/REGISTERED RESPIRATORY THERAPIST ONLY

PHARMACIES - PLEASE INDICATE IF THIS APPLICANT IS A CHAIN-OWNED PHARMACY WITH 11 OR MORE RETAIL PHARMACIES NATIONALLY. (FRANCHISES WHICH ARE INDIVIDUALLY OWNED ARE NOT CHAIN-OWNED UNLESS ONE INDIVIDUAL OR CORPORATION OWNS 11 OR MORE RETAIL STORES.)

☐ **YES** ☐ **NO**

(22) Please list each pharmacist/registered respiratory therapist name, Social Security Number, license number and effective date of employment.

Please indicate by the pharmacist name whether that pharmacist is certified to administer Vaccines. If you are providing Vaccines, the pharmacy will need to be enrolled in the Medicare program. Please include the pharmacy Medicare Billing Provider ID Number on the Medicare Verification Form and attach proof of Medicare enrollment to the application. Please refer to the Medicare Verification Form for proof of Medicare requirements.

A copy of current registered respiratory therapist is required. Subsequent renewal must be provided when issued.

NOTE: Registered Respiratory Therapists must enter registration number in license number field.

____________________ ________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number — _____ yes _____ no

______________________________ ________________
License/Registration Number — Effective Date of employment

____________________ ________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number — _____ yes _____ no

______________________________ ________________
License/Registration Number — Effective Date of employment

____________________ ________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number — _____ yes _____ no

______________________________ ________________
License/Registration Number — Effective Date of employment

____________________ ________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number — _____ yes _____ no

______________________________ ________________
License/Registration Number — Effective Date of employment

FOR OFFICE USE ONLY

Provider ID Number _____ Pending _____
Taxonomy Code _____ Computer _____
OK to Key _____
Provider Name _____ Keyed _____
Maintenance Checked _____

SECTION IV: PROVIDER GROUP AFFILIATIONS

(23) If the applicant is affiliated with a group practice or an organization that is authorized to submit Medicaid claims on their behalf, the applicant must complete this section and sign the Appointment of Billing Intermediary Statement. Add extra sheets if necessary.

_____ _____ _____ _____
Last Name First Name M. I. Title

_____
Group Organization Name

_____ _____
Group Provider ID Number Effective Date (Applicant Joined Group)

_____ _____
Group Taxonomy Code Expiration Date (Applicant Left Group)

_____ _____ _____
City State Zip Code

The undersigned Provider authorizes the above-listed Group Practice Organization to submit claims to the Arkansas Division of Medical Services (hereinafter the Division) on his/her/its behalf, in accordance with the applicable Division regulations. The Provider also authorizes the Division to issue payment checks on his/her/its behalf to the above listed Group Practice Organization, in accordance with applicable Division requirements.

The Provider accepts full liability to the Division for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules or regulations governing the Medical Assistance Program or the Provider's agreement with the Division, the Provider shall be fully liable to the Division as if such acts were the Provider's own acts.

The Provider agrees to notify the Division at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

An original or approved electronic signature of the individual provider is mandatory. (No stamped or copied signature is allowed; "approved electronic signature" is described at the Arkansas Medicaid website, https://www.medicaid.state.ar.us/.)

_____ _____ _____
Signature Title Date

_____ _____
Typed or Printed Name

_____
Provider ID Number

_____
Provider Taxonomy Code

Primary Care Physicians must complete the Primary Care Physician Agreement in order to have their managed care fees paid to a new group Provider ID Number. (See item 25)

FOR OFFICE USE ONLY

Provider ID Number _____ Pending _____
Taxonomy Code _____ Computer _____
OK to Key _____
Provider Name _____ Keyed _____
Maintenance Checked _____

SECTION IV: PROVIDER GROUP AFFILIATIONS

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_____ _____ _____
Signature Title Date

_____ _____
Typed or Printed Name

_____
Provider ID Number

_____
Provider Taxonomy Code

Primary Care Physicians must complete the Primary Care Physician Agreement in order to have their managed care fees paid to a new group Provider ID Number. (See item 25)