

ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**



Secretary of State

Mark Martin

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Little Rock, Arkansas 72201-1094

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For Office

Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Alexandra Rouse E-mail Alexandra.Rouse@dhs.arkansas.gov Phone 501-508-8875

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: Technical Corrections—Removal of References to Provider Electronic Solutions (PES) Software & Updating Outdated Terminology in Arkansas Medicaid Provider Manuals

Intended Effective Date

(Check One)

☐ Emergency (ACA 25-15-204)

☐ 10 Days After Filing (ACA 25-15-204)

☒ Other 07/01/2020
(Must be more than 10 days after filing date.)

Legal Notice Published

Final Date for Public Comment

Reviewed by Legislative Council

Adopted by State Agency

Date

03/28/2020

04/26/2020

06/19/2020

06/19/2020

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Jack Tiner

jack.tiner@dhs.arkansas.gov

06/19/2020

Contact Person

E-mail Address

Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Janet Mann
Signature

501-320-6270

Janet.Mann@dhs.arkansas.gov

Phone Number

E-mail Address

Director

Title

June 19, 2020

Date



Division of Medical Services
P.O. Box 1437, Slot S401
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HUMANSERVICES.ARKANSAS.GOV

TO: Arkansas Medicaid Health Care Providers – Adult Developmental Day Treatment

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal ADDT-3-19

REMOVE

Section	Effective Date
241.000	7-1-18

INSERT

Section	Effective Date
241.000	7-1-20

Explanation of Updates

Section 241.000 is updated to remove the reference to Provider Electronic Solutions (PES) and to make other minor technical corrections.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

241.000 Introduction to Billing

7-1-20

Adult Developmental Day Treatment service providers use form CMS-1500 to bill the Arkansas Medicaid Program for services provided to Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – ARChoices In Homecare Home and Community-Based 2176 Waiver

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal ARCHOICES-4-19

REMOVE

Section	Effective Date
261.000	10-1-16

INSERT

Section	Effective Date
261.000	7-1-20

Explanation of Updates

Section 261.000 is updated to remove the reference to Provider Electronic Solutions (PES).

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Janet Mann
DMS Director

TOC not required

261.000 Introduction to Billing

7-1-20

ARChoices providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – ARKids First-B

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal ARKIDS-3-19

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
200.110	8-1-15	200.110	7-1-20
200.200	1-1-14	200.200	7-1-20
200.320	2-1-10	200.320	7-1-20
221.200	12-1-19	221.200	7-1-20

Explanation of Updates

Sections 200.110, 200.200, and 200.320 are revised to remove references to Provider Electronic Solutions (PES) software and make other minor grammatical edits.

Section 221.200 is revised to remove a service from the exclusion list for ARKids First-B beneficiaries as the service is now covered under PASSE and a minor grammatical edit.

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Janet Mann
Director

*TOC not required***200.110 ARKids First-A and ARKids First-B****7-1-20**

Medicaid-eligible children in the SOBRA eligibility category for pregnant women, infants, and children (category 61 PW-PL) and newborn children born to Medicaid-eligible mothers (categories 52 and 63), are known as ARKids First-A beneficiaries. Un-insured, non Medicaid-eligible children that meet additional established eligibility requirements will have health coverage under ARKids First-B, a CHIP separate child health program. All ARKids First beneficiaries will receive a program identification card without indication of level of coverage (either ARKids First-A or ARKids First-B).

A Medicaid eligibility verification transaction response either through the provider portal via the web or through the Voice Response System (VRS) will indicate that the individual is either an ARKids First-A beneficiary or an ARKids First-B beneficiary. The response will also indicate that cost sharing may be required for ARKids First-B beneficiaries. Refer to Section I of the Arkansas Medicaid provider manual for automated eligibility verification procedures.

When a child presents as an ARKids First-A eligible beneficiary, the provider must refer to the regular Medicaid provider policy manuals. When an ARKids First-B eligible beneficiary is identified, the provider must refer to the ARKids First-B Provider Manual for determination of levels of coverage, as well as the associated Medicaid provider policy manuals for the services provided.

200.200 Eligibility**7-1-20**

Eligibility criteria for ARKids First-B are:

- A. Family income must be above 142% and not exceed 211% plus five-percent (5%) disregard (216%) of the federal poverty level;
- B. Applicants must be age eighteen (18) and under;
- C. Applicants must have had no health insurance that covers comprehensive medical services, other than Medicaid, within the preceding ninety (90) days (unless insurance coverage was lost through no fault of the applicant);
- D. Applicants whose health insurance is inaccessible are considered uninsured. An example of "inaccessible" is when an out of state, non-custodial parent, has HMO insurance for his or her children but the HMO network does not contain medical providers where the children reside; and
- E. Children who do not have primary comprehensive health insurance or have non-group or non-employer-sponsored insurance, are considered to be uninsured. Primary comprehensive health insurance is defined as insurance that covers both physician and hospital charges.

An application must be completed by the applicant or family. Application forms are available at local Department of Human Services (DHS) county offices, Arkansas Department of Health local health units, churches, licensed day care centers, hospitals, selected physician offices and clinics, public schools, community and neighborhood centers, and pharmacies. Applicants may call the ARKids First-B toll free number or complete an online request by [visiting the Arkansas Medicaid website](#) to have an application mailed to them. [View or print the ARKids First-B telephone number.](#)

The State has assigned Aid Category 01 to ARKids First-B beneficiaries. The Aid Category Description for ARKids First-B beneficiaries is AK.

A Medicaid eligibility verification transaction response either through the provider portal via the web or through the Voice Response System (VRS) will indicate that the individual is an ARKids First-B beneficiary. The response will also indicate that cost sharing may be required. Refer to Section I of the Arkansas Medicaid provider manual for automated eligibility verification procedures.

200.320 Provider Verification of Eligibility

7-1-20

The ARKids First identification card does not guarantee an individual's eligibility. Payment is subject to verification that the beneficiary is eligible at the time services are provided. It is crucial to the provider that eligibility is determined at each visit.

Eligibility verification transactions may be made through the provider portal via the web or through the Voice Response System (VRS). Refer to Section I of the Arkansas Medicaid provider manual for automated eligibility verification procedures.

221.200 Exclusions

7-1-20

Services Not Covered for ARKids First-B Beneficiaries:

Adult Development Day Treatment (ADDT)

Audiological Services; EXCEPTION, Tympanometry, CPT procedure code **92567**, when the diagnosis is within the ICD range. ([View ICD codes.](#))

Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Diapers, Underpads, and Incontinence Supplies

Early Intervention Day Treatment (EIDT)

End Stage Renal Disease Services

Hearing Aids

Hospice

Hyperalimentation

Non-Emergency Transportation

Nursing Facilities

Orthotic Appliances and Prosthetic Devices

Personal Care

Private Duty Nursing Services

Rehabilitative Services for Children

Rehabilitative Services for Persons with Physical Disabilities (RSPD)

Targeted Case Management

Ventilator Services



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TO: Arkansas Medicaid Health Care Providers – Ambulatory Surgical Center

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal ASC-2-19

REMOVE

Section	Effective Date
241.000	7-1-14
242.400	11-1-15

INSERT

Section	Effective Date
241.000	7-1-20
242.400	7-1-20

Explanation of Updates

Sections 241.000 and 242.400 are updated to remove the reference to Provider Electronic Solutions (PES).

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required**241.000 Introduction to Billing****7-1-20**

Ambulatory Surgical Center providers use the Uniform Billing form CMS-1450 (UB-04) to bill the Arkansas Medicaid Program on paper. Each claim may contain charges for only one (1) beneficiary.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

Section III of this manual contains information regarding available options for electronic claims submission.

All details billed (electronically or on paper) by an ASC provider require the modifier SG, "Ambulatory Surgical Center (ASC) facility service." See Section 242.100 for Dental billing.

National Correct Coding Initiative (NCCI) editing applies to all claim submissions.

Arkansas Medicaid accepts claims that include national modifiers.

242.400 Drug Procedure Codes and National Drug Codes (NDCs)**7-1-20**

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on or after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A "covered labeler" is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor](#) website.

A complete listing of "**Covered Labelers**" is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

LABELER CODE	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the NDC termination date. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA-assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233

01111 456 71

01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

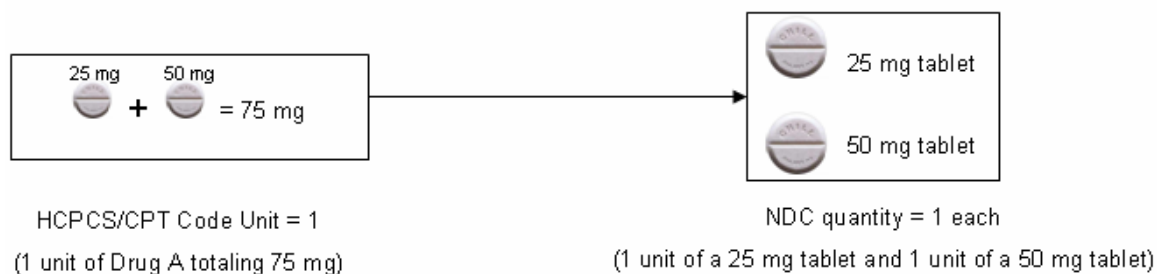
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

C. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

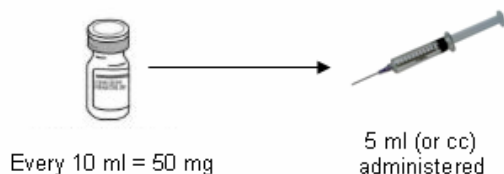
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug, whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5.

Diagram 5



HCP/CS/CPT Code Unit = 1
(one 25 mg unit of Drug B)

NDC Quantity = 5 for the 5 ml administered

Waste = 5 ml or 25 mg
(for the 5 ml or 25 mg not administered)

D. Electronic Claims Filing 837I (Outpatient)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid will require providers using electronic filing through the Provider Portal to use the required NDC format when billing HCP/CS/CPT codes for administered drugs.

E. Paper Claims Filing CMS-1450 (UB-04)

Arkansas Medicaid will require providers billing drug HCP/CS/CPT codes, including covered unlisted drug procedure codes, to use the required NDC format.

For institutional outpatient claims on the CMS-1450 (UB-04), use the locator field 43 (Description) to list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 - International Unit; GR - Gram; ML - Milliliter; UN - Unit), and number of units of the actual NDC administered, spaced and arranged exactly as in Diagram 6. Each NDC, when billed under the same procedure code on the same date of service, is defined as a "sequence." When billing a single HCP/CS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in the detail locator field 47 and total HCP/CS/CPT code units in locator field 46. Each subsequent sequence number should show zeros in locator fields 46 and 47. See Detail 1, sequence 2 in Diagram 6. The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one (1) NDC is associated with the HCP/CS/CPT code.

Diagram 6

Detail 1	42 REV. CD.	43 DESCRIPTION	44 HCP/CS / RATE / NDC CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
Sequence 1	0636	N4 12345678912 UN 1.00	Z1234	08/01/07	1	25.00		1
Sequence 2	0636	N4 01111222233 UN 1.00	Z1234	08/01/07	0	0.00		2
Detail 2	0305	Hemogram	85025	08/01/07	1	55.00		3
Sequence 1	0636	N4 44444555506 UN 5.00	Z6789	08/01/07	1	21.00		4
Detail 3								5

F. Procedure Code/NDC Detail Attachment Form-DMS-664

For drug HCP/CS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 7 for an example of the completed form. [View or print form DMS-664 and instructions for completion.](#)

Diagram 7

Detail #	Sequence #	NDC												Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2		Z1234	ABC drug/25 MG/Oral	0
1	2	0	1	1	1	1	2	2	2	2	3	3		Z1234	XYZ drug/50 MG/Oral	0
3	1	4	4	4	4	4	5	5	5	5	0	6		Z6789	PRQ drug/5 ML/IV	5 ML

G. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

H. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

I. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, disputes or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing the purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.



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TO: Arkansas Medicaid Health Care Providers – Autism Waiver

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal AUTISM-2-19

REMOVE

Section	Effective Date
230.100	10-1-12

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Section	Effective Date
230.100	7-1-20

Explanation of Updates

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Janet Mann
DMS Director

TOC not required

230.100 Introduction to Billing

7-1-20

The Autism waiver providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program, on paper, for services provided to eligible Medicaid beneficiaries. Each claim should contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Chiropractic

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal CHIRO-1-19

REMOVE

Section	Effective Date
241.000	11-1-06

INSERT

Section	Effective Date
241.000	7-1-20

Explanation of Updates

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DMS Director

TOC not required

241.000 Introduction to Billing

7-1-20

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Section III of this manual contains information about available options for electronic claims submission.



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TO: Arkansas Medicaid Health Care Providers – Certified Nurse-Midwife

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal CNM-1-19

REMOVE

Section	Effective Date
240.100	7-1-07
271.000	10-1-15
272.531	11-1-15

INSERT

Section	Effective Date
240.100	7-1-20
271.000	7-1-20
272.531	7-1-20

Explanation of Updates

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Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

240.100 Procedure for Obtaining Prior Authorization

7-1-20

- A. Certain medical and surgical procedures are covered only when prior authorized because of federal requirements or because of the elective nature of the surgery. DHS or its designated vendor issues prior authorizations for restricted medical and surgical procedures covered by the Arkansas Medicaid Program. [View or print contact information.](#)
- B. Prior authorization determinations are in accordance with established medical and administrative criteria combined with the professional judgment of physician advisors.
- C. Written documentation is not required for prior authorization. However, the patient's records must substantiate all information given. Any retrospective review of a case will rely on the written record.
- D. It is the responsibility of the certified nurse-midwife who will perform the procedure to initiate the prior authorization request.

The following specific information must be furnished: **(If request is made by phone, all calls will be tape recorded.)**

- 1. Patient Name and Address;
- 2. Beneficiary Medicaid Identification Number;
- 3. Certified Nurse-Midwife Name and License Number;
- 4. Certified Nurse-Midwife Medicaid Provider Number;
- 5. Hospital Name; and
- 6. Date of Service for Requested Procedure.

The caller must provide **all** patient identification information and medical information related to the necessity of the procedure.

If surgery is involved, a copy of the authorization will be sent to the hospital where the service will be performed. If the hospital has not received a copy of the authorization before the time of admission, the hospital will contact the admitting certified nurse-midwife or DHS or its designated vendor to verify that prior authorization has been granted.

It is the responsibility of the primary surgeon to distribute a copy of the authorization to the assistant surgeon if the assistant has been requested and approved. The Medicaid Program will not pay for inpatient hospital services that require prior authorization if the prior authorization has not been requested and approved.

Consulting physicians are responsible for having their required or restricted procedures added to the PA file. A letter verifying the PA number will be sent to the consultant upon request.

Post-authorization will be granted only for emergency procedures or for services provided to a Medicaid beneficiary during a period of retroactive eligibility. Requests for emergency procedures must be made no later than the first working day after the procedure has been performed. In cases of retroactive eligibility, the provider must contact DHS or its designated vendor for post-authorization within sixty (60) days of the eligibility authorization date. [View or print contact information.](#)

271.000 Introduction to Billing

7-1-20

Certified Nurse-Midwife providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Procedure codes payable to certified nurse-midwives do not require modifiers unless specified in the policy.

Section III of this manual contains information about available options for electronic claims submission.

272.531 National Drug Codes (NDCs)

7-1-20

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A "covered labeler" is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor](#) website.

A complete listing of "**Covered Labelers**" is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The Labeler termination date indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the termination date.

Diagram 1

LABELER CODE	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345-6789-1	12345678901
1111-2222-33	01111222233
01111-456-71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

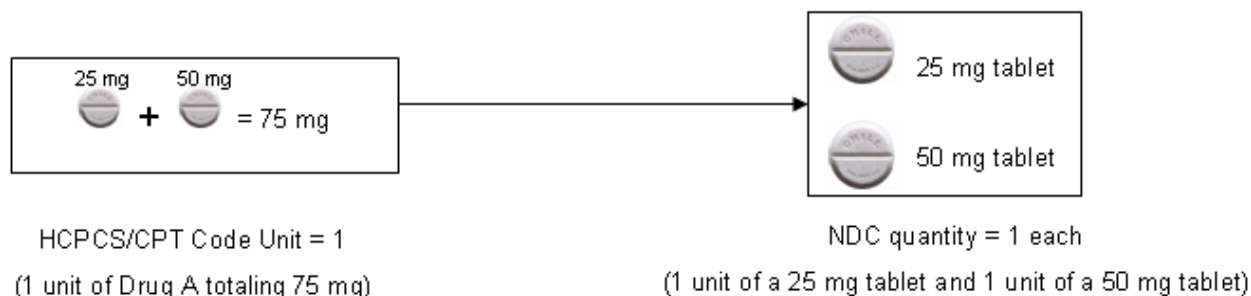
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

II. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

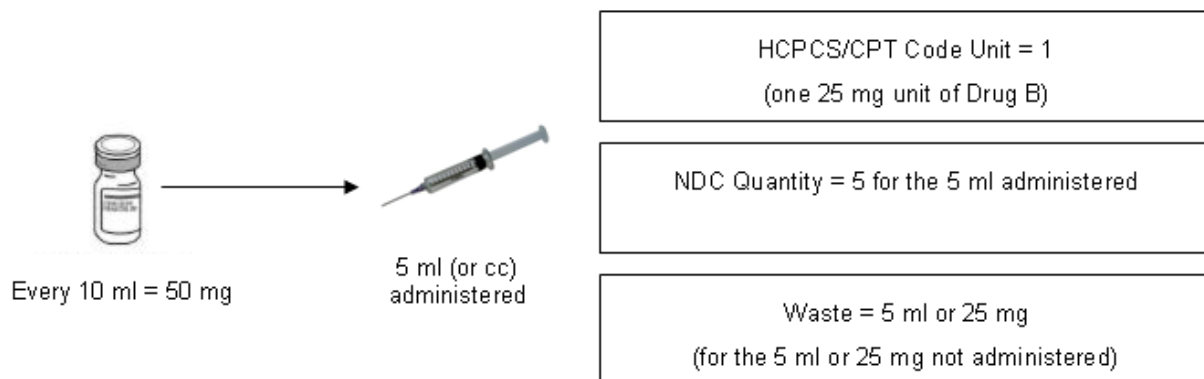
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid requires providers using electronic filing through the Provider Portal to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

B. Paper Claims Filing – CMS-1500

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of “N4”, the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed under the same procedure code on the same date of service is defined as a “sequence.” When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, Sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one (1) NDC is associated with the HCPCS/CPT code.

Diagram 6

Detail #	Sequence #	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF SERVICE	H. UNIT	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
		MM	DD	YY	MM	DD	YY			UNIT	1	2	3						
Detail 1	Sequence 1	N4	123456789	12	UN	1.00							1	25	00	1		123456789	
	Sequence 2		08	01	07	08	01	07	11		Z1234								
Detail 2	Sequence 1	N4	01111222233	UN	1.00								1	0	00	0		123456789	
	Sequence 2		08	01	07	08	01	07	11		Z1234								
Detail 3	Sequence 1		08	01	07	08	01	07	11		99213			1	55	00	1		
	Sequence 2		08	01	07	08	01	07	11		Z6789			1	35	00	1		

Procedure Code/NDC Detail Attachment Form – DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** “Procedure Code/NDC Detail Attachment Form.” Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

Detail #	Sequence #	NDC											Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML

III. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

IV. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.

See Section 272.533 for additional information regarding drug code billing.



Division of Medical Services
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Little Rock, AR 72203-1437
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HUMANSERVICES.ARKANSAS.GOV

TO: Arkansas Medicaid Health Care Providers – Dental

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal DENTAL-1-19

REMOVE

Section	Effective Date
261.000	7-1-07

INSERT

Section	Effective Date
261.000	7-1-20

Explanation of Updates

Section 261.000 is updated to remove the reference to Provider Electronic Solutions (PES).

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

261.000 Introduction to Billing

7-1-20

Dental providers must use the American Dental Association (ADA) form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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HUMANSERVICES.ARKANSAS.GOV

TO: Arkansas Medicaid Health Care Providers – Developmental Rehabilitation Services

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal DRS-1-19

REMOVE

Section	Effective Date
261.000	7-1-07

INSERT

Section	Effective Date
261.000	7-1-20

Explanation of Updates

Section 261.000 is updated to remove the reference to Provider Electronic Solutions (PES) from the manual.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

261.000 Introduction to Billing

7-1-20

Developmental Rehabilitation Services Program providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Division of Youth Services (DYS) and Division of Children and Family Services (DCFS) Targeted Case Management

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal DYSDCFS-1-19

REMOVE

Section	Effective Date
261.000	4-1-05

INSERT

Section	Effective Date
261.000	7-1-20

Explanation of Updates

Section 261.000 is revised to remove references to Provider Electronic Solutions (PES) and make a minor grammatical change.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC not required

261.000 Introduction to Billing

7-1-20

DYS/DCFS targeted case management providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about options available for electronic claims submission.



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TO: Arkansas Medicaid Health Care Providers – Early Intervention Day Treatment

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal EIDT-3-19

REMOVE

Section	Effective Date
231.000	7-1-18

INSERT

Section	Effective Date
231.000	7-1-20

Explanation of Updates

Section 231.000 is updated to remove the reference to Provider Electronic Solutions (PES) and to make other minor technical corrections.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

231.000 **Introduction to Billing**

7-1-20

Early Intervention Day Treatment providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claims submission.



Division of Medical Services
P.O. Box 1437, Slot S401
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TO: Arkansas Medicaid Health Care Providers – Federally Qualified Health Center

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal FQHC-2-19

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
261.000	7-1-07	261.000	7-1-20
262.441	11-1-15	262.441	7-1-20

Explanation of Updates

Sections 261.000 and 262.441 are updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make other technical changes.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required**261.000 Introduction to Billing****7-1-20**

Federally Qualified Health Center providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

For settlement purposes, each of these procedures are considered an encounter.

262.441 National Drug Codes (NDCs)**7-1-20**

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A "covered labeler" is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor](#) website.

A complete listing of "**Covered Labelers**" is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

LABELER CODE	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	123456789 01
1111-2222-33	01 1111222233
01111 456 71	01111 0 45671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

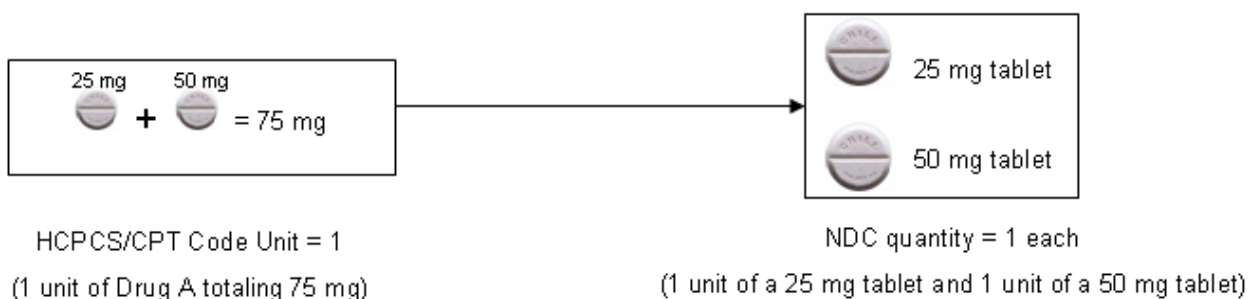
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

II. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

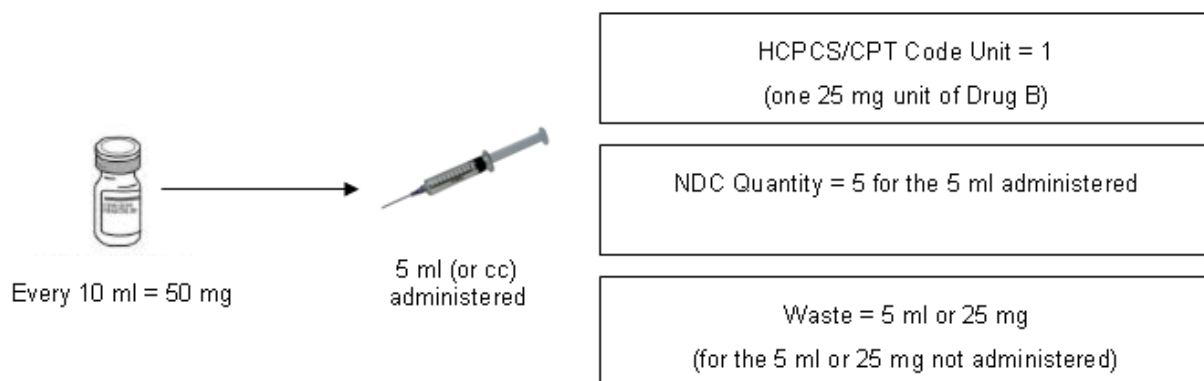
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid requires providers using electronic filing through the Provider Portal to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

B. Paper Claims Filing – CMS-1500

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of “N4,” the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed under the same procedure code on the same date of service is defined as a “sequence.” When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, first detail, sequences one (1) and two (2). Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence one (1) gives an example where only one (1) NDC is associated with the HCPCS/CPT code.

Diagram 6

Detail #	Sequence #	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMS	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF SERVICE	H. SPATIAL REL	I. ID. QUAL	J. RENDERING PROVIDER ID. #
		MM	DD	YY	MM	DD	YY			1	2						
Detail 1	Sequence 1	08	01	07	08	01	07	11		Z1234		1	25	00	1		123456789
	Sequence 2	08	01	07	08	01	07	11		Z1234		1	0	00	0		123456789
Detail 2	3	08	01	07	08	01	07	11		99213		1	55	00	1		123456789
	4	08	01	07	08	01	07	11		Z6789		1	35	00	1		123456789
Detail 3	Sequence 1	08	01	07	08	01	07	11									
	5																

Procedure Code/NDC Detail Attachment Form – DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 “Procedure Code/NDC Detail Attachment Form.” Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

Detail #	Sequence #	NDC											Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML

III. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

IV. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.



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Little Rock, AR 72203-1437
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HUMANSERVICES.ARKANSAS.GOV

TO: Arkansas Medicaid Health Care Providers – Hearing Services

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal HEARING-1-19

REMOVE

Section

241.000

Effective Date

7-1-07

INSERT

Section

241.000

Effective Date

7-1-20

Explanation of Updates

Section 241.000 is updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make a minor technical change.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

241.000 Introduction to Billing

7-1-20

Hearing Services providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Home Health

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal HOMEHLTH-1-19

REMOVE

Section	Effective Date
218.100	11-1-10
241.000	7-1-07
242.143	11-1-15

INSERT

Section	Effective Date
218.100	7-1-20
241.000	7-1-20
242.143	7-1-20

Explanation of Updates

Section 218.100 is updated to replace CHMS with EIDT and to make other minor grammatical changes.

Section 241.000 and 242.143 are revised to remove references to Provider Electronic Solutions (PES) and other grammatical changes.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC required**218.100 Retrospective Review of Physical Therapy for Beneficiaries Under the Age of 21****7-1-20****A. Medical Necessity**

Physical therapy services must be medically necessary for the treatment of the individual's illness or injury. A diagnosis alone is insufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical therapist; and
3. There must be a reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Evaluation and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed, including:

1. Date of evaluation;
2. Child's name and date of birth;
3. Diagnosis specific to therapy;
4. Background information including pertinent medical history and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months;}$$

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores, or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services;
6. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone, or a narrative of the child's functional mobility skills (strengths and weaknesses);

8. An interpretation of the results of the evaluation including recommendations for therapy/minutes per week;
9. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
10. Signature and credentials of the therapist performing the evaluation.

C. Interpretation and Eligibility: Ages Birth to 21

1. Tests used must be norm-referenced, standardized, and specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.
3. All subtests, components, and scores must be reported for all tests used for eligibility purposes.
4. Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one (1) subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.
5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing, or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason a standardized test could not be used must be included in the evaluation.
6. The Mental Measurement Yearbook (MMY) is the standard reference to determine reliability/validity. Refer to the "Accepted Tests" section for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.
7. Range of Motion: A limitation of greater than ten (10) degrees or documentation of how a deficit limits function.
8. Muscle Tone: Modified Ashworth Scale.
9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
10. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
11. Children (birth to age twenty-one (21)) receiving services outside of the public schools must be evaluated annually.
12. Children (birth to age two (2)) in the Early Intervention Day Treatment (EIDT) program must be evaluated every six (6) months.
13. Children (age three (3) to twenty-one (21)) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three (3) years; however, an annual update of progress is required.

D. Frequency, Intensity, and Duration of Physical Therapy Services

The frequency, intensity, and duration of physical therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable

medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.

2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical therapist to be performed safely and effectively.
3. Duration of Services: Therapy services should be provided if reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring, or establishment of a home program should be implemented.

E. Progress Notes

1. Child's name;
2. Date of service;
3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of entry with a full signature and credentials; and
8. Graduate students must have the supervising physical therapist co-sign progress notes.

241.000 Introduction to Billing

7-1-20

Home Health providers who submit paper claims must use the CMS-1450 claim form, which also is known as the UB-04 claim form.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

Section III of every Arkansas Medicaid provider manual contains information about available electronic claim options.

242.143 National Drug Codes (NDCs)

7-1-20

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A "covered labeler" is a pharmaceutical manufacturer that has

entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor website](#).

A complete listing of “**Covered Labelers**” is located on the website. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*. For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA-assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 1 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the “5-4-2” format.

Diagram 1

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 2 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 2

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

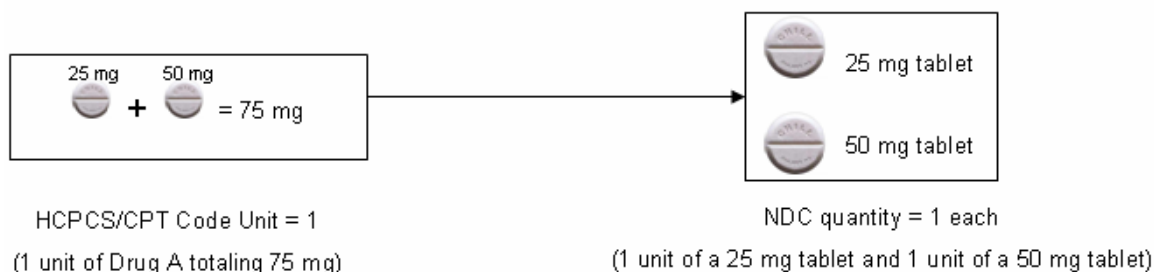
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

C. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

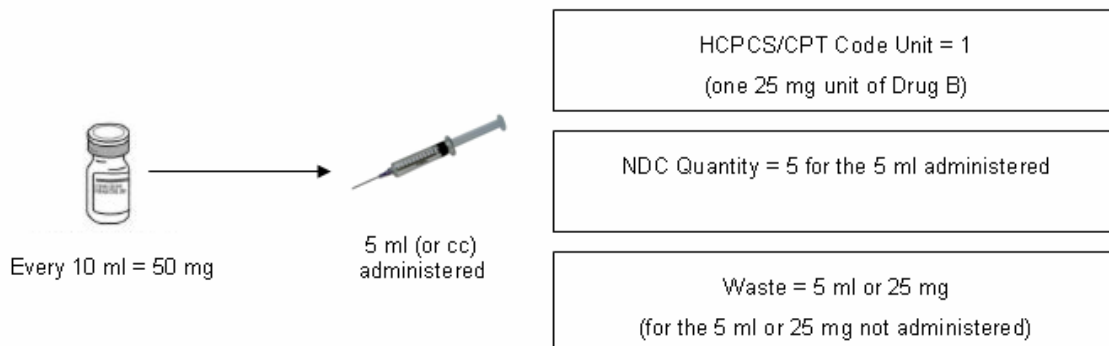
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug, whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example, whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 3.

Diagram 3



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 10 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted.

Diagram 4



D. Electronic Claims Filing 837I (Outpatient)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid will require providers using electronic filing through the provider portal to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

E. Paper Claims Filing CMS-1450 (UB-04)

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes, including covered unlisted drug procedure codes, to use the required NDC format.

For institutional outpatient claims on the CMS-1450 (UB-04), use the locator field 43 (Description) to list the qualifier of "N4," the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and number of units of the actual NDC administered, spaced and arranged exactly as in Diagram 5. Each NDC when billed under the same procedure code on the same date of service is defined as a "sequence." When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in detail locator field 47 and total HCPCS/CPT code units in locator field 46. Each subsequent sequence number should show zeros in locator fields 46 and 47. See Detail 1, sequence 2 in Diagram 5. The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 5, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one (1) NDC is associated with the HCPCS/CPT code.

Diagram 5

Detail #	Sequence #	46 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPFS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
Detail 1	Sequence 1	0636	N4 12345678912 UN 1.00	Z1234	08/01/07	1	25.00		1
	Sequence 2	0636	N4 01111222233 UN 1.00	Z1234	08/01/07	0	0.00		2
Detail 2		0305	Hemogram	85025	08/01/07	1	55.00		3
	Sequence 1	0636	N4 44444555506 UN 5.00	Z6789	08/01/07	1	21.00		4
Detail 3									5

F. Procedure Code/NDC Detail Attachment Form-DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 6 for an example of the completed form. [View or print form DMS-664 and instructions for completion.](#)

Diagram 6

Detail #	Sequence #	NDC												Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0	
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0	
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML	

G. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

H. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

I. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, disputes or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing the purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.



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TO: Arkansas Medicaid Health Care Providers – Hospice

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal HOSPICE-2-19

REMOVE

Section	Effective Date
218.000	11-1-06
250.100	12-1-07

INSERT

Section	Effective Date
218.000	7-1-20
250.100	7-1-20

Explanation of Updates

Section 218.000 is updated to replace ElderChoices with ARChoices in Homecare, correct the DHS acronym, and make other minor grammatical changes.

Section 250.100 is revised to remove references to Provider Electronic Solutions (PES) and minor grammatical changes.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

*TOC not required***218.000****Plan of Care****7-1-20**

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

- A. The attending physician, the medical director or physician designee, and the interdisciplinary group must establish the plan of care before hospice care begins.
- B. The attending physician, the medical director or physician designee, and the interdisciplinary group must review and update the plan at intervals specified in the plan. Reviews must be documented.
- C. The plan of care must:
 - 1. Include an assessment of the individual's needs and identification of the services, including:
 - a. Management of discomfort; and
 - b. Symptom relief.
 - 2. State in detail the scope and frequency of services needed to meet the patient's and family's needs.
- D. In establishing the initial plan of care, the member of the interdisciplinary group who assesses the patient's needs must meet or confer by telephone with at least one (1) other IDG member before writing the initial plan of care.
 - 1. At least one (1) of the persons developing the initial plan of care must be a nurse or physician.
 - 2. The plan must be established on the same day as the assessment if the day of the assessment is to be a covered day of hospice care.
 - 3. The other two (2) members of the IDG must review the initial plan of care and provide their contributions to it within two (2) calendar days following the day of assessment.
- E. Waiver Services
 - 1. Waiver Eligibility

Some Medicaid beneficiaries are eligible under special programs known as waivers. The claims system will indicate waiver eligibility status with "NO" (not a waiver client) or the letter "W" followed by a number currently (one (1) or two (2)).

Waiver clients may receive only services listed in the plan of care designed for them under the guidelines of the waiver program in which they participate.
 - 2. ARChoices in Homecare Waiver Clients
 - a. If the hospice provider intends to initiate care to a W2 waiver client, contact must be made with the DHS County Office in the client's county of residence for the name and location of the DHS RN responsible for the client's ARChoices plan of care. Through contact with the DHS RN, the hospice services may be included in the plan of care before rendering the service.
 - b. The ARChoices plan of care supersedes any other plan of care previously developed by another Medicaid provider for the beneficiary. The ARChoices plan of care must be obtained from the client's family.
 - c. The ARChoices plan of care must include all appropriate ARChoices services

and certain non-waiver services appropriate to the applicant, such as Hospice.

- d. The hospice provider must report services to an ARChoices client to the DHS RN. The services must be included on the ARChoices plan of care prior to beginning services. All changes in services or changes in the ARChoices client's circumstances must be reported promptly to the DHS RN. Services provided that are not included on the ARChoices plan of care may be subject to recoupments by the Arkansas Medicaid Program.

250.100 Introduction to Billing

7-1-20

- A. Hospice providers use Uniform Billing form (red-lined sensor paper) CMS-1450 (UB-04) for paper claims.
 1. Each claim may contain charges for only one (1) beneficiary.
 2. A Hospice claim must be for charges incurred within a single calendar month.
- B. Section III of this manual contains information about available options for filing electronic claims.
- C. Medicaid does not supply providers with Uniform Billing claim forms. Numerous vendors sell UB-04 claim forms. [View a sample CMS-1450 \(UB-04\) claim form.](#)
- D. Complete Arkansas Medicaid Hospice Program claims in accordance with the National Uniform Billing Committee *Official UB-04 Data Specifications Manual* (UB-04 Manual) and Arkansas Medicaid's billing instructions and rules.
- E. The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA).
 1. The NUBC is the official source of information regarding the UB-04 claim form. [View or print NUBC contact information.](#)
 2. The committee develops, maintains, and distributes to its subscribers the UB-04 Manual and periodic updates.
 3. The NUBC is also a vendor of UB-04 claim forms.



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TO: Arkansas Medicaid Health Care Providers – Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal HOSPITAL-4-19

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
218.100	11-1-10	218.100	7-1-20
218.200	4-16-12	218.200	7-1-20
271.000	7-1-07	271.000	7-1-20
272.102	11-1-15	272.102	7-1-20

Explanation of Updates

Section 218.100 is updated to replace CHMS with EIDT and to make other minor grammatical changes.

Section 218.200 is changed to replace all instances of speech therapy with speech-language therapy. CHMS is replaced by EIDT. Other minor grammatical changes are also included.

Sections 271.000 and 272.102 are revised to remove references to Provider Electronic Solutions (PES) and make other minor grammatical changes.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC required

SECTION II - HOSPITAL / CRITICAL ACCESS HOSPITAL (CAH) / END-STAGE RENAL DISEASE (ESRD)

218.100 **Guidelines for Retrospective Review of Occupational and Physical Therapy for Beneficiaries Under the Age of 21** **7-1-20**

A. Medical Necessity

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is insufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Evaluations and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:

1. Date of evaluation;
2. Child's name and date of birth;
3. Diagnosis specific to therapy;
4. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores, or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services;
6. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone, or a narrative description of the child's functional mobility skills (strengths and weaknesses);
8. An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week;
9. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
10. Signature and credentials of the therapist performing the evaluation.

C. Interpretation and Eligibility: Ages Birth to 21

1. Tests used must be norm-referenced, standardized, and specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.
3. All subtests, components, and scores must be reported for all tests used for eligibility purposes.
4. Eligibility for therapy will be based upon a score of -1.50 standard deviations (SD) below the mean or greater in at least one (1) subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.
5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason a standardized test could not be used must be included in the evaluation.
6. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine reliability/validity. Refer to "Accepted Tests" sections for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.
7. Range of Motion: A limitation of greater than ten (10) degrees or documentation of how a deficit limits function.
8. Muscle Tone: Modified Ashworth Scale.
9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
10. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
11. Children (birth to age twenty-one (21)) receiving services outside of the public schools must be evaluated annually.
12. Children (birth to age two (2)) in the Early Intervention Day Treatment (EIDT) program must be evaluated every six (6) months.
13. Children (age three (3) to twenty-one (21)) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three (3) years; however, an annual update of progress is required.

D. Frequency, Intensity, and Duration of Physical or Occupational Therapy Services

The frequency, intensity, and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder.

Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.
3. Duration of Services: Therapy services should be provided if reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring, or establishment of a home program should be implemented.

E. Progress Notes

1. Child's name;
2. Date of service;
3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of entry with a full signature and credentials; and
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

218.200

Speech-Language Therapy Guidelines for Retrospective Review for Beneficiaries Under Age 21

7-1-20

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is insufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.
3. There must be a reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Types of Communication Disorders

1. Language Disorders — Impaired comprehension or use of spoken, written, or other symbol systems. This disorder may involve the following components: forms of

language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) or the perception/processing of language. Language disorders may involve one (1), all, or a combination of the above components.

2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice, or fluency. Speech Production disorders may involve one (1), all, or a combination of these components of the speech production system.

An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete, or deviant use of the phonological system, i.e., phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal or oral apraxia, dysarthria.

3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures, or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

Mild: Scores between 84-78; -1.0 standard deviation

Moderate: Scores between 77-71; -1.5 standard deviations

Severe: Scores between 70-64; -2.0 standard deviations

Profound: Scores of sixty-three (63) or lower; -2.0+ standard deviations

2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 218.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Language disorder must include:
 - a. Date of evaluation;
 - b. Child's name and date of birth;
 - c. Diagnosis specific to therapy;
 - d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

- e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients, or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section

214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

- f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 - g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of the orofacial structures;
 - h. Formal or informal assessment of hearing, articulation, voice, and fluency skills;
 - i. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;
 - j. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - k. Signature and credentials of the therapist performing the evaluation.
3. SPEECH PRODUCTION (Articulation, Phonological, Apraxia): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 218.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:
- a. Date of evaluation;
 - b. Child's name and date of birth;
 - c. Diagnosis specific to therapy;
 - d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

- e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
- f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
- g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;
- h. Formal screening of language skills. Examples include, but are not limited to, the Fluarty-2, KLST-2, CELF-4 Screen, or TTFC;
- i. Formal or informal assessment of hearing, voice, and fluency skills;

- j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;
 - k. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - l. Signature and credentials of the therapist performing the evaluation.
4. **SPEECH PRODUCTION (Voice):** To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 218.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:
- a. A medical evaluation to determine the presence or absence of a physical etiology is a prerequisite for evaluation of voice disorder;
 - b. Date of evaluation;
 - c. Child's name and date of birth;
 - d. Diagnosis specific to therapy;
 - e. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.
- NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:**
- 7 months - [(40 weeks) - 28 weeks] / 4 weeks]**
- 7 months - [(12) / 4 weeks]**
- 7 months - [3]**
- 4 months**
- f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
 - g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 - h. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;
 - i. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;
 - j. Formal or informal assessment of hearing, articulation, and fluency skills;
 - k. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;
 - l. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - m. Signature and credentials of the therapist performing the evaluation.
5. **SPEECH PRODUCTION (Fluency):** To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer

to Section 218.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:

- a. Date of evaluation;
- b. Child's name and date of birth;
- c. Diagnosis specific to therapy;
- d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

- e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
 - f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 - g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;
 - h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;
 - i. Formal or informal assessment of hearing, articulation, and voice skills;
 - j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;
 - k. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and.
 - l. Signature and credentials of the therapist performing the evaluation.
6. **ORAL MOTOR/SWALLOWING/FEEDING:** To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 218.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:
- a. Date of evaluation;
 - b. Child's name and date of birth;
 - c. Diagnosis specific to therapy;
 - d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided

in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

4 months

- e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients, or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
- f. If swallowing problems or signs of aspiration are noted, then include a statement indicating that a referral for a videofluoroscopic swallow study has been made;
- g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
- h. Formal or informal assessment of hearing, language, articulation, voice, and fluency skills;
- i. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;
- j. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
- k. Signature and credentials of the therapist performing the evaluation.

D. Interpretation and Eligibility: Ages Birth to 21

1. **LANGUAGE:** Two (2) language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one (1) being a norm-referenced, standardized test with good reliability and validity. (Use of two (2) one-word vocabulary tests alone will not be accepted.)
 - a. For children age birth to three (3): criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.
 - b. For children age three (3) to twenty-one (21), criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 218.200, part D, paragraph 8.)
 - c. Age birth to three (3): Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test, with corroborating data from a criterion-referenced measure. When these two (2) measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.
 - d. Age three (3) to twenty-one (21): Eligibility for language therapy will be based upon two (2) composite or quotient scores that are -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both scores, a third standardized score indicating a -1.5 SD or greater is

required to support the medical necessity of services.

2. **ARTICULATION OR PHONOLOGY:** Two (2) tests or procedures must be administered, with at least one (1) being from a norm-referenced, standardized test with good reliability and validity.

Eligibility for articulation or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from accepted procedures can be used to support the medical necessity of services (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)

3. **APRAXIA:** Two (2) tests or procedures must be administered, with at least one (1) being a norm-referenced, standardized test with good reliability and validity.

Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from a criterion-referenced test or accepted procedures can be used to support the medical necessity of services. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)

(Review Section 218.210 — Accepted Tests for Speech-Language Therapy.)

4. **VOICE:** Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.

Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.

5. **FLUENCY:** At least one (1) norm-referenced, standardized test with good reliability and validity, and at least one (1) supplemental tool to address effective components.

Eligibility for fluency therapy will be based upon an SS of -1.5 SD below the mean or greater on the standardized test.

6. **ORAL MOTOR/SWALLOWING/FEEDING:** An in-depth, functional profile of oral motor structures and function.

Eligibility for oral-motor/swallowing/feeding therapy will be based upon an in-depth functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by a videofluoroscopic swallow study, the patient can be treated for feeding difficulties via the recommendations set forth in the swallow study report.

7. All subtests, components, and scores must be reported for all tests used for eligibility purposes.

8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth functional profile of the child's communication abilities. An in-depth functional profile is a detailed narrative or description of a child's communication behaviors that specifically explains and justifies the following:

- a. The reason standardized testing is inappropriate for this child,
 - b. The communication impairment, including specific skills and deficits, and
 - c. The medical necessity of therapy.
- d. Supplemental instruments from Accepted Tests for Speech-Language Therapy may be useful in developing an in-depth functional profile.

9. Children (birth to age twenty-one (21)) receiving services outside of the schools must be evaluated annually.
10. Children (birth to twenty-four (24) months) in the Early Intervention Day Treatment (EIDT) Program must be evaluated every six (6) months.
11. Children (age three (3) to twenty-one (21)) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three (3) years; however, an annual update of progress is required.
12. Children (age three (3) to twenty-one (21)) receiving privately contracted services, apart from or in addition to those within the schools, must have a full evaluation annually.
13. IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

E. Progress Notes

1. Child's name;
2. Date of service;
3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form of measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of the entry with a full signature and credentials; and
8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

271.000 Introduction to Billing

7-1-20

Hospital providers who submit paper claims must use the CMS-1450 claim form, which also is known as the UB-04 claim form.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

Section III of every Arkansas Medicaid provider manual contains information about available electronic claim options.

272.102 Drug Procedure Codes and National Drug Codes (NDC)

7-1-20

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on or after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor website](#).

A complete listing of “**Covered Labelers**” is located on the website. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*. For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA-assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 1 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the “5-4-2” format.

Diagram 1

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 2 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 2

	Required 11-digit NDC (5-4-2) Billing Format
10-digit FDA NDC on PACKAGE	
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

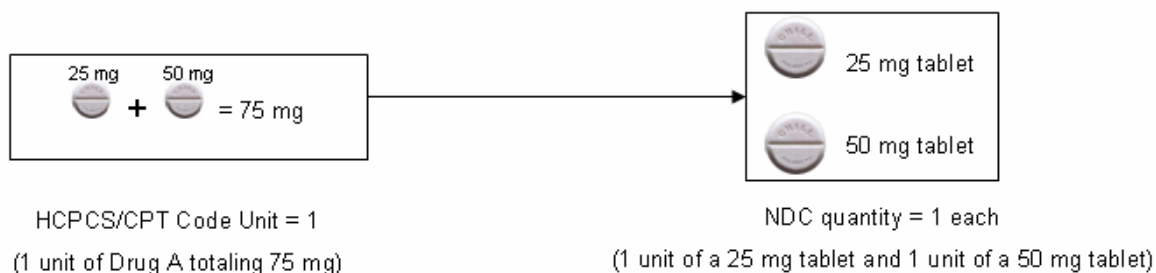
Exception: There is no requirement for an NDC when billing for vaccines.

C. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

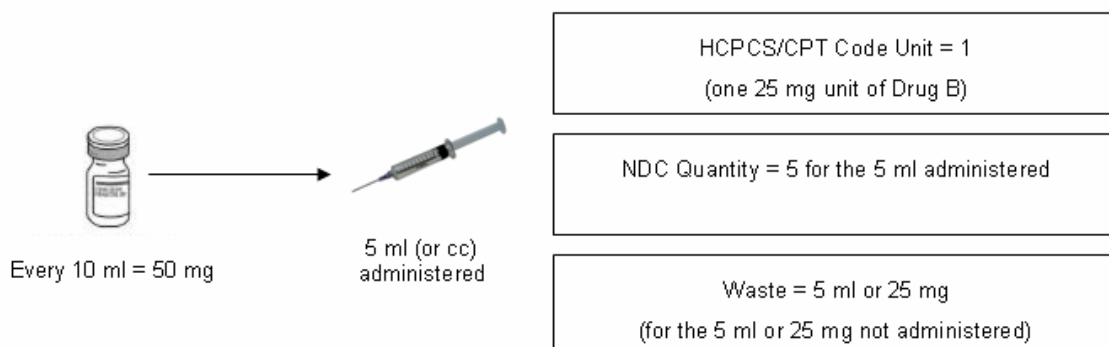
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug, whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example, whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 3.

Diagram 3



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted.

Diagram 4



D. Electronic Claims Filing 837I (Outpatient)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid will require providers using electronic filing through the provider portal to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

E. Paper Claims Filing CMS-1450 (UB-04)

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes, including covered unlisted drug procedure codes, to use the required NDC format.

For institutional outpatient claims on the CMS-1450 (UB-04), use the locator field 43 (Description) to list the qualifier of "N4," the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and number of units of the actual NDC administered, spaced and arranged exactly as in Diagram 5. Each NDC when billed under the same procedure code on the same date of service is defined as a "sequence." When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in detail locator field 47 and total HCPCS/CPT code units in locator field 46. Each subsequent sequence number should show zeros in locator fields 46 and 47. See Detail 1, sequence 2 in Diagram 5. The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 5, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one (1) NDC is associated with the HCPCS/CPT code.

Diagram 5

Detail #	Sequence #	46 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
Detail 1	Sequence 1	0636	N4 12345678912 UN 1.00	Z1234	08/01/07	1	25.00		1
	Sequence 2	0636	N4 01111222233 UN 1.00	Z1234	08/01/07	0	0.00		2
Detail 2		0305	Hemogram	85025	08/01/07	1	55.00		3
Detail 3	Sequence 1	0636	N4 44444555506 UN 5.00	Z6789	08/01/07	1	21.00		4
									5

F. Procedure Code/NDC Detail Attachment Form- DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 6 for an example of the completed form. [View or print form DMS-664 and instructions for completion.](#)

Diagram 6

Detail #	Sequence #	NDC											Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML

G. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

H. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

I. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, disputes or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing the purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.

See Section 272.510 for additional information regarding National Drug Code (NDC) billing.



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TO: Arkansas Medicaid Health Care Providers – Hyperalimentionation

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal HYPER-2-19

REMOVE

Section	Effective Date
241.000	8-1-05
242.401	11-1-15

INSERT

Section	Effective Date
241.000	7-1-20
242.401	7-1-20

Explanation of Updates

Sections 241.000 and 242.401 are updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make other minor technical changes.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required**241.000 Introduction to Billing****7-1-20**

Hyperalimentation providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

242.401 National Drug Codes (NDCs)**7-1-20**

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor](#) website.

A complete listing of “**Covered Labelers**” is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

LABELER CODE	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

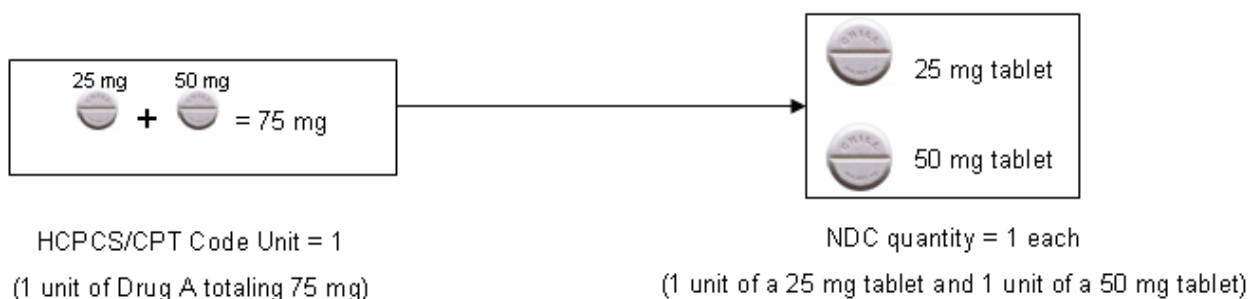
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

II. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

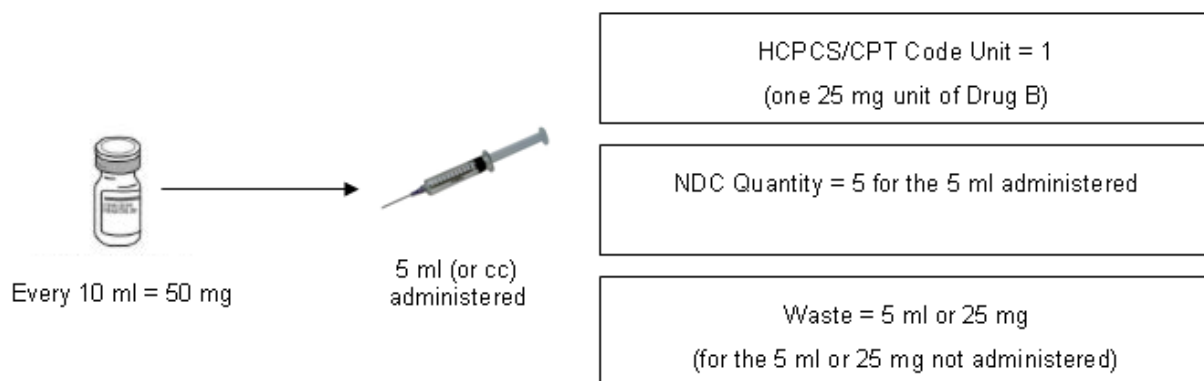
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid requires providers using electronic filing through the Provider Portal to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

B. Paper Claims Filing – CMS-1500

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4," the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed under the same procedure code on the same date of service is defined as a "sequence." When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one (1) NDC is associated with the HCPCS/CPT code.

Diagram 6

Detail #	Sequence #	24. A. DATE(S) OF SERVICE											B. PLACE OF SERVICE	C. EMS	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS	F. CHARGES	G. DAYS	H. UNITS	I. QUAL	J. RENDERING PROVIDER ID #
		MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD			PTHCPCS	MODIFIER						
Detail 1	Sequence 1	N4	1234	66789	12	UN	1.00								Z1234		1	25	00	1		123456789
	Sequence 2	08	01	07	08	01	07	11							Z1234		1	0	00	0		123456789
Detail 2	Sequence 1	N4	0111	122233	UN	1.00																123456789
	Sequence 2	08	01	07	08	01	07	11							99213		1	55	00	1		123456789
Detail 3	Sequence 1	N4	4444	555506	ML	5.00																123456789
	Sequence 2	08	01	07	08	01	07	11							Z6789		1	35	00	1		123456789

Procedure Code/NDC Detail Attachment Form- DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

Detail #	Sequence #	NDC											Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML

III. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

IV. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.



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TO: Arkansas Medicaid Health Care Providers – Inpatient Psychiatric Services for Under Age Twenty-one (21)

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal INPPSYCH-1-19

REMOVE

Section	Effective Date
213.100	8-15-05
261.000	7-1-07

INSERT

Section	Effective Date
213.100	7-1-20
261.000	7-1-20

Explanation of Updates

Section 213.100 is updated to change RSPMI to OBHS and make minor grammatical corrections.

Section 261.000 is revised to remove references to Provider Electronic Solutions (PES) and make minor grammatical corrections.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC not required

213.100 Medicaid Eligible at Admission

7-1-20

A PCP referral is generally obtained for Medicaid-eligible children prior to each admission to an inpatient psychiatric facility. However, a PCP is given the option of providing a referral after a service is provided. If a PCP chooses to make a referral after a service has been provided, the referral must be received by the Outpatient Behavioral Health Services (OBHS) provider no later than forty-five (45) calendar days after the date of service. The PCP has no obligation to give a retroactive referral.

The inpatient psychiatric provider may not file a claim and will not be reimbursed for any service that requires a PCP referral unless the referral has been received.

261.000 Introduction to Billing

7-1-20

Inpatient psychiatric providers who submit paper claims must use the CMS-1450 claim form, also known as the UB-04 claim form.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

Section III of every Arkansas Medicaid provider manual contains information about available electronic claim options.



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TO: Arkansas Medicaid Health Care Providers – Living Choices Assisted Living

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal LCAL-2-19

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
214.000	1-1-13	214.000	7-1-20
261.000	7-1-07	261.000	7-1-20

Explanation of Updates

Sections 214.000 and 261.000 are updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make other minor technical changes.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

214.000**Benefit Limits****7-1-20**

- A. Living Choices Assisted Living bundled services are limited to one (1) unit per day.
- B. Living Choices Assisted Living Program beneficiaries may have as many as nine (9) prescription drugs per month covered by Medicaid. Dual eligibles, receiving both Medicare and Medicaid, receive prescription drug coverage through Part D Medicare. Medicare has no restrictions on the number of prescription drugs that can be received during a month. Section III of this manual contains information about available options for electronic claim submission.

261.000**Introduction to Billing****7-1-20**

Living Choices Assisted Living providers use form CMS-1500 to bill the Arkansas Medicaid Program on paper for services provided to Medicaid beneficiaries. Form CMS-1500 is the official paper counterpart of the Professional (837P) electronic transaction format. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Nurse Practitioner

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal NURSEPR-4-19

REMOVE

Section	Effective Date
252.000	7-1-07
252.438	11-1-15

INSERT

Section	Effective Date
252.000	7-1-20
252.438	7-1-20

Explanation of Updates

Sections 252.000 and 252.438 are updated to remove the reference to Provider Electronic Solutions (PES) from the manual.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required**252.000 Introduction to Billing****7-1-20**

Nurse Practitioner providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

252.438 National Drug Codes (NDCs)**7-1-20**

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each State a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first 5 digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first 5 digits of the NDC) to the list of covered labelers which is maintained on the website at <https://arkansas.magellanrx.com/provider/documents/>.

A complete listing of “**Covered Labelers**” is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

LABELER CODE	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

In order for a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three segments or codes: a 5-digit labeler code, a 4-digit product code and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero in one of the three segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five digits with leading zeros; the product code as four digits with leading zeros; the package code as two digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one labeler to another, from one package size to another and from one time period to another.

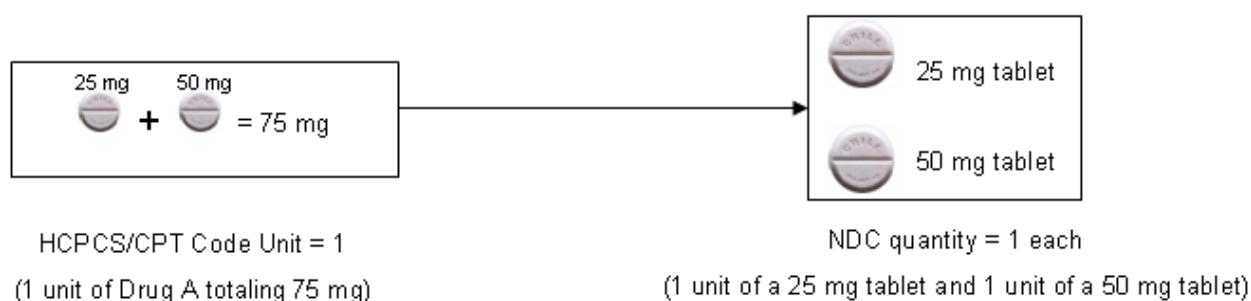
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals and allergen immunotherapy.

II. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

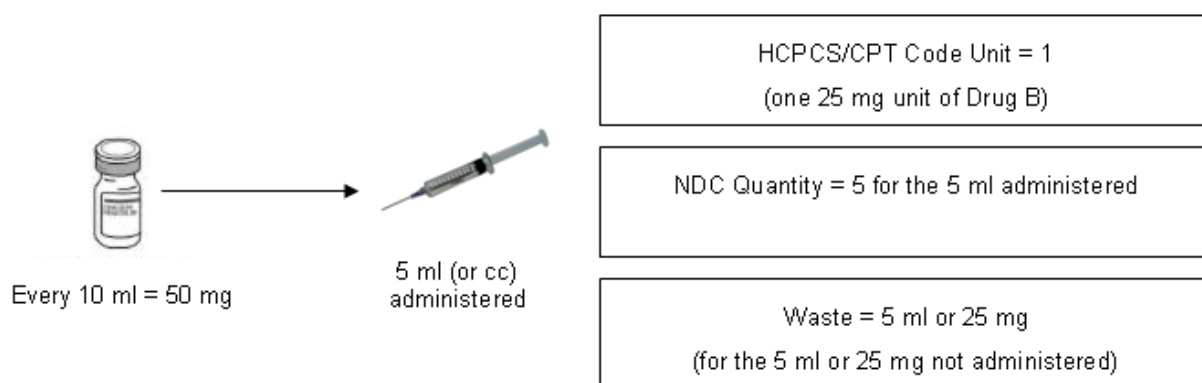
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid requires providers using electronic filing through the provider portal to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

B. Paper Claims Filing – CMS-1500

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of “N4”, the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed under the same procedure code on the same date of service is defined as a “sequence.” When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one NDC is associated with the HCPCS/CPT code.

Diagram 6

Detail #	Sequence #	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF SERVICE	H. SPATIAL REL	I. ID. QUAL	J. RENDERING PROVIDER ID. #
		MM	DD	YY	MM	DD	YY			PT	HCPCS	MODIFIER	UNIT						
Detail 1	Sequence 1	N4	1234	66789	12	UN	1.00							1	25	00	1		123456789
	Sequence 2	08	01	07	08	01	07	11			Z1234							NPI	
Detail 2	Sequence 1	N4	0111	1222	233	UN	1.00							1	0	00	0		123456789
	Sequence 2	08	01	07	08	01	07	11			Z1234							NPI	
Detail 3	Sequence 1	08	01	07	08	01	07	11			99213			1	55	00	1		123456789
	Sequence 2	N4	4444	5555	666	ML	5.00							1	35	00	1		123456789
		08	01	07	08	01	07	11			Z6789							NPI	
																		NPI	

Procedure Code/NDC Detail Attachment Form- DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 “Procedure Code/NDC Detail Attachment Form.” Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

Detail #	Sequence #	NDC											Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML

III. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

IV. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.



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TO: Arkansas Medicaid Health Care Providers – Outpatient Behavioral Health Services

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal OBHS-2-19

REMOVE

Section	Effective Date
251.000	7-1-17

INSERT

Section	Effective Date
251.000	7-1-20

Explanation of Updates

Section 251.000 is updated to remove the reference to Provider Electronic Solutions (PES).

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

251.000 Introduction to Billing

7-1-20

Outpatient Behavioral Health Services providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary. [View a CMS-1500 sample form.](#)

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Private Duty Nursing

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal PDN-1-19

REMOVE

Section	Effective Date
241.000	7-1-06

INSERT

Section	Effective Date
241.000	7-1-20

Explanation of Updates

Section 241.000 is updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make a minor technical change.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

*TOC not required***201.100 Private Duty Nursing Services Providers****7-1-20**

Private Duty Nursing Services (PDN) providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. The PDN provider must have either a Class A or Class B license issued by the Arkansas Department of Health. It must be designated on the license that the PDN agency is a provider of extended care services.
 - 1. A copy of the license must accompany the provider application and Medicaid contract.
 - 2. For purposes of review under the Arkansas Medicaid Program, agencies enrolled as Class B operators providing private duty nursing services must adhere to those standards governing quality of care, skill, and expertise applicable to Class A operators.

Providers who have agreements with Medicaid to provide other services to Medicaid beneficiaries must have a separate provider application and Medicaid contract to provide private duty nursing services. A separate provider number is assigned.

- B. All owners, principals, employees, and contract staff of a private duty nursing services provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three (3) years.

241.000 Introduction to Billing**7-1-20**

Private Duty Nursing providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Personal Care

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal PERSCARE-2-19

REMOVE

Section	Effective Date
261.000	3-1-08

INSERT

Section	Effective Date
261.000	7-1-20

Explanation of Updates

Section 261.000 is revised to remove references to Provider Electronic Solutions (PES) and make a minor grammatical change.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC not required

261.000 Introduction to Billing

7-1-20

- A. Personal Care providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program on paper for services provided to Medicaid beneficiaries.
- B. Providers submitting claims electronically through the provider portal use the Professional claim format.
- C. A claim may contain charges for only one (1) beneficiary.
- D. Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Pharmacy

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal PHARMACY-3-19

REMOVE

Section	Effective Date
261.000	11-1-15

INSERT

Section	Effective Date
261.000	7-1-20

Explanation of Updates

Section 261.000 is updated to remove the reference to Provider Electronic Solutions (PES).

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

261.000 Introduction to Billing

7-1-20

For paper billing of non-NCPDP claims (including immunosuppressant drug crossover claims or vaccine claims), pharmacy providers use the CMS-1500 form to bill the Arkansas Medicaid Program for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary. The Arkansas Medicaid fiscal agent provides the ability for electronic claim submissions through the Provider Portal to providers for Non-NCPDP billing. Please contact the Provider Assistance Center for any questions or assistance with this software. [View or print the Provider Assistance Center contact information.](#)

The Arkansas Medicaid Pharmacy Program does not accept NCPDP paper claim forms for covered outpatient medications. Vendor systems are widely available for incorporation of electronic claims submission in the pharmacy practice.



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TO: Arkansas Medicaid Health Care Providers – Physician/Independent Lab/CRNA/Radiation Therapy Center

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal PHYSICN-3-19

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
203.130	10-13-03	203.130	7-1-20
203.210	1-1-09	203.210	7-1-20
203.220	10-13-03	203.220	7-1-20
227.200	11-1-10	227.200	7-1-20
227.300	4-16-12	227.300	7-1-20
291.000	7-1-07	291.000	7-1-20
292.210	7-1-07	292.210	7-1-20
292.440	11-1-17	292.440	7-1-20
292.910	11-1-15	292.910	7-1-20

Explanation of Updates

Section 203.130 is updated to replace DDTCS with ADDT.

Section 203.210 corrects speech therapy to speech-language therapy and changes the name of form DMS-640 to Therapy and Day Habilitation Services for Medicaid Eligible Beneficiaries. DDTCS is changed to ADDT. Other minor grammatical changes are also included.

Section 203.220 is updated to remove DDTCS and replace with ADDT. Other minor grammatical changes are also included.

Section 227.200 is replaced to correct minor grammatical changes, remove CHMS, and include EIDT.

Section 227.300 is replaced to correct all instances to speech-language therapy. CHMS is removed and EIDT is included. Other minor grammatical changes are also included.

Section 291.000 is revised to remove references to Provider Electronic Solutions (PES) and make a grammatical change.

Section 292.210 removes DDTCS and replaces with ADDT.

Section 292.440 and 292.910 are revised to remove references to Provider Electronic Solutions (PES) and make other grammatical changes.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC required**203.130 Physician's Role in Adult Developmental Day Treatment (ADDT) Services 7-1-20**

- A. Medicaid covers Adult Developmental Day Treatment (ADDT) services when provided to eligible Medicaid beneficiaries by qualified provider facilities.
- B. The Medicaid eligible beneficiary's attending physician must identify and certify with his or her original signature, the individual's medical needs that habilitation training can address. ADDT services also require a written prescription from the attending physician.
- C. The services must be provided according to a written plan of care developed by the Division of Developmental Disabilities Services. The physician certifying medical necessity must sign the plan of care.

203.210 Physician's Role in the Occupational, Physical, and Speech-Language Therapy Program 7-1-20

Medicaid covers occupational therapy, physical therapy, and speech-language therapy services when provided to eligible Medicaid beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. Occupational evaluations and occupational therapy services are payable only to a qualified occupational therapist. Speech-language therapy evaluations may be performed by the physician; however, treatment for speech-language therapy disorders must be referred to a qualified speech-language therapist. Physical therapy evaluations may be performed by the physician and physical therapy sessions may be performed by the qualified physician. Physical therapy treatment may also be referred to a qualified physical therapist.

Speech-language therapy services ONLY are covered for beneficiaries in the ARKids First-B Program benefits.

All occupational, physical, and speech-language therapy evaluations and services must be medically necessary and require a referral from the beneficiary's primary care physician (PCP) or the attending physician if the beneficiary is exempt from PCP Managed Care Program requirements. Therapy treatment services also require a prescription written by the physician who refers the patient to the therapist for specified services. For beneficiaries under age twenty-one (21), form DMS-640 must be used for the initial referral for evaluation and a separate DMS-640 is required for the prescription. [View or Print form DMS-640.](#) An electronic signature is accepted provided it is in compliance with Arkansas Code § 25-31-103. The physician must maintain the original Therapy and Day Habilitation Services for Medicaid Eligible Beneficiaries Prescription/Referral form—DMS-640—for each prescription in the beneficiary's medical records. The therapy provider must retain a copy of the DMS-640 in their established beneficiary medical chart/record. After the initial referral using the form DMS-640 and initial prescription utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640.

Therapy services for individuals over age twenty-one (21) are only covered when provided through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT) services, Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice, and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.

203.220 Physician's Role in Personal Care Services 7-1-20

Personal care services are medically necessary tasks performed by a personal care aide to assist with the management of a client's physical dependencies.

The physician's role in the personal care program is to prescribe medically necessary services to assist with the client's physical dependency needs in a home or other appropriate setting. Personal care aides perform non-skilled activities such as assisting with baths, preparing meals, assisting with toileting, and cleaning the immediate living area for patients unable to partially or completely perform these tasks for themselves. It may be therapeutic for patients to perform some or all of these tasks for themselves even though it may be difficult and time consuming for them to do so. Therefore, it is at the physician's discretion to prescribe personal care services. The Personal Care Program is not designed to provide full time services.

The physician reviews the service plan established by the provider. The physician may delete one (1) or more services from the service plan, yet, approve the remainder of the services. By signing the service plan the physician indicates his or her approval of the service plan.

If the physician has not seen the patient within the past sixty (60) days or is unable to determine whether the patient's condition warrants personal care services, he or she must request the patient make an office visit before prescribing personal care services. If the physician believes the personal care services are not medically necessary, he or she must not prescribe the services. The physician must retain a copy of the patient's service plan as well as copies of subsequent revisions to the service plan.

Medicaid beneficiaries under the age of twenty-one (21) may receive personal care in recognized locations outside the home. Public schools and Adult Developmental Day Treatment (ADDT) services provider facilities are recognized locations outside the home.

Benefit limits and other coverage restrictions may apply to Medicaid Personal Care services. Personal Care Program providers seeking authorization for service plans are expected to advise physicians regarding Medicaid clients' coverage and benefit status in the Personal Care Program.

227.200 Occupational and Physical Therapy Guidelines for Retrospective Review

7-1-20

A. Medical Necessity

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;
2. The services must be of such a level of complexity, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist; and
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Evaluations and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:

1. Date of evaluation;
2. Child's name and date of birth;

3. Diagnosis specific to therapy;
4. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores, or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services;
 6. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone, or a narrative description of the child's functional mobility skills (strengths and weaknesses);
 8. An interpretation of the results of the evaluation including recommendations for therapy/minutes per week;
 9. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 10. Signature and credentials of the therapist performing the evaluation.
- C. Interpretation and Eligibility: Ages Birth to 21
1. Tests used must be norm-referenced, standardized, and specific to the therapy provided.
 2. Tests must be age appropriate for the child being tested.
 3. All subtests, components, and scores must be reported for all tests used for eligibility purposes.
 4. Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one (1) subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.
 5. If the child cannot be tested with a norm-referenced standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason a standardized test could not be used must be included in the evaluation.
 6. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine reliability/validity. Refer to "Accepted Tests" sections for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.
 7. Range of Motion: A limitation of greater than ten (10) degrees or documentation of how a deficit limits function.

8. Muscle Tone: Modified Ashworth Scale.
9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
10. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
11. Children (birth to age twenty-one (21)) receiving services outside of the public schools must be evaluated annually.
12. Children (birth to age two (2)) in the Early Intervention Day Treatment (EIDT) program must be evaluated every six (6) months.
13. Children (age three (3) to twenty-one (21)) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three (3) years; however, an annual update of progress is required.

D. Frequency, Intensity, and Duration of Physical or Occupational Therapy Services

The frequency, intensity, and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.
3. Duration of Services: Therapy services should be provided if reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring, or establishment of a home program, should be implemented.

E. Progress Notes

1. Child's name;
2. Date of service;
3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of entry with a full signature and credentials; and
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is insufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist; and
3. There must be a reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Types of Communication Disorders

1. **Language Disorders** — Impaired comprehension or use of spoken, written or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) or the perception/processing of language. Language disorders may involve one (1), all, or a combination of the above components.
2. **Speech Production Disorders** — Impairment of the articulation of speech sounds, voice, or fluency. Speech Production disorders may involve one (1), all, or a combination of these components of the speech production system.

An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e., phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal or oral apraxia, dysarthria.

3. **Oral Motor/Swallowing/Feeding Disorders** — Impairment of the muscles, structures, or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components**1. STANDARDIZED SCORING KEY:**

Mild: Scores between 84-78; -1.0 standard deviation

Moderate: Scores between 77-71; -1.5 standard deviations

Severe: Scores between 70-64; -2.0 standard deviations

Profound: Scores of sixty-three (63) or lower; -2.0+ standard deviations

2. **LANGUAGE:** To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 227.300, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Language disorder must include:

- a. Date of evaluation;
- b. Child's name and date of birth;
- c. Diagnosis specific to therapy;
- d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be

tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

- e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients, or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
 - f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 - g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of the orofacial structures;
 - h. Formal or informal assessment of hearing, articulation, voice, and fluency skills.
 - i. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;
 - j. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - k. Signature and credentials of the therapist performing the evaluation.
3. **SPEECH PRODUCTION (Articulation, Phonological, Apraxia):** To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 227.300, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:
- a. Date of evaluation;
 - b. Child's name and date of birth;
 - c. Diagnosis specific to therapy;
 - d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

7 months - [3]**4 months**

- e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
 - f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 - g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;
 - h. Formal screening of language skills. Examples include, but are not limited to, the Fluarty-2, KLST-2, CELF-4 Screen, or TTFC;
 - i. Formal or informal assessment of hearing, voice, and fluency skills;
 - j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;
 - k. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - l. Signature and credentials of the therapist performing the evaluation.
4. **SPEECH PRODUCTION (Voice):** To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 227.300, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:
- a. A medical evaluation to determine the presence or absence of a physical etiology is a prerequisite for evaluation of voice disorder;
 - b. Date of evaluation;
 - c. Child's name and date of birth;
 - d. Diagnosis specific to therapy;
 - e. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

4 months

- f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

- g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 - h. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;
 - i. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;
 - j. Formal or informal assessment of hearing, articulation, and fluency skills;
 - k. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;
 - l. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - m. Signature and credentials of the therapist performing the evaluation.
5. **SPEECH PRODUCTION (Fluency):** To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 227.300, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:
- a. Date of evaluation;
 - b. Child's name and date of birth;
 - c. Diagnosis specific to therapy;
 - d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

4 months

- e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
- f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
- g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;
- h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;
- i. Formal or informal assessment of hearing, articulation, and voice skills;
- j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

- k. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - l. Signature and credentials of the therapist performing the evaluation.
6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 227.300, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:
- a. Date of evaluation;
 - b. Child's name and date of birth;
 - c. Diagnosis specific to therapy;
 - d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

- e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
 - f. If swallowing problems or signs of aspiration are noted, then include a statement indicating that a referral for a videofluoroscopic swallow study has been made;
 - g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 - h. Formal or informal assessment of hearing, language, articulation, voice, and fluency skills;
 - i. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;
 - j. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - k. Signature and credentials of the therapist performing the evaluation.
- D. Interpretation and Eligibility: Ages Birth to 21
- 1. LANGUAGE: Two (2) language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one (1) being a norm-referenced, standardized test with good reliability and validity. (Use of two (2) one-word vocabulary tests alone will not be accepted.)
 - a. For children age birth to three (3): criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.

- b. For children age three (3) to twenty-one (21): criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 227.300, part D, paragraph 8.)
 - c. Age birth to three (3): Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test, with corroborating data from a criterion-referenced measure. When these two (2) measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.
 - d. Age three (3) to twenty-one (21): Eligibility for language therapy will be based upon two (2) composite or quotient scores that are -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both scores, a third standardized score indicating a -1.5 SD or greater is required to support the medical necessity of services.
2. **ARTICULATION OR PHONOLOGY:** Two (2) tests or procedures must be administered, with at least one (1) being from a norm-referenced, standardized test with good reliability and validity.

Eligibility for articulation or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from accepted procedures can be used to support the medical necessity of services. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)
3. **APRAXIA:** Two (2) tests or procedures must be administered, with at least one (1) being a norm-referenced, standardized test with good reliability and validity.

Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from a criterion-referenced test or accepted procedures can be used to support the medical necessity of services. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)
4. **VOICE:** Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.

Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.
5. **FLUENCY:** At least one (1) norm-referenced, standardized test with good reliability and validity, and at least one (1) supplemental tool to address effective components.

Eligibility for fluency therapy will be based upon an SS of -1.5 SD below the mean or greater on the standardized test.
6. **ORAL MOTOR/SWALLOWING/FEEDING:** An in-depth, functional profile of oral motor structures and function.

Eligibility for oral-motor/swallowing/feeding therapy will be based upon an in-depth functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by a videofluoroscopic swallow study, the patient can be treated for pharyngeal dysphagia via the recommendations set forth in the swallow study report.
7. All subtests, components, and scores must be reported for all tests used for eligibility purposes.

8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth, functional profile of the child's communication abilities. An in-depth functional profile is a detailed narrative or description of a child's communication behaviors that specifically explains and justifies the following:
 - a. The reason standardized testing is inappropriate for this child;
 - b. The communication impairment, including specific skills and deficits; and
 - c. The medical necessity of therapy.Supplemental instruments from Accepted Tests for Speech-Language Therapy may be useful in developing an in-depth functional profile.
9. Children (birth to age twenty-one (21)) receiving services outside of the schools must be evaluated annually.
10. Children (birth to twenty-four (24) months) in the Early Intervention Day Treatment (EIDT) Program must be evaluated every six (6) months.
11. Children (age three (3) to twenty-one (21)) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three (3) years; however, an annual update of progress is required.
12. Children (age three (3) to twenty-one (21)) receiving privately contracted services, apart from or in addition to those within the schools, must have a full evaluation annually.
13. IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

E. Progress Notes

1. Child's name;
2. Date of service;
3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form of measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of the entry with a full signature and credentials; and
8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

291.000 Introduction to Billing

7-1-20

Physician/Independent Lab/CRNA/Radiation Therapy Center providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

292.210 National Place of Service Codes

7-1-20

Electronic and paper claims now require the same National Place of Service code.

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Doctor's Office	11
Patient's Home	12
Ambulatory Surgical Center	24
Day Care Facility or ADDT Facility	49
Nursing Facility	32
Skilled Nursing Facility	31
Other Locations	99
Independent Laboratory	81
End Stage Renal Disease Treatment Facility	65
Emergency Room	23
Inpatient Psychiatric Facility	51

292.440 Anesthesia Services**7-1-20**

Anesthesia procedure codes (**00100** through **01999**) must be billed in anesthesia time. Anesthesia modifiers **P1** through **P5** listed under Anesthesia Guidelines in the CPT must be used. When appropriate, anesthesia procedure codes that have a base of four (4) or fewer are eligible to be billed with a second modifier, "**22**," referencing surgical field avoidance.

Reimbursement for use and administration of local or topical anesthesia is included in the primary surgeon's reimbursement for the surgery that requires such anesthesia. No modifiers or time may be billed with these procedures.

A. Electronic Claims

Electronic claims submission may be used unless attachments are required.

B. Paper Claims

If paper billing is required, enter the procedure code, time, and units as shown in Section 292.447. Enter again the number of units (each fifteen (15) minutes of anesthesia equals one (1) time unit) in Field 24G. (See cutaway section of a completed claim in Section 292.447.)

C. The following CPT procedure codes for hysterectomies and abortions must be billed on CMS-1500 paper claims because they require attachments or documentation.

Procedure Code	Description	Documentation Required
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Procedure Code	Description	Documentation Required
00800	Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified	On females only, required to name each procedure done by surgeon in "Procedures, Services, or Supplies" column. Example - 1. colon resection 2. lysis of adhesions 3. appendectomy
00840	Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; not otherwise specified	On females only, required to name each procedure done by surgeon in "Procedures, Services, or Supplies" column. This code may not be used to bill Arkansas Medicaid for any hysterectomy anesthesia.
00846	Radical hysterectomy	Acknowledgement of Hysterectomy Information (DMS-2606) View or print form DMS-2606 and instructions for completion.
00848	Pelvic exenteration	Operative Report
00922	Anesthesia for procedures on male genitalia (including open urethral procedures); seminal vessels	Operative Report
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified	Required to name each procedure done by surgeon in "Procedures, Services or Supplies" column.
00944	Vaginal hysterectomy	Acknowledgement of Hysterectomy Information (DMS-2606)
01962	Anesthesia for urgent hysterectomy following delivery	Acknowledgement of Hysterectomy Information (DMS-2606)
01963	Anesthesia for cesarean hysterectomy without labor analgesia/anesthesia care	Acknowledgement of Hysterectomy Information (DMS-2606)
01965	Anesthesia for incomplete or missed abortion procedure	Procedure requires the following ICD diagnosis code (View ICD Codes.). Any other diagnosis billed with this procedure code requires paper billing and documentation to justify the procedure
01966	Anesthesia for induced abortions. Use for billing anesthesia services for all elective, induced abortions, including abortions performed for rape or incest.	Certification Statement for Abortion (DMS-2698). (See Sections 251.220, 261.000, 261.100, 261.200, and 261.260 of this manual.) View or print form DMS-2698 and instructions for completion.
01999	Unlisted anesthesia procedure(s)	Procedure Report

- D. Anesthesiologist/anesthetists may bill procedure code **00170** for any inpatient or outpatient dental surgery using place of service code “**24**,” “**21**,” “**22**,” or “**11**,” as appropriate. This code does not require Prior Approval for anesthesia claims.
- E. A maximum of seventeen (17) units of anesthesia are allowed for a vaginal delivery or Cesarean Section. Refer to Anesthesia Guidelines of the CPT book for procedure codes related to vaginal or Cesarean Section deliveries. Only one (1) anesthesia service is billable for Arkansas Medicaid as the anesthesia for a delivery. The anesthesia service ultimately provided should contain all charges for the anesthesia. No add-on codes are payable.

292.910 National Drug Codes (NDCs)**7-1-20**

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor website](#).

A complete listing of “**Covered Labelers**” is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

LABELER CODE		EFFECTIVE DATE		TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991		
00003	E.R. SQUIBB & SONS, INC	1/1/1991		
00004	HOFFMANN-LA ROCHE	1/1/1991		
00005	LEDERLE LABORATORIES	1/1/1991		
00006	MERCK & CO., INC.	1/1/1991		
00007	GLAXOSMITHKLINE	1/1/1991		
00008	WYETH LABORATORIES	1/1/1991		
00009	PFIZER, INC.	1/1/1991		
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991		7/1/1998
00013	PFIZER, INC.	1/1/1991		

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from

one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

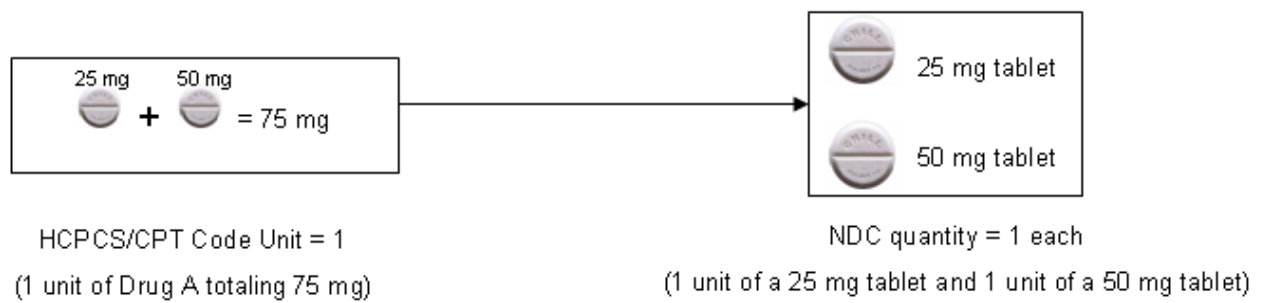
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

II. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

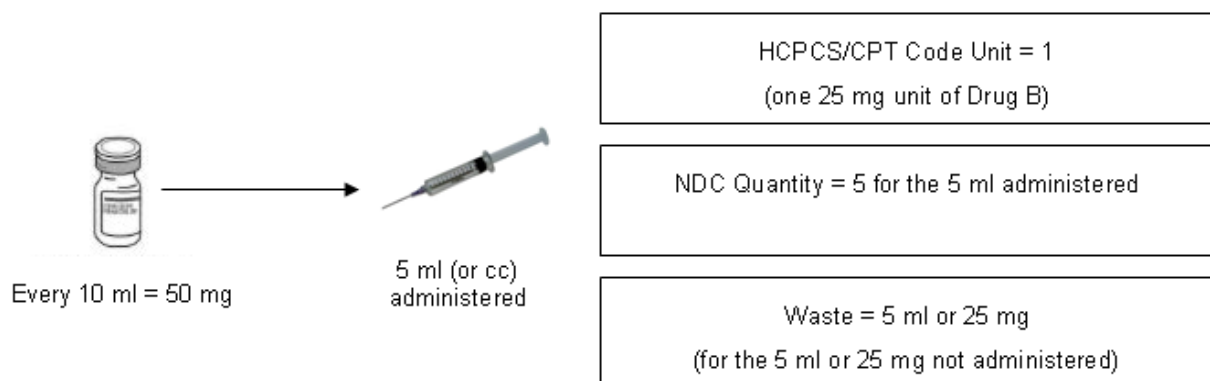
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters, or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid requires providers using electronic claims filing through the provider portal to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

B. Paper Claims Filing – CMS-1500

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of “N4”, the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit), and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed under the same procedure code on the same date of service is defined as a “sequence.” When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one (1) NDC is associated with the HCPCS/CPT code.

Diagram 6

Detail 1		24. A. DATE(S) OF SERVICE											B. PLACE OF SERVICE	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS SUPPLY	H. UNIT	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	K. SUPPLIER INFORMATION	
Sequence 1		MM	DD	YY	MM	DD	YY	11															
Sequence 2		1	N4	123456789	12	UN	1.00													123456789			
			08	01	07	08	01	07	11						Z1234			1	25	00	1	NPI	
Detail 2		2	N4	0111222233	UN	1.00															123456789		
			08	01	07	08	01	07	11						Z1234			1	0	00	0	NPI	
Sequence 1		3		08	01	07	08	01	07	11					99213			1	55	00	1	NPI	
Detail 3		4	N4	4444455555	06	ML	5.00															123456789	
			08	01	07	08	01	07	11						Z6789			1	35	00	1	NPI	
Sequence 2		5																				NPI	

Procedure Code/NDC Detail Attachment Form - DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 “Procedure Code/NDC Detail Attachment Form.” Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

Detail #	Sequence #	NDC											Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML

III. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

IV. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.

See Section 292.950 for additional information regarding drug code billing.



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TO: Arkansas Medicaid Health Care Providers – Podiatrist

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal PODIATR-1-19

REMOVE

Section	Effective Date
241.000	7-1-07
242.450	7-15-11

INSERT

Section	Effective Date
241.000	7-1-20
242.450	7-1-20

Explanation of Updates

Sections 241.000 and 242.450 are updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make other minor technical changes.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC required**241.000 Introduction to Billing****7-1-20**

Podiatrist providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

242.450 National Drug Codes (NDCs)**7-1-20**

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare & Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor](#) website.

A complete listing of “**Covered Labelers**” is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

LABELER CODE	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. *NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.*

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

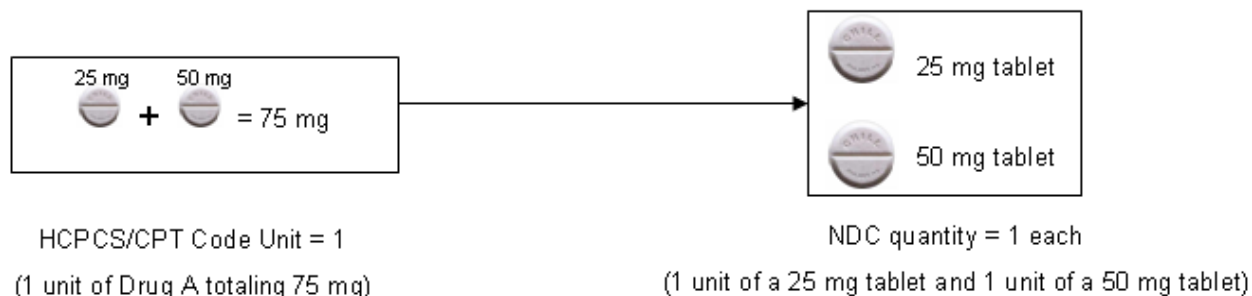
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

II. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

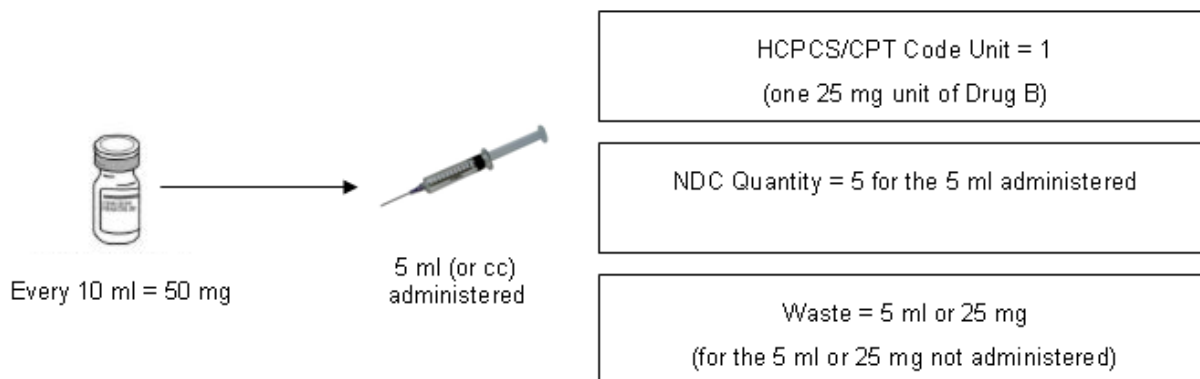
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid requires providers using electronic filing through the Provider Portal to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

B. Paper Claims Filing – CMS-1500 and CMS-1450 (UB-04)

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.

See Diagram 6 for CMS-1500 and Diagram 7 for CMS-1450 (UB-04).

CMS-1500

For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 - International Unit; GR - Gram; ML - Milliliter; UN - Unit), and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC, when billed under the same procedure code on the same date of service is defined as a "sequence". When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in the detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, first detail, sequences one (1) and two (2). Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence one (1) gives an example where only one (1) NDC is associated with the HCPCS/CPT code.

Diagram 6

Detail 1		24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE	C. EMS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. QTY	H. UNIT	I. NDC	J. RENDERING PROVIDER ID #	K. SUPPLIER INFORMATION
		MM	DD	YY	MM	DD	YY					CPT	HCPCS	MODIFIER										
Sequence 1		1	N4	12	34	56	78	91	2	UN	1.00				Z1234			1	25	00	1		123456789	
Sequence 2		2	N4	01	11	12	22	33	UN	1.00					Z1234			1	0	00	0		123456789	
Detail 2		3	08	01	07	08	01	07	11						99213			1	55	00	1		123456789	
Sequence 1		4	N4	44	44	55	55	06	ML	5.00					Z5789			1	35	00	1		123456789	
Detail 3		5																						

CMS-1450 (UB-04)

For institutional outpatient claims on the CMS-1450 (UB-04), use the locator field 43 (Description) to list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 - International Unit; GR - Gram; ML - Milliliter; UN - Unit), and number of units of the actual NDC administered, spaced, and arranged exactly as in Diagram 7.

Each NDC, when billed under the same procedure code on the same date of service is defined as a "sequence". When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in the detail locator field 47 and total HCPCS/CPT code units in locator field 46. Each subsequent sequence number should show zeros in locator fields 46 and 47. See Detail 1, sequence 2 in Diagram 7.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 7, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one (1) NDC is associated with the HCPCS/CPT code.

Diagram 7

Detail 1	Sequence 1	42 PREV CD	43 DESCRIPTION	44 HCPCS / RATE / NPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	Sequence 2	0636	N4 12345678912 UN 1.00	Z1234	08/01/07	1	25.00		1
Detail 2		0636	N4 01111222233 UN 1.00	Z1234	08/01/07	0	0.00		2
	Sequence 1	0305	Hemogram	85025	08/01/07	1	55.00		3
Detail 3		0636	N4 44444555506 UN 5.00	Z6789	08/01/07	1	21.00		4
									5
									6

Procedure Code/NDC Detail Attachment Form - DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 8 for an example of the completed form. A copy of form DMS-664 is attached and may be copied for claim submission. [View or print form DMS-664 and instructions for completion.](#)

Diagram 8

Detail #	Sequence #	NDC												Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0	
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0	
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML	

III. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

IV. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, disputes or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer. At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include NDC invoices showing the purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.



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TO: Arkansas Medicaid Health Care Providers – Portable X-Ray

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal PORTX-1-19

REMOVE

Section	Effective Date
241.000	11-1-06

INSERT

Section	Effective Date
241.000	7-1-20

Explanation of Updates

Section 241.000 is updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make a minor technical change.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

241.000 Introduction to Billing

7-1-20

Podiatrist providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Prosthetics

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal PROSTHET-4-19

REMOVE

Section	Effective Date
241.000	8-1-05
242.401	11-1-15

INSERT

Section	Effective Date
241.000	7-1-20
242.401	7-1-20

Explanation of Updates

Sections 241.000 and 242.401 are updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make minor technical changes.

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Janet Mann
DMS Director

TOC not required**241.000 Introduction to Billing****7-1-20**

Prosthetics providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

242.401 National Drug Codes (NDCs)**7-1-20**

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Health Care Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor](#) website .

A complete listing of “**Covered Labelers**” is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

LABELER CODE	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

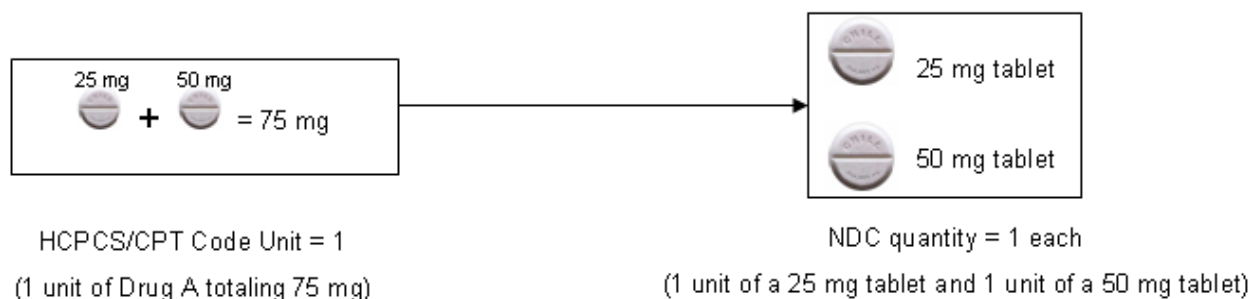
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

II. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

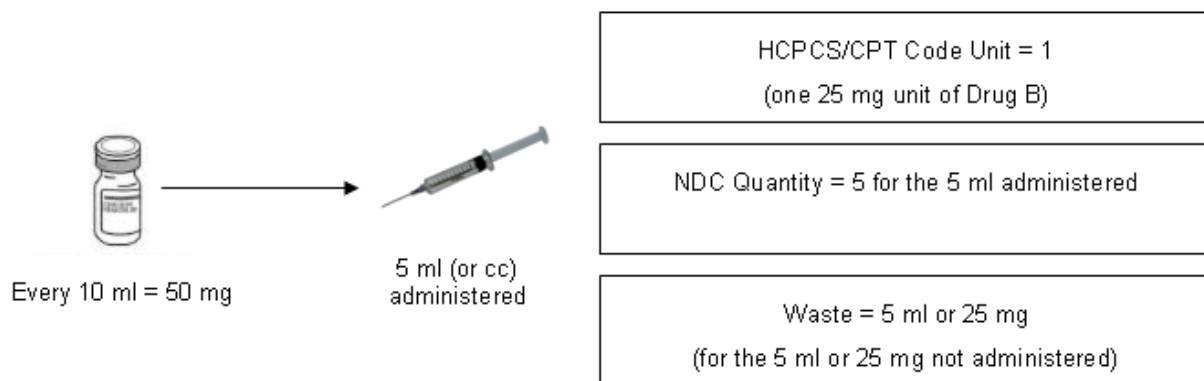
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid requires providers using electronic filing through the Provider Portal to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

B. Paper Claims Filing – CMS-1500

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of “N4”, the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML - Milliliter; UN – Unit), and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed under the same procedure code on the same date of service is defined as a “sequence.” When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one (1) NDC is associated with the HCPCS/CPT code.

Diagram 6

Detail 1		24. A. DATE(S) OF SERVICE											B. PLACE OF SERVICE	C. EMS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINT	F. CHARGES		G. DAYS OF SERVICE	H. UNITS	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	K. SUPPLIER INFORMATION
Sequence 1		MM	DD	YY	MM	DD	YY	UN	1.00																	
Sequence 2		08	01	07	08	01	07	11					Z1234				1		25	00	1			NPI	123456789	
		N4	01	11	22	23	33	UN	1.00																123456789	
Detail 2		08	01	07	08	01	07	11					Z1234				1		0	00	0			NPI	123456789	
		08	01	07	08	01	07	11					99213				1		55	00	1			NPI	123456789	
Sequence 1		N4	44	44	44	55	55	06	ML	5.00															123456789	
		08	01	07	08	01	07	11					Z6789				1		35	00	1			NPI		
Detail 3		5																						NPI		

Procedure Code/NDC Detail Attachment Form—DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 “Procedure Code/NDC Detail Attachment Form.” Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

Detail #	Sequence #	NDC											Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML

III. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

IV. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.



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TO: Arkansas Medicaid Health Care Providers – Rehabilitative Hospital

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal REHABHSP-3-19

REMOVE

Section	Effective Date
216.100	11-1-10
216.200	4-16-12
241.000	7-1-07

INSERT

Section	Effective Date
216.100	7-1-20
216.200	7-1-20
241.000	7-1-20

Explanation of Updates

Sections 216.100 and 216.200 are updated to replace CHMS with EIDT and change Speech Therapy to Speech-Language Therapy where it appears. Other minor grammatical changes are also included.

Section 241.000 is revised to remove references to Provider Electronic Solutions (PES) and make a minor grammatical change.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC required**216.100 Occupational and Physical Therapy Guidelines for Retrospective Review for Beneficiaries Under the Age of 21 7-1-20****A. Medical Necessity**

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is insufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Evaluation and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:

1. Date of evaluation;
2. Child's name and date of birth;
3. Diagnosis specific to therapy;
4. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores, or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services;
6. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone, or a narrative description of the child's functional mobility skills (strengths and weaknesses);

8. An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week;
9. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
10. Signature and credentials of the therapist performing the evaluation.

C. Interpretation and Eligibility: Ages Birth to 21

1. Tests used must be norm-referenced, standardized, and specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.
3. All subtests, components, and scores must be reported for all tests used for eligibility purposes.
4. Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one (1) subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.
5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason a standardized test could not be used must be included in the evaluation.
6. The Mental Measurement Yearbook (MMY) is the standard reference to determine reliability and validity. Refer to "Accepted Tests" sections for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.
7. Range of Motion: A limitation of greater than ten (10) degrees or documentation of how a deficit limits function.
8. Muscle Tone: Modified Ashworth Scale.
9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
10. Transfer Skills: Documented as the amount of assistance required to perform transfer, e.g., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
11. Children (birth to age Twenty-one (21)) receiving services outside of the public schools must be evaluated annually.
12. Children (birth to age two (2)) in the Early Intervention Day Treatment (EIDT) program must be evaluated every six (6) months.
13. Children (age three (3) to twenty-one (21)) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three (3) years; however, an annual update of progress is required.

D. Frequency, Intensity, and Duration of Physical or Occupational Therapy Services

The frequency, intensity, and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable

medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.

2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.
3. Duration of Services: Therapy services should be provided if reasonable progress is made toward established goals. If reasonable, functional progress cannot be expected with continued therapy, services should be discontinued and monitoring, or establishment of a home program, should be implemented.

E. Progress Notes

1. Child's name;
2. Date of service;
3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of entry with a full signature and credentials; and
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

216.200 Speech-Language Therapy Guidelines for Retrospective Review for Beneficiaries Under Age 21

7-1-20

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is insufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.
3. There must be reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Types of Communication Disorders

1. Language Disorders — Impaired comprehension or use of spoken, written, or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics), or the perception/processing of language. Language disorders may involve one (1), all, or a combination of the above components.

2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice, or fluency. Speech Production disorders may involve one (1), all, or a combination of these components of the speech production system.

An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e. phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e. verbal or oral apraxia, dysarthria.

3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures, or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

Mild: Scores between 84-78; -1.0 standard deviation

Moderate: Scores between 77-71; -1.5 standard deviations

Severe: Scores between 70-64; -2.0 standard deviations

Profound: Scores of sixty-three (63) or lower; -2.0+ standard deviations

2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 216.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for a Language disorder must include:

- a. Date of evaluation;
- b. Child's name and date of birth;
- c. Diagnosis specific to therapy;
- d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

- e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients, or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
- f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

- g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of the orofacial structures;
 - h. Formal or informal assessment of hearing, articulation, voice, and fluency skills;
 - i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment;
 - j. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - k. Signature and credentials of the therapist performing the evaluation.
3. **SPEECH PRODUCTION (Articulation, Phonological, Apraxia):** To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 216.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:
- a. Date of evaluation;
 - b. Child's name and date of birth;
 - c. Diagnosis specific to therapy;
 - d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

- e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
- f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
- g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;
- h. Formal screening of language skills. Examples include, but are not limited to, the Fluarty-2, KLST-2, CELF-4 Screen, or TTFC;
- i. Formal or informal assessment of hearing, voice, and fluency skills;
- j. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment;
- k. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem, and
- l. Signature and credentials of the therapist performing the evaluation.

4. **SPEECH PRODUCTION (Voice):** To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 216.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:
- a. A medical evaluation to determine the presence or absence of a physical etiology as a prerequisite for evaluation of voice disorder;
 - b. Date of evaluation;
 - c. Child's name and date of birth;
 - d. Diagnosis specific to therapy;
 - e. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant, has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

- f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
 - g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 - h. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;
 - i. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;
 - j. Formal or informal assessment of hearing, articulation, and fluency skills;
 - k. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment;
 - l. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - m. Signature and credentials of the therapist performing the evaluation.
5. **SPEECH PRODUCTION (Fluency):** To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 216.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:
- a. Date of evaluation;
 - b. Child's name and date of birth;
 - c. Diagnosis specific to therapy;

- d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant, has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

4 months

- e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
 - f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 - g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;
 - h. Formal screening of language skills. Examples include, but are not limited to, the Fluarty-2, KLST-2, CELF-4 Screen, or TTFC;
 - i. Formal or informal assessment of hearing, articulation, and voice skills;
 - j. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment;
 - k. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 - l. Signature and credentials of the therapist performing the evaluation.
6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 216.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:
- a. Date of evaluation;
 - b. Child's name and date of birth;
 - c. Diagnosis specific to therapy;
 - d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant, has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

7 months - [(12) / 4 weeks]**7 months - [3]****4 months**

- e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);
- f. If swallowing problems or signs of aspiration are noted, then include a statement indicating that a referral for a videofluoroscopic swallow study has been made;
- g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
- h. Formal or informal assessment of hearing, language, articulation, voice, and fluency skills;
- i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment;
- j. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
- k. Signature and credentials of the therapist performing the evaluation.

D. Interpretation and Eligibility: Ages Birth to 21

1. **LANGUAGE:** Two (2) language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one (1) being a norm-referenced, standardized test with good reliability and validity. (Use of two (2) one-word vocabulary tests alone will not be accepted.)
 - a. For children age birth to three (3): criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.
 - b. For children age three (3) to twenty-one (21), criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 216.200, part D, paragraph 8).
 - c. Age birth to three (3): Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test with corroborating data from a criterion-referenced measure. When these two (2) measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.
 - d. Age three (3) to twenty-one (21): Eligibility for language therapy will be based upon two (2) composite or quotient scores that are -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both scores, a third standardized score indicating a -1.5 SD or greater is required to support the medical necessity of services.
2. **ARTICULATION OR PHONOLOGY:** Two (2) tests or procedures must be administered, with at least one (1) being from a norm-referenced, standardized test with good reliability and validity.

Eligibility for articulation or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from accepted procedures can be used to support the medical necessity of services (For a list of accepted tests,

refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)

3. **APRAXIA:** Two (2) tests or procedures must be administered, with at least one (1) being a norm-referenced, standardized test with good reliability and validity.

Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from a criterion-referenced test or accepted procedures can be used to support the medical necessity of services. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)
4. **VOICE:** Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.

Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.
5. **FLUENCY:** At least one (1) norm-referenced, standardized test with good reliability and validity, and at least one (1) supplemental tool to address affective components.

Eligibility for fluency therapy will be based upon an SS of -1.5 SD below the mean or greater on the standardized test.
6. **ORAL MOTOR/SWALLOWING/FEEDING:** An in-depth, functional profile of oral motor structures and function.

Eligibility for oral-motor/swallowing/feeding therapy will be based upon an in-depth, functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by videofluoroscopic swallow study, the patient can be treated for feeding difficulties via the recommendations set forth in the swallow study report.
7. All subtests, components, and scores must be reported for all tests used for eligibility purposes.
8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth, functional profile of the child's communication abilities. An in-depth, functional profile is a detailed narrative or description of a child's communication behaviors that specifically explains and justifies the following:
 - a. The reason standardized testing is inappropriate for this child;
 - b. The communication impairment, including specific skills and deficits; and
 - c. The medical necessity of therapy.
 - d. Supplemental instruments from Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual may be useful in developing an in-depth, functional profile.
9. Children (birth to age twenty-one (21)) receiving services outside of the schools must be evaluated annually.
10. Children (age birth to twenty-four (24) months) in the Early Intervention Day Treatment (EIDT) Program must be evaluated every six (6) months.
11. Children (age three (3) to twenty-one (21)) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three (3) years; however, an annual update of progress is required.

12. Children (age three (3) to twenty-one (21)) receiving privately contracted services, apart from or in addition to those within the schools must have a full evaluation annually.
13. IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

E. Progress Notes

1. Child's name;
2. Date of service;
3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and activities rendered during each therapy session, along with a form of measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of the entry with a full signature and credentials; and
8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

241.000 Introduction to Billing

7-1-20

Rehabilitative Hospital providers who submit paper claims must use the CMS-1450 claim form, which also is known as the UB-04 claim form.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

Section III of every Arkansas Medicaid provider manual contains information about available electronic claim options.



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TO: Arkansas Medicaid Health Care Providers – Rehabilitative Services for Persons with Physical Disabilities

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal RSPD-1-19

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
213.100	3-1-06	213.100	7-1-20
217.300	3-1-06	217.300	7-1-20

Explanation of Updates

Section 213.100 is updated to remove RSPMI and to include OBHS in the listing of services that could be medically necessary if criteria is met.

Section 217.300 is updated to remove programs DDSACS, DDTCS, ElderChoices, and RSPMI. These programs have been replaced by ADDT, ARChoices, DDSCES, and OBHS. Other minor grammatical changes have also been included.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC not required**213.100 Medical Necessity****7-1-20**

RSPD services are covered by Medicaid for eligible beneficiaries when medically necessary. The medical necessity criteria include:

- A. A prescription from a licensed physician stating that the Medicaid beneficiary needs RSPD services. An individualized plan of care may serve as the prescription for services. The prescription or plan of care must be signed and dated by the physician.
- B. The physician must have examined the patient within the thirty (30) days preceding the date of the written prescription or plan of care.
- C. The prescription or plan of care will be effective for up to three (3) months from the prescription date and must be renewed before services may continue beyond three (3) months.

Persons needing rehabilitative services on a less intensive basis than those provided in the inpatient setting may receive outpatient rehabilitative services through other appropriate Medicaid services, e.g., outpatient hospital, physical therapy, occupational therapy, speech-language therapy, Outpatient Behavioral Health Services (OBHS), and home health.

217.300 Services Limitation**7-1-20**

Because certain services would either result in a duplication (i.e., the service is included in the RSPD global coverage) or would not be appropriate for persons residing in an RSPD facility, services in the below listed Medicaid Programs are not available to Medicaid beneficiaries who have received RSPD services on the same date of service. These include:

- A. Adult Developmental Day Treatment (ADDT).
- B. Developmental Disabilities Services (DDS) Community and Employment Support (CES) Waiver.
- C. ARChoices in Homecare.
- D. Home Health.
- E. Hospice.
- F. Hyperalimentation (Parenteral Nutrition).
- G. Individual or Group Psychological Therapy/Counseling or Testing.
- H. Inpatient Hospital (Acute Care/General or Rehabilitative).
- I. Inpatient Psychiatric Services for Under Age Twenty-one (21).
- J. Nursing Home.
- K. Personal Care.
- L. Occupational, Physical, or Speech-Language Therapy, including evaluations.
- M. Private Duty Nursing Services.
- N. Outpatient Behavioral Health Services (OBHS).

- O. Targeted Case Management.
- P. Ventilator Equipment.



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TO: Arkansas Medicaid Health Care Providers – Rural Health Clinic

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal RURLHLTH-2-19

REMOVE

Section	Effective Date
251.000	7-1-07

INSERT

Section	Effective Date
251.000	7-1-20

Explanation of Updates

Section 251.000 is updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make minor technical changes.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

251.000 Introduction to Billing

7-1-20

Rural Health Clinic providers who submit paper claims must use either the CMS-1450 claim form, which also is known as the UB-04 claim form, or the CMS-1500.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – School-Based Mental Health Services

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal SBMH-1-19

REMOVE

Section	Effective Date
271.000	7-1-07

INSERT

Section	Effective Date
271.000	7-1-20

Explanation of Updates

Section 271.000 is updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make a minor technical change.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

271.000 Introduction to Billing

7-1-20

School-based mental health providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim should contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal Sect-2-19

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
105.140	10-1-12	105.140	7-1-20
105.170	1-1-16	105.170	7-1-20
110.300	9-15-09	110.300	7-1-20
123.000	7-15-13	123.000	7-1-20
123.100	6-1-08	123.100	7-1-20

Explanation of Updates

Section 105.140 is updated to change DDSACS to DDSCES and make other minor grammatical changes.

Section 105.170 is updated to change DDTCS to ADDT and make other minor grammatical changes.

Section 110.300 is updated to remove CHMS and RSPMI and to include EIDT, OBHS, and ABHSCI. Other minor grammatical changes are also included.

Sections 123.000 and 123.100 are revised to remove references to Provider Electronic Solutions (PES).

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC required**105.140 DDS Community and Employment Support (CES)****7-1-20**

The Developmental Disability Services Community and Employment Support (DDS CES) 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 individuals with intellectual disabilities (ICF/IID).

DDS CES eligibility requires a determination of categorical eligibility, a determination of level of care, the development of a plan of care, and a cost comparison to determine the cost-effectiveness of the plan of care. The DDS CES program further requires advising the beneficiary that he or she may freely choose between waiver and institutional services.

Services supplied through this program are:

- A. Supportive living
- B. Respite care
- C. Supplemental support services
- D. Supported employment services
- E. Environmental modifications
- F. Adaptive equipment
- G. Specialized medical supplies
- H. Community transition services
- I. Consultation services
- J. Crisis intervention services

105.170 Non-Emergency Transportation Services (NET)**7-1-20**

Medicaid non-emergency transportation (NET) services for Medicaid beneficiaries are furnished by regional brokers under the authority of a capitated selective contract waiver. Medicaid beneficiaries contact their local transportation broker for non-emergency transportation to appointments with Medicaid providers.

Adult Developmental Day Treatment (ADDT) providers transporting Medicaid beneficiaries to ADDT Clinic Service providers for ADDT 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 ADDT 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 individuals with intellectual disabilities (ICF/IID);
- 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);
- F. ARKids First-B beneficiaries; or
- G. Periods of retroactive eligibility.

Detailed information may be found in the Transportation provider manual and on the [Arkansas Medicaid website](#).

110.300 Utilization Review Section

7-1-20

The Utilization Review (UR) Section of the Arkansas Medicaid Program performs professional medical utilization review(s) for a wide variety of services in a timely and cost-effective manner. Medicaid's UR participates in the development of clinically based standard(s) of care coverage determinations and serves as a resource to Arkansas Medicaid providers. UR has a responsibility for assuring quality medical care to Arkansas Medicaid beneficiaries through detection and reporting quality of care concerns to appropriate bodies, in addition to protecting the integrity of state and federal funds supporting the Medicaid Program.

Utilization Review provides professional review(s) for:

- A. Pre- and post-payment of medical services;
- B. Prior authorization for private duty nursing, hearing aids and hearing aid repair, extension of benefits for home health beneficiaries age twenty-one (21) and older, extension of benefits for personal care for beneficiaries age twenty-one (21) and older, medical supplies, and incontinence products;
- C. Monitoring contractors performing prior authorizations and extension of benefits for the following programs: in-patient psychiatric services, in-patient and out-patient hospitalization, emergency room utilization, personal care for beneficiaries under the age of twenty-one (21), Early Intervention Day Treatment, therapy, OBHS, ABHSCI, transplants, durable medical equipment, and hyperalimentation services; and
- D. Authorization and arrangement of out-of-state transportation for beneficiaries for medically necessary services/treatments not available in-state.

[View or print the Utilization Review contact information.](#)

123.000 Medicaid Eligibility Information

7-1-20

Under contract with the Division of Medical Services, the fiscal agent provides Medicaid eligibility verification through the provider portal via the web or through the Voice Response System (VRS). To access the VRS, providers can call the Provider Assistance Center automated help line. [View or print the Provider Assistance Center contact information.](#)

Eligibility requests can be submitted interactively through the provider portal via the web. Instructions for verifying eligibility through the provider portal are available using the site's online Help feature.

Medicaid providers are able to verify a beneficiary'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 electronic solutions.** Providers must print and retain eligibility documentation in the beneficiary's record each time services are provided or to document retroactive eligibility.

The Provider Assistance Center 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.

Electronic Benefit Eligibility information only indicates information on claims that have been processed. It does not reflect any claims that may still be pending.

123.100 Date Specific Medicaid Eligibility

7-1-20

Beneficiary eligibility in the Arkansas Medicaid Program is date specific. Medicaid eligibility may begin or end on any day of a month. An electronic response through the provider portal or Voice Response System (VRS) provides the current eligibility period through the date of the inquiry. An electronic eligibility verification inquiry and positive response through the provider portal or VRS (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.



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TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal SecIII-1-19

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
301.120	11-1-17	—	—
301.200	11-1-17	301.200	7-1-20
301.210	11-1-17	301.210	7-1-20
301.220	11-1-17	301.220	7-1-20
301.230	11-1-17	301.230	7-1-20
302.400	11-1-17	302.400	7-1-20
303.000	11-1-17	303.000	7-1-20

Explanation of Updates

Section 301.120 is removed.

Sections 301.200, 301.210, 301.220, 301.230, 302.400, and 303.000 are revised to remove references to Provider Electronic Solutions (PES) and make other grammatical changes.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC required**301.200 Electronic Transactions 7-1-20**

The Arkansas Medicaid fiscal agent offers electronic transactions that are compliant with Health Insurance Portability and Accountability Act (HIPAA) regulations through the provider portal.

301.210 Eligibility Verification 7-1-20

Providers can check a beneficiary's eligibility through the provider portal via the web or through the Voice Response System (VRS). To access the VRS, providers can call the Provider Assistance Center automated help line. [View or print the Provider Assistance Center contact information.](#)

Eligibility requests can be submitted interactively through the provider portal via the web. Instructions for verifying eligibility through the provider portal are available using the site's online Help feature.

301.220 Claim Status Inquiry 7-1-20

Providers can check the status of one (1) or more claims through the provider portal. Claim status requests can be submitted interactively (one (1) at a time) via the provider portal. Claim status requests can be submitted interactively (one (1) at a time) via the web. Instructions for checking a claim status via the provider portal are available by using the site's online Help feature.

Providers with vendor systems can also check a claim's status by utilizing the ASC X.12 5010A 276/277 transactions with the appropriate X.12 companion guide.

301.230 Remittance Advice Reports 7-1-20

Providers can retrieve their electronic Remittance Advice (RA) reports through the provider portal

Providers with vendor systems can also receive remittance advice reports by utilizing the ASC X.12 5010A 835 transaction with the appropriate X.12 companion guide.

302.400 Claims With Retroactive Eligibility 7-1-20

Retroactive eligibility does not constitute an exception to the filing deadline policy. If an appeal or other administrative action delays an eligibility determination, the provider must submit the claim within the 12-month filing deadline. If the claim is denied for beneficiary ineligibility, the provider may resubmit the claim when the patient becomes eligible for the retroactive date(s) of service. Medicaid may then consider the claim for payment because the provider submitted the initial claim within the 12-month filing deadline and the denial was not the result of an error by the provider.

Occasionally the State Medicaid agency or a federal agency, such as the Social Security Administration, is unable to complete a Medicaid eligibility determination in time for service providers to file timely claims. Arkansas Medicaid's claims processing system is unable to accept a claim for services provided to an ineligible individual or to suspend that claim until the individual is retroactively eligible for the claim dates of service.

To resolve this dilemma, Arkansas Medicaid considers the pseudo beneficiary identification number 9999999999 to represent an "...error originating within (the) State's claims system." Therefore, a claim containing that number is a clean claim if it contains all other information necessary for correct processing.

By defining the initial timely filed claim as a clean claim denied because of agency processing error, we may allow the provider to refile the claim when the government agency completes the eligibility determination. With the claim, the provider must submit proof of the initial filing and a letter or other documentation sufficient to explain that administrative processes (such as determination of SSI eligibility) prevented the resubmittal before the filing deadline.

To submit a claim for services provided to a patient who is not yet eligible for Medicaid, enter, on the claim form or on the electronic format (provider portal or billing vendor/trading partner), a pseudo Medicaid beneficiary identification number, 9999999999. Medicaid will deny the claim. Retain the denial or rejection for proof of timely filing if eligibility determination occurs more than twelve (12) months after the date of service.

Providers have twelve (12) months from the approval date of the patient's Medicaid eligibility to resubmit a clean claim after filing a pseudo claim. After the 12-month filing deadline (twelve (12) months from the Medicaid approval date) claims will be denied for timely filing and will not be paid. It is the responsibility of the provider to verify the eligibility approval date.

303.000 Claim Inquiries

7-1-20

The Arkansas Medicaid Program distributes weekly Remittance Advice (RA) reports, to each provider with claims paid, denied, or pending, as of the previous weekend processing cycle. (Sections 310.000 through 314.800 of this manual contain a complete explanation of the RA.) Use the RA to verify claim receipt and to track claims through the system. Adjudicated claims will appear on the RA within the weekly financial cycle.

If a claim does not appear on the RA within the amount of time appropriate for its method of submission, contact the Provider Assistance Center (PAC). [View or print PAC contact information](#). A Provider Assistance Center representative can explain what system activity, if any, regarding the submission has occurred since the Arkansas Medicaid fiscal agent printed and mailed the last RA. If the transaction on the RA cannot be understood or is in error, the representative can explain its status and suggest remedies when appropriate. If there is no record of the transaction, the representative will suggest that the claim be resubmitted.



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TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal SecIV-2-19

REMOVE

Section	Effective Date
400.000	9-1-14

INSERT

Section	Effective Date
400.000	7-1-20

Explanation of Updates

Section 400.000 is updated to remove outdated terminology, add new terminology, and make other minor grammatical changes. References to Provider Electronic Solutions (PES) and specific vendors' names are removed.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

SECTION IV - GLOSSARY**400.000****7-1-20**

AAFP	American Academy of Family Physicians
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ABESPA	Arkansas Board of Examiners in Speech-Language Pathology and Audiology
ABHSCI	Adult Behavioral Health Services for Community Independence
ACD	Augmentative Communication Device
ACIP	Advisory Committee on Immunization Practices
ACES	Arkansas Client Eligibility System
ACS	Alternative Community Services
ADDT	Adult Developmental Day Treatment
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)
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
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
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
DDSCES	Developmental Disabilities Services Community and Employment Support
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
EIDT	Early Intervention Day Treatment
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
IADL	Instrumental Activities of Daily Living
ICD	International Classification of Diseases
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
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
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
OBHS	Outpatient Behavioral Health Services
OTC	Over the Counter
PA	Prior Authorization
PAC	Provider Assistance Center
PASSE	Provider-led Arkansas Shared Savings Entity Program
PCP	Primary Care Physician
PERS	Personal Emergency Response Systems
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
QIDP	Qualified Intellectual Disabilities Professional
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice. Also called Remittance and Status Report
RFP	Request for Proposal
RHC	Rural Health Clinic
BID	Beneficiary Identification Number
RSPD	Rehabilitative Services for Persons with Physical Disabilities
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 daily 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 individual directly or indirectly controls or has the power to control another individual
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
Attending Physician	<i>See Performing Physician.</i>
Automated Eligibility Verification Claims Submission (AEVCS)	Online 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	<i>See Plan of Care (POC).</i>
Case Head	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 with Chronic Health Conditions (CHC)	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 children with chronic physical illnesses or disabilities.
Claim	A request for payment for services rendered
Claim Detail	<i>See Line Item.</i>
Clinic	(1) A facility for diagnosis and treatment of outpatients. (2) A group practice in which several physicians work together
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	<p>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.</p> <p>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 of its customers.</p>
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 twenty-one (21). <i>See Child Health Services.</i>

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 or her 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) An individual 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 (2) or more persons. If a service is a “group” therapy or other group service, there must be two (2) 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	<p>An institution that meets the following qualifications:</p> <ul style="list-style-type: none"> • 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
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 (1) 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 the Arkansas Medicaid fiscal agent or DMS and resolved before processing of the claim can be completed. <i>See Suspended Claim.</i>
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, or blind and institutions for individuals with disabilities.
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	A diagnosis coding system used by medical providers to identify a patient's diagnosis 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.
Limited Services Provider Agreement	An agreement for a specific period of time not to exceed twelve (12) months, which must be renewed in order for the provider to continue to participate in the Title XIX Program.
Line Item	A service provided to a beneficiary. A claim may be made up of one (1) 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 unless objective clinical evidence demonstrates circumstances making the service necessary.
Mis-Utilization	Any usage of the Medicaid Program by any of its providers or beneficiaries which is not in conformance with both State and Federal regulations and laws (including, but not limited to, 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 or beneficiaries not in conformance with professional judgment and both State and Federal regulations and laws (including, but not limited to, 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 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 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. 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 (6) or nine (9) 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 (1) 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 (3) 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 individuals with disabilities (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
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 (5) 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



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TO: Arkansas Medicaid Health Care Providers – Targeted Case Management

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal TCM-2-19

REMOVE

Section	Effective Date
261.000	3-1-08

INSERT

Section	Effective Date
261.000	7-1-20

Explanation of Updates

Section 261.000 is revised to remove references to Provider Electronic Solutions (PES) and make a minor grammatical change.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx>.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC not required

261.000 Introduction to Billing

7-1-20

Targeted case management providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Occupational, Physical, Speech Therapy Services

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal THERAPY-2-19

REMOVE

Section	Effective Date
261.000	7-1-07

INSERT

Section	Effective Date
261.000	7-1-20

Explanation of Updates

Section 261.000 is updated to remove the reference to Provider Electronic Solutions (PES) and to make other minor technical corrections.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

TOC not required

261.000 Introduction to Billing

7-1-20

Occupational, Physical, and Speech-Language Therapy providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Transportation

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal TRANSP-2-19

REMOVE

Section	Effective Date
251.000	7-1-07
252.110	11-1-15
291.000	7-1-18

INSERT

Section	Effective Date
251.000	7-1-20
252.110	7-1-20
291.000	7-1-20

Explanation of Updates

Sections 251.000, 252.110, and 291.000 are updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make minor technical changes.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
DMS Director

*TOC not required***251.000 Introduction to Billing****7-1-20**

Ambulance transportation providers use the CMS-1500 claim format to bill the Arkansas Medicaid Program for services provided to eligible Medicaid beneficiaries. Each claim must contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

252.110 National Drug Codes (NDC) Billing Protocol**7-1-20**

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor](#) website.

A complete listing of “**Covered Labelers**” is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The Labeler termination date indicates that the manufacturer no longer participates in the federal rebate program, and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the termination date.

Diagram 1

LABELER CODE	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the NDC termination date. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid.

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug

administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

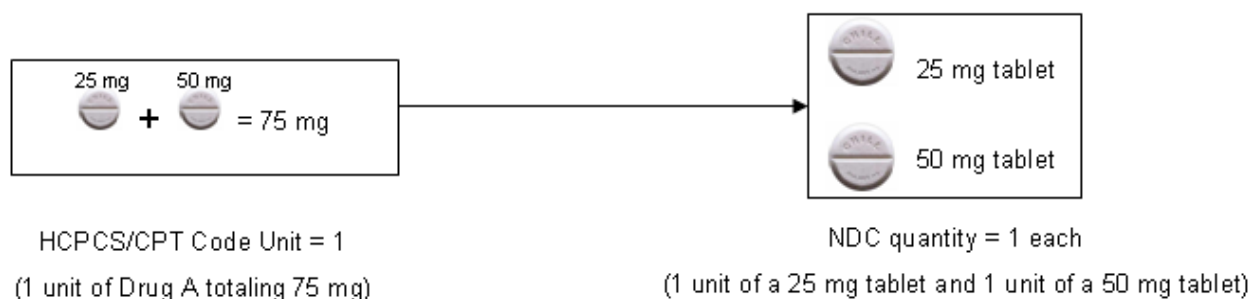
Exception: There is no requirement for an NDC when billing for vaccines.

II. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

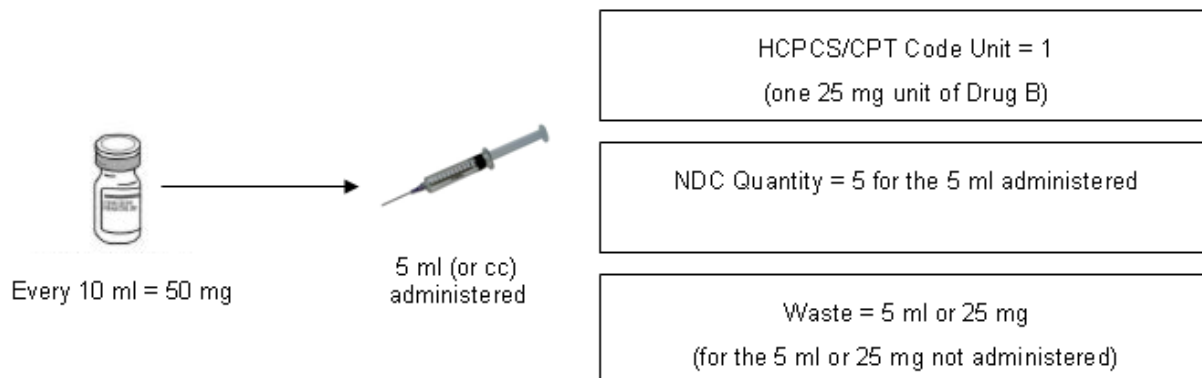
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5.

Diagram 5



A. Electronic Claims Filing – 837P (Professional)

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid will require providers using electronic filing through the Provider Portal to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

B. Paper Claims Filing – CMS-1500

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.

See Diagram 6 for CMS-1500.

CMS-1500

For professional claims, CMS-1500, list the qualifier of “N4”, the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML - Milliliter; UN – Unit), and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC, when billed under the same procedure code on the same date of service is defined as a “sequence.” When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one (1) NDC is associated with the HCPCS/CPT code.

Diagram 6

	24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E.	F.		G.	H.	I.	J.
		From	To	MM	YY	MM	YY												
Detail 1																			
Sequence 1	1	N4	123456789	12	UN	1.00				Z1234			1	25	00	1		NPI	123456789
Sequence 2	2	N4	0111122233	UN	1.00					Z1234			1	0	00	0		NPI	123456789
Detail 2	3									99213			1	55	00	1		NPI	123456789
Sequence 1	4	N4	4444455555	06	ML	5.00							1	35	00	1		NPI	123456789
Detail 3	5																	NPI	

Procedure Code/NDC Detail Attachment Form- DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 “Procedure Code/NDC Detail Attachment Form.” Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 7 for an example of the completed form. Section V of the provider manual includes this form.

Complete instructions for accurate completion of form DMS-664 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

Diagram 7

Detail #	Sequence #	NDC												Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0	
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0	
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML	

III. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

IV. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

See Section 252.100 for additional information regarding drug code billing.

291.000 Introduction to Billing

7-1-20

EIDT and ADDT transportation providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim should contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Ventilator Equipment

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal VENT-2-19

REMOVE

Section	Effective Date
241.000	9-1-05

INSERT

Section	Effective Date
241.000	7-1-20

Explanation of Updates

Section 241.000 is updated to remove the reference to Provider Electronic Solutions (PES) from the manual and to make a minor technical change.

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Janet Mann
DMS Director

TOC not required

241.000 Introduction to Billing

7-1-20

Ventilator equipment providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.



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TO: Arkansas Medicaid Health Care Providers – Visual Care

EFFECTIVE DATE: July 1, 2020

SUBJECT: Provider Manual Update Transmittal VISUAL-2-19

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241.000	12-1-06

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241.000	7-1-20

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Janet Mann
DMS Director

TOC not required

241.000 Introduction to Billing

7-1-20

Visual care providers use the CMS-1500 claim form or the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.