ARKANSAS REGISTER

Proposed Rule Cover Sheet

Secretary of State
John Thurston
500 Woodlane Street, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable

Previous Agency Name, If Applicable

Contact Person Mac Golden

Contact E-mail Mac.E.Golden@dhs.arkansas.gov

Contact Phone 501-563-7634

Name of Rule Technical Corrections – Vendor Name Removal from Medicaid Provider Manuals

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TOC not required

215.120 Benefit Extension Requests

~~2-1-05~~8-1-21

A. Requests to extend benefits for outpatient visits and laboratory and x-ray services, including those for fetal ultrasounds and fetal non-stress tests, must be submitted to DHS or its designated vendor. ~~mailed to Arkansas Foundation for Medical Care, Inc. (AFMC).~~ **View or print contact information for how to obtain information regarding submission processes~~Arkansas Foundation for Medical Care, Inc. (AFMC) contact information~~.** Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

~~1. AFMC will not accept benefit extension requests transmitted via electronic facsimile (FAX).~~

~~2. Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.~~

B. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

C. ~~AFMC reserves the right to request a~~Additional information will be requested as needed to process a benefit extension request. Failures to timely provide requested additional information within the specified timeline will result in technical denials.~~, r~~Reconsiderations for technical denials are not available.~~of which are not available.~~

D. ~~AFMC must receive a b~~Benefit extension requests must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

~~1. AFMC will consider extending benefits only when extended benefits are medically necessary and all required documentation is received timely.~~

~~2. Requests received after the 90-day deadline will not be considered.~~

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.123 Provider Notification of Benefit Extension Determinations

~~2-1-05~~8-1-21

~~AFMC will approve or deny~~Approval or denial of a benefit extension request—or ~~ask~~ request for additional information—will be made within thirty (30) calendar days.

~~A. AFMC r~~Reviewers will simultaneously advise the provider and the beneficiary when a benefit extension request is denied.

~~B. Provider notification of benefit extension approval includes:~~

~~1. The procedure code approved,~~

~~2. The total number of units approved for the procedure code,~~

~~3. The benefit extension control number and~~

~~4. The approved beginning and ending dates of service.~~

~~C. A denial notification letter is signed by a member of the benefit extension reviewing staff.~~

221.000 Prior Authorization Information

~~7-1-14~~8-1-21

MARKUP

A. Clinical criteria for prior authorization (PA) must support the medical necessity for the procedure and~~/or~~ must be ~~appropriate~~ suitable for the ~~particular~~ diagnosed condition or disorder.

B. DHS or its designated vendor reviews and determines approval or denial for outpatient surgery PA. **View or print contact information for information on how to submit an outpatient surgery PA.**~~Arkansas Foundation for Medical Care, Inc. (AFMC), Arkansas Medicaid's Quality Improvement Organization (QIO), reviews and approves or denies requests for outpatient surgery PA.~~

~~1. Request PA for outpatient surgeries by telephone. **View or print AFMC contact information.** AFMC records all calls.~~

~~2. The performing physician must initiate the PA request; however, the call to AFMC may be made by a member of the physician's medical staff who is familiar with medical records and conversant in medical terminology; for instance, an RN or a physician's assistant.~~

~~3. The performing physician must have on file in the patient's medical records the documentation of medical necessity that supports the request for PA.~~

C. Prior authorization does not guarantee payment: providers must comply with all Medicaid regulations related to the medical service.

~~1. The beneficiary must be eligible on the date of service.~~

~~2. The provider's Arkansas Medicaid enrollment must be effective for the date of service.~~

~~3. Most ASC outpatient surgeries require a referral from the beneficiary's primary care physician (PCP).~~

~~4. The PA number must be on the claim (i.e. the procedure code billed must be the procedure code on the PA file).~~

~~5.~~ Claims for some procedures must be submitted on paper and accompanied by operative reports, consent forms or other documentation and are not accepted electronically or without the required attachments.

221.100 Prior Authorization Request and Notification Procedures

~~11-1-17~~**8-1-21**

The procedures in this section apply to all requests for prior authorization (PA) of outpatient surgeries.

A. The attending physician or the physician's office nurse (or a licensed physician assistant) must furnish the ~~following~~ necessary information ~~by telephone~~ to DHS or its designated vendor. **View or print contact information regarding submission processes.** ~~AFMC~~.

~~1. The beneficiary's name and address~~

~~2. The beneficiary's Medicaid identification number~~

~~3. The physician's name and state license number~~

~~4. The physician's provider identification number~~

~~5. The facility's name~~

~~6. The date of the procedure~~

B. ~~AFMC approves or denies the request by telephone and follows up with~~ The provider will receive written confirmation of the determination.

~~1. In approved cases, AFMC assigns a prior authorization control number to the case.~~

MARKUP

2. When AFMC denies a PA request is denied, the provider and the beneficiary have administrative and legal rights to reconsideration and appeal (explained in Sections 160.000 through 169.000 of the Arkansas Medicaid provideris manual).

C. AFMC forwards iIndividual written confirmation is given to the surgeon.

D. It is important to note that tThe surgeon is ultimately responsible for ensuring that the facility (as well as any other affected provider, such as the anesthetist) has a copy of the authorization to file and to use for billing purposes.

E. When obtaining a Prior Authorization (PA) from the Arkansas Foundation for Medical Care (AFMC), please send your requests to the following:

In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax	(479) 649-0799
Web portal	https://afmc.org/reviewpoint/https://afmc.org/reviewpoint/
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	5111 Rogers Avenue, Suite 476 Fort Smith, AR 72903
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

MARKUP

TOC not required

215.120 Benefit Extension Requests 8-1-21

A. Requests to extend benefits for outpatient visits and laboratory and x-ray services, including those for fetal ultrasounds and fetal non-stress tests, must be submitted to DHS or its designated vendor. **View or print contact information for how to obtain information regarding submission processes.** Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

B. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

C. Additional information will be requested as needed to process a benefit extension request. Failures to timely provide requested additional information within the specified timeline will result in technical denials. Reconsiderations for technical denials are not available.

D. Benefit extension requests must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

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C. Prior authorization does not guarantee payment: providers must comply with all Medicaid regulations related to the medical service.

Claims for some procedures must be submitted on paper and accompanied by operative reports, consent forms or other documentation and are not accepted electronically or without the required attachments.

221.100 Prior Authorization Request and Notification Procedures 8-1-21

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B. The provider will receive written confirmation of the determination.

PROPOSED

When a PA request is denied, the provider and the beneficiary have administrative and legal rights to reconsideration and appeal (explained in Sections 160.000 through 169.000 of the Arkansas Medicaid provider manual).

C. Individual written confirmation is given to the surgeon.

D. The surgeon is ultimately responsible for ensuring that the facility (as well as any other affected provider, such as the anesthetist) has a copy of the authorization to file and to use for billing purposes.

PROPOSED

TOC not required

214.100 Extension of Benefits for X-Ray Services

~~11-1-06~~8-1-21

A. Requests for extension of benefits for x-ray services must be submitted to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient days.**~~mailed to Arkansas Foundation for Medical Care, Inc. (AFMC), Attention EOB Review.~~ **~~View or print the Arkansas Foundation for Medical Care, Inc. contact information.~~**

1. Requests for extension of benefits for x-ray services are considered only after a claim is filed and is denied because the patient's benefits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

B. A request for extension of benefits for x-ray services must be received ~~by AFMC~~ within ninety (90) calendar days of the date of benefits-exhausted denial.

214.110 Completion of Request Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services"

~~7-1-07~~8-1-21

Requests for extension of benefits for Clinical Services (Physician's Visits), Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc.), must be submitted to ~~AFMC~~ DHS or its designated vendor for consideration. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.** Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print form DMS-671.**

Complete instructions for accurate completion of form DMS-671 (including indication of required attachments) accompany the form.

214.200 Administrative Reconsideration of Extensions of Benefits Denial

~~11-1-06~~8-1-21

A. A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to ~~AFMC~~ DHS or its designated vendor within thirty (30) calendar days of the denial. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.** The request must include a copy of the denial letter and **additional** supporting documentation.

B. The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of ~~this~~ the Arkansas Medicaid provider manual. A request received ~~by AFMC~~ within thirty-five (35) calendar days of a denial will be deemed timely. A request received later than thirty-five (35) calendar days will be considered on an individual basis. ~~Reconsideration requests must be mailed and will not be accepted via facsimile or email.~~

MARKUP

TOC not required

214.100 Extension of Benefits for X-Ray Services 8-1-21

A. Requests for extension of benefits for x-ray services must be submitted to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient days.**

1. Requests for extension of benefits for x-ray services are considered only after a claim is filed and is denied because the patient's benefits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

B. A request for extension of benefits for x-ray services must be received within ninety (90) calendar days of the date of benefits-exhausted denial.

214.110 Completion of Request Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services" 8-1-21

Requests for extension of benefits for Clinical Services (Physician's Visits), Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc), must be submitted to DHS or its designated vendor for consideration. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.** Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print form DMS-671.**

Complete instructions for accurate completion of form DMS-671 (including indication of required attachments) accompany the form.

214.200 Administrative Reconsideration of Extensions of Benefits Denial 8-1-21

A. A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to DHS or its designated vendor within thirty (30) calendar days of the denial. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.** The request must include a copy of the denial letter and **additional** supporting documentation.

B. The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of the Arkansas Medicaid provider manual. A request received within thirty-five (35) calendar days of a denial will be deemed timely. A request received later than thirty-five (35) calendar days will be considered on an individual basis.

PROPOSED

TOC not required

201.600 Dentist Role in the Pharmacy Program

~~3-14-15~~8-1-21

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the Arkansas Division of Medical Services (DMS) Pharmacy website. **View or print numeric listing of approved pharmaceutical companies and the respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

PRESCRIPTION DRUG INFORMATION

View or print contact information for prescription drug prior authorization concerns and the latest information regarding prescription drug coverage. ~~If you have prescription drug prior authorization concerns, please call the~~ **~~View or print Prescription Drug PA contact information.~~**

~~Prescribers may also refer to the website at **https://arkansas.magellanrx.com/provider/documents/** to obtain the latest information regarding prescription drug coverage.~~

236.000 Prescription Prior Authorization

~~3-14-15~~8-1-21

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program pursuant to an order from an authorized prescriber. Certain prescription drugs may require prior authorization.

The dental provider must request prior authorization before prescribing a prescription drug to an eligible Medicaid beneficiary.

View or print contact information ~~**Dental providers must refer to the website at https://arkansas.magellanrx.com/provider/documents/**~~ **for information relative to the following:**

A. Prescription drugs requiring prior authorization

B. Drugs subject to specific prescribing requirements

C. Criteria for drugs requiring prior authorization

261.000 Introduction to Billing

~~7-1-20~~8-1-21

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~~the Arkansas Medicaid provider manual contains information about available options for electronic claim submission. When billing electronically, the provider's NPI number is required.

MARKUP

262.400 Billing Instructions – ADA Claim Form - Paper Claims Only

~~5-1-14~~8-1-21

Dental providers must complete the ADA claim form when:

A. Billing for services when using the ADA procedure codes

B. Requesting prior authorization

C. Approving prior authorization

D. Requesting prior authorization for all orthodontic services

For prior authorizations, the provider should send the ADA claim form to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

Claims submitted on paper will be paid only once a month. The only claims exempt from this process are those that require attachments or manual pricing.

The same ADA claim form on which the treatment plan was submitted to obtain prior authorization must be used to submit the claim for payment. If this is done, the header information and the "Request for Payment for Services Provided" portions of the form are to be completed.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

If this form is being used to request Prior Authorization, it should be forwarded to the Division of Medical Services Medical Assistance Attention Dental Services. **View or print the Division of Medical Services Dental Unit contact information.**

Completed claim forms should be forwarded to the Claims Department. **View or print the Claims Department contact information.**

To bill for dental or orthodontic services, the ADA claim form must be completed. The following numbered items correspond to the numbered fields on the claim form. **View or print form ADA-J430.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

COMPLETION OF FORM

Field Number and Name	Instructions for Completion
HEADER INFORMATION	
1. Type of Transaction	Check one of the following: Statement of Actual Services EPSDT/Title XIX Request for Predetermination/Preauthorization
2. Predetermination/ Preauthorization Number	If the procedure(s) being billed requires prior authorization and authorization is granted by the Medicaid Dental Program, enter the 10-digit PA control number assigned by the Medicaid Program.

MARKUP

Field Number and Name	Instructions for Completion
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company/Plan Name, Address, City, State, Zip Code	Enter the carrier's name and address.
OTHER COVERAGE	
4. Dental? Medical?	Check the applicable box and complete items 5-11. If none, leave blank. (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4.	Enter Policyholder/Subscriber's name. Format: Last name, first name.
6. Date of Birth	Enter Policyholder/Subscriber's date of birth. Format: MM/DD/CCYY.
7. Gender	Check M for male or F for female.
8. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
9. Plan/Group Number	Not required.
10. Patient's Relationship to Person Named in #5	Check one of the following: Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the name and address of the other company providing dental or medical coverage.
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)	
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter the name and address of the policyholder/subscriber of the insurance identified in item 3.
13. Date of Birth	Enter the policyholder/subscriber's date of birth. Format: MM/DD/CCYY.
14. Gender	Check M for male or F for female.
15. Policyholder/Subscriber ID	Enter the patient Medicaid ID number.
16. Plan/Group Number	Enter the plan or group number for the insurance identified in item 3.
17. Employer Name	Not required.
PATIENT INFORMATION	
18. Relationship to Policyholder/Subscriber in #12 Above.	Check one of the following: Self Spouse Dependent Child Other
19. Reserved for Future Use	

MARKUP

Field Number and Name	Instructions for Completion
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter last name, first name, middle initial, suffix, address, city, state and Zip code.
21. Date of Birth	Enter the patient's date of birth. Format: MM/DD/CCYY.
22. Gender	Check "M" for male or "F" for female.
23. Patient ID/Account # (Assigned by Dentist)	Enter the patient ID/Account # assigned by the dentist.
RECORD OF SERVICES PROVIDED	
24. Procedure Date	Enter the date on which the procedure was performed. Format: MM/DD/CCYY.
25. Area of Oral Cavity	Not required.
26. Tooth System	Not required.
27. Tooth Number(s) or Letter(s)	Required if applicable. List only one tooth number per line.
28. Tooth Surface	Required if applicable. Enter one of the following: M – Mesial D – Distal L – Lingual I – Incisal B – Buccal O – Occlusal L – Labial F - Facial
29. Procedure Code	Required for Medicaid. These codes are listed in Section 262.100 for beneficiaries under age 21 or Section 262.200 for medically eligible beneficiaries age 21 and older.
29a. Diag. Pointer	Diagnosis Code Pointer. Enter A-D as applicable from item 34a.
29b. Qty.	Quantity. Indicates the number of units of the procedure code(s) listed in field 29.
30. Description	Required for Medicaid.
31. Fee	List the usual and customary fee.
31a. Other Fee(s)	Enter the total of payments previously received on this claim from any private insurance. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B copayments.
32. Total Fee	Required for Medicaid. Enter the total fee charged.
33. Missing Teeth Information (Place an 'X' on each missing tooth)	Draw an X through the number of each missing tooth.
34. Diagnosis Code List Qualifier	Enter B for ICD-9-CM or AB for ICD-10-CM.

MARKUP

Field Number and Name	Instructions for Completion
34a. Diagnosis Code(s) (Primary diagnosis in "A")	Enter up to four diagnosis codes in A-D. Enter the primary diagnosis in A.
35. Remarks	Not required.
AUTHORIZATIONS	
36. Agreement of responsibility	Patient or guardian must sign and date here.
37. Authorization of direct payment	Subscriber must sign and date here.
ANCILLARY CLAIM/TREATMENT INFORMATION	
38. Place of Treatment (e.g. 11=Office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	Enter the two-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are: 11–Office 12–Home 21–Inpatient Hospital 22–Outpatient Hospital 31–Skilled Nursing Facility 32–Nursing Facility The full list is available online at http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf.
39. Enclosures (Y or N)	If there are enclosures such as radiographs, oral images or models, enter Y for Yes. If there are no enclosures, enter N for No.
40. Is Treatment for Orthodontics?	Check No or Yes. If No, skip items 41 and 42. If Yes, complete items 41 and 42.
41. Date Appliance Placed	Enter date appliance placed. Format: MM/DD/CCYY.
42. Months of Treatment Remaining	Enter months of orthodontic treatment remaining.
43. Replacement of Prosthesis	Check No or Yes. If Yes, complete item 44.
44. Date of Prior Placement	Enter the date of prior placement of the prosthesis. Format: MM/DD/CCYY.
45. Treatment Resulting from	Check one of the following, if applicable: Occupational illness/injury Auto accident Other accident If item 45 is applicable, complete item 46. If item 45 is "Auto accident," also complete item 47.
46. Date of accident	Enter date of accident. Format: MM/DD/CCYY.
47. Auto Accident State	Enter two-letter abbreviation for state in which auto accident occurred.
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)	
48. Name, Address, City, State, Zip Code	Enter the name and address of the billing dentist or dental entity.

MARKUP

Field Number and Name	Instructions for Completion
49. NPI	~~Not r~~Required.
50. License Number	Optional.
51. SSN or TIN	Optional.
52. Phone Number	Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code.
52a. Additional Provider ID	Enter the Dentist or Oral Surgeon's 9-digit Arkansas Medicaid billing provider number. The provider number should end with "08" for an individual Dentist number or "31" for a Dental group. The provider number should end in "79" for an individual Oral Surgeon number or "80" for an Oral Surgeon group.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. Certification	The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
54. NPI	~~Not r~~Required.
55. License Number	Optional.
56. Address, City, State, Zip Code	Enter the complete address of the treating dentist.
56a. Provider Specialty Code	Indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes. For a complete list of codes, see the Provider Specialty table in the instructions accompanying the ADA-J430 claim form. **View or print form ADA-J430**.
57. Phone Number	Enter the 10-digit telephone number of the treating dentist, beginning with area code.
58. Additional Provider ID	If the billing provider number in Field 52a is a group or clinic ending in "31" for Dentists or "80" for Oral Surgeons, the individual provider number must be entered for the provider rendering the service. The provider number should end with "08" for an individual Dentist number or "79" for an individual Oral Surgeon number.

MARKUP

TOC not required

201.600 Dentist Role in the Pharmacy Program 8-1-21

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The dental provider must request prior authorization before prescribing a prescription drug to an eligible Medicaid beneficiary.

View or print contact information for information relative to the following:

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C. Criteria for drugs requiring prior authorization

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B. Requesting prior authorization

C. Approving prior authorization

D. Requesting prior authorization for all orthodontic services

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Completed claim forms should be forwarded to the Claims Department. **View or print the Claims Department contact information.**

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2. Predetermination/ Preauthorization Number	If the procedure(s) being billed requires prior authorization and authorization is granted by the Medicaid Dental Program, enter the 10-digit PA control number assigned by the Medicaid Program.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company/Plan Name, Address, City, State, Zip Code	Enter the carrier's name and address.
OTHER COVERAGE	
4. Dental? Medical?	Check the applicable box and complete items 5-11. If none, leave blank. (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4.	Enter Policyholder/Subscriber's name. Format: Last name, first name.

PROPOSED

Field Number and Name	Instructions for Completion
6. Date of Birth	Enter Policyholder/Subscriber's date of birth. Format: MM/DD/CCYY.
7. Gender	Check M for male or F for female.
8. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
9. Plan/Group Number	Not required.
10. Patient's Relationship to Person Named in #5	Check one of the following: Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the name and address of the other company providing dental or medical coverage.
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)	
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter the name and address of the policyholder/subscriber of the insurance identified in item 3.
13. Date of Birth	Enter the policyholder/subscriber's date of birth. Format: MM/DD/CCYY.
14. Gender	Check M for male or F for female.
15. Policyholder/Subscriber ID	Enter the patient Medicaid ID number.
16. Plan/Group Number	Enter the plan or group number for the insurance identified in item 3.
17. Employer Name	Not required.
PATIENT INFORMATION	
18. Relationship to Policyholder/Subscriber in #12 Above.	Check one of the following: Self Spouse Dependent Child Other
19. Reserved for Future Use	
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter last name, first name, middle initial, suffix, address, city, state and Zip code.
21. Date of Birth	Enter the patient's date of birth. Format: MM/DD/CCYY.
22. Gender	Check "M" for male or "F" for female.
23. Patient ID/Account # (Assigned by Dentist)	Enter the patient ID/Account # assigned by the dentist.
RECORD OF SERVICES PROVIDED	

PROPOSED

Field Number and Name	Instructions for Completion
24. Procedure Date	Enter the date on which the procedure was performed. Format: MM/DD/CCYY.
25. Area of Oral Cavity	Not required.
26. Tooth System	Not required.
27. Tooth Number(s) or Letter(s)	Required if applicable. List only one tooth number per line.
28. Tooth Surface	Required if applicable. Enter one of the following: M – Mesial D – Distal L – Lingual I – Incisal B – Buccal O – Occlusal L – Labial F - Facial
29. Procedure Code	Required for Medicaid. These codes are listed in Section 262.100 for beneficiaries under age 21 or Section 262.200 for medically eligible beneficiaries age 21 and older.
29a. Diag. Pointer	Diagnosis Code Pointer. Enter A-D as applicable from item 34a.
29b. Qty.	Quantity. Indicates the number of units of the procedure code(s) listed in field 29.
30. Description	Required for Medicaid.
31. Fee	List the usual and customary fee.
31a. Other Fee(s)	Enter the total of payments previously received on this claim from any private insurance. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B copayments.
32. Total Fee	Required for Medicaid. Enter the total fee charged.
33. Missing Teeth Information (Place an 'X' on each missing tooth)	Draw an X through the number of each missing tooth.
34. Diagnosis Code List Qualifier	Enter B for ICD-9-CM or AB for ICD-10-CM.
34a. Diagnosis Code(s) (Primary diagnosis in "A")	Enter up to four diagnosis codes in A-D. Enter the primary diagnosis in A.
35. Remarks	Not required.
AUTHORIZATIONS	
36. Agreement of responsibility	Patient or guardian must sign and date here.
37. Authorization of direct payment	Subscriber must sign and date here.
ANCILLARY CLAIM/TREATMENT INFORMATION	

PROPOSED

Field Number and Name	Instructions for Completion
38. Place of Treatment (e.g. 11=Office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	Enter the two-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are: 11–Office 12–Home 21–Inpatient Hospital 22–Outpatient Hospital 31–Skilled Nursing Facility 32–Nursing Facility The full list is available online at http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf.
39. Enclosures (Y or N)	If there are enclosures such as radiographs, oral images or models, enter Y for Yes. If there are no enclosures, enter N for No.
40. Is Treatment for Orthodontics?	Check No or Yes. If No, skip items 41 and 42. If Yes, complete items 41 and 42.
41. Date Appliance Placed	Enter date appliance placed. Format: MM/DD/CCYY.
42. Months of Treatment Remaining	Enter months of orthodontic treatment remaining.
43. Replacement of Prosthesis	Check No or Yes. If Yes, complete item 44.
44. Date of Prior Placement	Enter the date of prior placement of the prosthesis. Format: MM/DD/CCYY.
45. Treatment Resulting from	Check one of the following, if applicable: Occupational illness/injury Auto accident Other accident If item 45 is applicable, complete item 46. If item 45 is "Auto accident," also complete item 47.
46. Date of accident	Enter date of accident. Format: MM/DD/CCYY.
47. Auto Accident State	Enter two-letter abbreviation for state in which auto accident occurred.
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)	
48. Name, Address, City, State, Zip Code	Enter the name and address of the billing dentist or dental entity.
49. NPI	Required.
50. License Number	Optional.
51. SSN or TIN	Optional.
52. Phone Number	Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code.

PROPOSED

Field Number and Name	Instructions for Completion
52a. Additional Provider ID	Enter the Dentist or Oral Surgeon's 9-digit Arkansas Medicaid billing provider number. The provider number should end with "08" for an individual Dentist number or "31" for a Dental group. The provider number should end in "79" for an individual Oral Surgeon number or "80" for an Oral Surgeon group.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. Certification	The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
54. NPI	Required.
55. License Number	Optional.
56. Address, City, State, Zip Code	Enter the complete address of the treating dentist.
56a. Provider Specialty Code	Indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes. For a complete list of codes, see the Provider Specialty table in the instructions accompanying the ADA-J430 claim form. **View or print form ADA-J430**.
57. Phone Number	Enter the 10-digit telephone number of the treating dentist, beginning with area code.
58. Additional Provider ID	If the billing provider number in Field 52a is a group or clinic ending in "31" for Dentists or "80" for Oral Surgeons, the individual provider number must be entered for the provider rendering the service. The provider number should end with "08" for an individual Dentist number or "79" for an individual Oral Surgeon number.

PROPOSED

TOC not required

202.200 The FQHC's Role in the Arkansas Medicaid Pharmacy Program ~~12-18-15~~8-1-21

Medicaid covers prescription drugs in accordance with rules set forth in this section (Section 202.200) and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with current rebate agreements and listed labeler codes.

~~A. Prescribers may also refer to the Arkansas Medicaid Pharmacy website at **https://arkansas.magellanrx.com/provider/documents/** to~~ **Click here to obtain the latest information regarding prescription drug coverage.**

220.201 Benefit Extension Requests ~~2-1-05~~8-1-21

A. Requests to extend the FQHC core service encounter benefit must be ~~mailed~~ submitted to ~~Arkansas Foundation for Medical Care, Inc. (AFMC).~~DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient days.~~Arkansas Foundation for Medical Care, Inc. (AFMC), contact information.~~**

~~1. AFMC will not accept benefit extension requests transmitted via electronic facsimile (FAX).~~

~~2.~~ Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

B. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

C. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.~~AFMC reserves the right to request additional information as needed to process a benefit extension request. Failures to timely provide requested additional information will result in technical denials, reconsiderations of which are not available.~~

D. Additional information shall be requested when needed to process a benefit extension request. Failures to provide requested additional information within the specified timeline will result in technical denials. Reconsideration are no available.~~AFMC must receive a benefit extension request within 90 calendar days of the date of the benefits-exhausted denial.~~

~~1. AFMC will consider extending benefits only when required documentation has been received and requested services are deemed medically necessary.~~

~~2. Requests received after the 90-day deadline will not be considered.~~

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

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220.204 Provider Notification of Benefit Extension Determinations

~~2-1-05~~8-1-21

~~AFMC will approve or deny~~Approval or denial of a benefit extension request—or ~~ask~~ request for additional information—will be made within thirty (30) calendar days.

A. ~~AFMC r~~Reviewers will simultaneously advise the provider and the beneficiary when a benefit extension request is denied.

~~B. Provider notification of benefit extension approval includes:~~

~~1. The procedure code approved,~~

~~2. The total number of units approved for the procedure code,~~

~~3. The benefit extension control number and~~

~~4. The approved beginning and ending dates of service.~~

~~C. A denial notification letter is signed by a member of the benefit extension reviewing staff.~~

MARKUP

TOC not required

202.200 The FQHC's Role in the Arkansas Medicaid Pharmacy Program 8-1-21

Medicaid covers prescription drugs in accordance with rules set forth in this section (Section 202.200) and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with current rebate agreements and listed labeler codes.

Click here to obtain the latest information regarding prescription drug coverage.

220.201 Benefit Extension Requests 8-1-21

A. Requests to extend the FQHC core service encounter benefit must be submitted to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient days.**

   Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

B. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

C. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

D. Additional information shall be requested when needed to process a benefit extension request. Failures to provide requested additional information within the specified timeline will result in technical denials. Reconsideration are no available.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

220.204 Provider Notification of Benefit Extension Determinations 8-1-21

Approval or denial of a benefit extension request—or request for additional information—will be made within thirty (30) calendar days.

A. Reviewers will simultaneously advise the provider and the beneficiary when a benefit extension request is denied.

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TOC required

204.210 Availability of ESRD Medical Records

~~8-1-05~~8-1-21

The Arkansas Department of Health and Human Services, its designees and other state and federal agencies review medical records for documentation of services provided and billed and to evaluate the medical necessity of delivered services.

A. All records must be retained in their original or legally reproduced form for at least five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.

B. Pertinent records concerning the provision of Medicaid-covered health care services are to be made available, upon request, during regular business hours to authorized representatives of the Arkansas Division of Medical Services (DMS) who are acting within the scope and course of their employment.

1. All requested documentation must be made available to DMS representatives at the time of an audit ~~by the Medicaid Field Audit Unit~~.

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

C. Pertinent records are also to be made available to DMS's contracted Quality Improvement Organization (QIO)~~, Arkansas Foundation for Medical Care, Inc. (AFMC)~~.

D. Additionally, providers are required to furnish records, when so requested, to the Office of Medicaid Inspector General (OMIG); Medicaid Fraud Control Unit (MFCU) of the Arkansas Office of the Attorney General and to representatives of the Secretary of the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS).

1. When requested records are stored off-premises or they are in active use, the provider may so certify in writing and set a date and hour within three (3) working days that the records will be available.

2. Failure to furnish medical records upon request will result in the imposition of sanctions. (See Section I of ~~this~~ the Arkansas Medicaid provider manual.)

212.401 Inpatient Hospital Services Benefit Limit

~~10-22-10~~8-1-21

A. There is no benefit limit for acute care/general and rehabilitative hospital inpatient services for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. Inpatient services must be approved by the QIO as medically necessary.

B. The benefit limit for acute care/general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged twenty-one (21) and older.

C. Included in the total of paid inpatient days are any days covered by primary third party resources (except Medicare and Railroad Retirement) for which Medicaid receives a secondary-payer claim that it adjudicates as paid. A Medicaid-secondary claim that adjudicates as a paid claim is counted toward the inpatient benefit limit.

1. Medicaid, when it is secondary to a third party resource other than Medicare or Railroad Retirement, covers only the difference between the primary resource's remittance and Medicaid's per diem or maximum allowable fee for Medicaid-covered services reimbursed by the primary resource.

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2. Even when the Medicaid paid amount is $0.00 because the third party payment equals or exceeds Medicaid's per diem, the days thus paid are counted toward the benefit limit.

D. Extension of the 24-day inpatient benefit is ~~un~~available under the Medicaid Utilization Management Program (MUMP).

E. Inpatient stays that are prior authorized for heart, liver and lung transplants are not counted toward the 24-day inpatient benefit limit.

F. See Section 272.406 regarding special billing instructions for beneficiaries who turn age 21 during an inpatient hospital stay.

212.500 Medicaid Utilization Management Program (MUMP)

~~6-1-06~~8-1-21

A. ~~The Quality Improvement Organization (QIO), Arkansas Foundation for Medical Care, Inc. (AFMC), under contract to the Arkansas Medicaid Program,~~ DHS or its designated vendor determines covered lengths of stay in acute care/general and rehabilitative hospitals in Arkansas and states bordering Arkansas. **View or print DHS or designated vendor contact information to obtain MUMP information.** Determination are made~~,~~ in accordance with the guidelines of the ~~Arkansas Medicaid Utilization Management Program (~~MUMP~~)~~.

B. MUMP guidelines do not apply to lengths of stay in psychiatric facilities.

Sections 212.501 through 212.507 generally set forth MUMP guidelines. Sections 212.510 through 212.550 address specific issues and procedures.

212.501 Length of Stay Determination

~~6-1-06~~8-1-21

A. ~~AFMC uses t~~The *Solucient Length of Stay by Diagnosis and Operation Data Files* is used to assist non-physician reviewers in determining appropriate Arkansas Medicaid Utilization Management Program (MUMP) lengths of stay.

B. ~~AFMC's n~~Nurse-reviewers are not authorized to deny certification requests.

1. The nurse-reviewer refers to an in-house physician adviser~~, cases in which~~ when:
   a. The length of stay requested is beyond that indicated by the Solucient guide or
   b. A beneficiary's medical condition does not appear to meet the guidelines or
   c. It technically meets the guidelines, but in the nurse's judgment inpatient care may not be necessary.
2. The in-house physician adviser determines, based on his or her medical judgment, whether to approve, partially approve or deny the certification request.

212.502 Reconsiderations

~~6-1-06~~8-1-21

Once per admission~~, the QIO~~ DHS or the designated vendor will reconsider a denied extension.

A. ~~AFMC must receive t~~The reconsideration request must be received by DHS or its designated vendor within thirty (30) days of the provider's receipt of the denial.~~first business day following the date of the postmark on the envelope in which the provider received the denial confirmation.~~

B. When requesting reconsideration, a provider must submit the complete medical record of the admission.

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212.503 Paper Review After Reconsiderations: Special Cases

~~6-1-06~~8-1-21

A. Infrequently, the following sequence of events may occur: An extension of days is denied or only partially approved and the determination is upheld on reconsideration; however, before the patient can be discharged, he or she becomes acutely ill and remains hospitalized for treatment of that illness.

B. In strict accordance with the regulation above in Section 212.502, the provider would be precluded from requesting certification of any of the inpatient days required for treatment of the late-appearing acute illness, because the case has already been reconsidered once.

C. However, if the beneficiary had not been hospitalized when he or she became acutely ill, Medicaid would have covered up to four (4) inpatient days without certification and the beneficiary's case would have been eligible for consideration for certification if the stay for treatment had been longer than four (4) days.

D. In order to give due consideration to cases of true medical necessity while avoiding repeated reviews of the same admission, ~~AFMC has established~~ the following procedure for reviewing cases of this nature has been established.

E. After the beneficiary's discharge, the provider may submit the medical record for the entire admission ~~to AFMC~~ and indicate in writing the dates to be considered for certification.

1. Only the dates requested by the provider ~~AFMC~~ will be considered for possible authorization~~, only the dates requested by the provider.~~

2. The review and determination procedure is the same as described in Section 212.501.

F. AFMC will not reconsider denials and partial denials of these requests; however, the beneficiary may appeal the decision or the provider may appeal on behalf of the beneficiary.

212.510 MUMP Applicability

~~6-1-06~~8-1-21

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer. ~~,~~The days are subject to retrospective review for medical necessity.

B. If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified ~~by AFMC~~.

C. When a patient is transferred from one hospital to another, the stay must be certified from the first day.

212.520 MUMP Certification Request Procedure

~~4-1-07~~8-1-21

When a patient is transferred from another hospital (see Section 212.530 below) or when a patient's attending physician determines the patient should not be discharged by the fifth day of hospitalization, hospital utilization review or case management personnel may ~~contact AFMC and~~ request an extension of inpatient days. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting MUMP certification.**

~~A. The following information is required.~~

~~1. Patient name and address (including ZIP code)~~

~~2. Patient birth date~~

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~~3. Patient Medicaid number~~

~~4. Admission date~~

~~5. Hospital name~~

~~6. Hospital provider identification number~~

~~7. Attending physician provider identification number~~

~~8. Principal diagnosis and other diagnoses influencing this stay~~

~~9. Surgical procedures performed or planned~~

~~10. The number of days being requested for continued inpatient care~~

~~11. All available medical information justifying or supporting the necessity of continued stay in the hospital.~~

~~B. AFMC may be contacted between 8:30 a.m. and 5:00 p.m., Monday through Friday, except State holidays.~~ **~~View or print AFMC contact information.~~** ~~Calls are limited to 10 minutes to allow equal access to all providers.~~

~~C. Calls for extension of days may be made at any time during the inpatient stay, except in the case of a transfer from another hospital (see Section 212.530).~~

~~1. If the provider delays calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable.~~

~~2. If the fifth day of the admission is a Saturday, Sunday or holiday, it is recommended that the hospital provider call for an extension before the fifth day if the physician has recommended a continued stay.~~

~~D. The AFMC reviewer assigns an authorization control number to an approved extension request, orally advises the provider of the control number and number of days certified and forwards to the hospital written confirmation of that information on the next business day.~~

~~E. When an extension of days is denied or only partially approved, the AFMC reviewer so advises the provider during the telephone call and forwards on the next business day, to the hospital, the attending physician and the beneficiary, written notification that includes the reason(s) for the denial or partial approval.~~

~~F~~A. Additional extensions may be requested as needed.

~~G~~B. The Arkansas Medicaid Utilization Management Program (MUMP) certification process is separate from prior authorization requirements.

1. Prior authorization for medical procedures must be obtained by the appropriate providers.
2. Hospital stays for restricted procedures are disallowed when required prior authorizations are not obtained.

~~H~~C. Except for the exemptions listed in Section 212.511, Medicaid does not cover fifth and subsequent days of inpatient hospital admissions unless they have been certified ~~by the QIO~~, in accordance with applicable procedures ~~in this manual~~ for concurrent ~~and/~~or retroactive MUMP certification.

212.530 Transfer Admissions

~~6-1-06~~**8-1-21**

~~A.~~ When a patient is transferred from one hospital to another, the receiving facility must contact DHS or designated contractor~~AFMC~~ within twenty-four (24) hours of admission to certify the

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inpatient stay. **View or print contact information to obtain instructions for submitting the transfer request.**

~~B. When a transfer admission occurs on a weekend or holiday, the provider must contact AFMC before 4:30 PM of the first working day following the weekend or holiday.~~

212.540 Post Certification Due to Retroactive Eligibility

~~6-1-06~~8-1-21

~~A.~~ When eligibility is determined while the patient is still an inpatient, the hospital may request post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. **View or print contact information to obtain instructions for submitting the request.**

~~B. When eligibility is determined after discharge, the hospital may call AFMC for post-certification of inpatient days beyond the first 4 (or for all days if the admission was by transfer).~~

~~C. When eligibility is determined after discharge and the provider is seeking certification of a stay longer than 30 days, the provider must submit the entire medical record to AFMC for review.~~

212.550 Third Party and Medicare Primary Claims

~~6-1-06~~8-1-21

If a provider did not request MUMP certification of an inpatient stay because of apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted etc., post-certification required by the MUMP may be obtained. **View or print contact information to obtain instructions for submitting the request.** ~~as follows:~~

~~A. Send a copy of the third party payer's denial notice to AFMC.~~ ~~**View or print AFMC contact information.**~~

~~1. Include a written request for post-certification.~~

~~2. Include complete provider contact information (full name and title, telephone number and extension).~~

~~B. An AFMC coordinator will call the provider contact for the certification information.~~

~~C. If a third party insurer pays the provider for an approved number of days, Medicaid will not grant an extension of days beyond the number of days approved by the private insurer.~~

215.100 Benefit Extension Requests

~~2-1-05~~8-1-21

A. Requests to extend benefits for outpatient hospital visits and laboratory and X-ray services, including those for fetal ultrasounds and fetal non-stress tests, must be submitted to DHS or its designated vendor. **View or print contact information to obtain instructions for submitting the benefit extension request.** ~~mailed to Arkansas Foundation for Medical Care, Inc. (AFMC).~~ ~~**View or print Arkansas Foundation for Medical Care, Inc. (AFMC) contact information.**~~

   ~~1. AFMC will not accept benefit extension requests transmitted via electronic facsimile (FAX)~~

   ~~2.~~ Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

B. Submit ~~with the request~~ a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.

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C. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.~~AFMC reserves the right to request additional information as needed to process a benefit extension request, reconsiderations of which are not available. Failures to timely provide requested additional information will result in technical denials.~~

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.~~AFMC must receive a benefit extension request within 90 calendar days of the date of the benefits-exhausted denial.~~

~~1. AFMC will consider extending benefits only when extended benefits are medically necessary and all required documentation is received timely.~~

~~2. Requests received after the 90-day deadline will not be considered.~~

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.103 Provider Notification of Benefit Extension Determinations ~~2-1-05~~8-1-21

~~AFMC will approve or deny~~Approvals or denials of a benefit extension request—or ask for additional information—shall be made within thirty (30) calendar days.~~ of their receiving the request.~~

A. Provider notification of benefit extension approval includes:

1. The procedure code approved,
2. The total number of units approved for the procedure code,
3. The benefit extension control number and
4. The approved beginning and ending dates of service.

B. ~~AFMC r~~Reviewers will simultaneously advise the provider and the beneficiary when a request is denied.

~~C. A denial notification letter is signed by a member of the benefit extension reviewing staff.~~

215.420 CAH Coverage Restrictions ~~10-13-03~~8-1-21

A. Arkansas Department of Health regulations stipulate that Critical Access Hospitals (CAH) may provide medically necessary acute inpatient care for a period not to exceed ninety-six (96) hours, unless:

1. A longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions or
2. A peer review organization or equivalent entity, upon request, waives the ninety-six (96) hour restriction on a case-by-case basis.

B. ~~The Arkansas Medicaid Program has contracted with Arkansas Foundation for Medical Care, Inc., (AFMC) to~~DHS or its designated vendor shall determine and certify lengths of stay in the Medicaid Utilization Management Program (MUMP). **View or print contact information to obtain the DHS or designated vendor regarding coverage restrictions.**

1. CAHs shall ~~contact AFMC and~~ follow MUMP procedures to certify stays longer than four (4) days.

MARKUP

2. CAHs receiving inpatients by transfer from a hospital or another CAH must obtain ~~AFMC~~ certification of inpatient stays of any length.

3. In addition to MUMP criteria of medical necessity, ~~AFMC~~DHS or its designated vendor will, when applicable, review a CAH's justification for retaining a patient instead of transferring the patient to a hospital.

   a. Inpatient stays of any length may be retrospectively reviewed for medical necessity.~~AFMC may retrospectively review inpatient stays of any length for medical necessity.~~

   b. ~~AFMC may retrospectively review i~~Inpatient stays of any length may be retrospectively reviewed~~for~~ to ascertain justification for retaining a patient instead of transferring the patient to a hospital.

C. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the 96-hour inpatient stay limitation and the MUMP policy for dates of service before their first birthday.

D. A CAH may provide medically necessary acute inpatient care for a period that does not exceed, as determined on an annual average basis, ninety-six (96) hours per patient.

1. Discharges and average stays are identified and calculated by the Medicare fiscal intermediary and are the same as those used for Medicare purposes.

2. The CAH's average lengths of stay will be reported to the CMS regional office by the Medicare fiscal intermediary.

   a. If a CAH exceeds the average length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS regional office.

   b. If the CAH fails to implement the corrective action plan, the CAH will be subject to termination of its Medicaid provider agreement and other sanctions established under Title XVIII of the Social Security Act.

217.060 Transplants

~~3-15-05~~8-1-21

A. All transplants require prior approval.

B. Medicaid covers the following transplants for beneficiaries of all ages: bone marrow, corneal, heart, kidney, liver and lung.

C. Medicaid covers the following transplants for beneficiaries under the age of twenty-one (21) who are participating in the Child Health Services (EPSDT) Program: liver/bowel ~~(effective for dates of service on and after December 3, 2004)~~, pancreas/kidney and skin transplants for burns.

D. Inpatient hospital stays for corneal, kidney, pancreas/kidney and skin transplants are subject to Medicaid Utilization Management Program~~—~~ (MUMP)~~—~~ precertification.

E. Regarding inpatient stays related to all organ transplants except bone marrow, corneal, kidney, pancreas/kidney and skin:

1. Hospital days in excess of transplant length of stay averages require medical review and approval by DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor regarding transplants.**~~the Quality Improvement Organization (QIO), which is Arkansas foundation for Medical Care, Inc. (AFMC).~~

2. ~~AFMC's r~~Reference sources for organ transplant length-of-stay (LOS) averages are the *Centers for Medicare and Medicaid Services (CMS) Acute Inpatient Prospective Payment System (PPS)*—using the "Arithmetic Mean LOS" method—and/or the most recently published *Medicare National Coverage Decisions*.

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F. ~~With the exception of~~Except for cornea, kidney and pancreas/kidney acquisition, Medicaid covers hospitals' organ acquisition costs by means of the reimbursement methodologies explained in detail in Section 250.714.

G. ~~With the exception of~~Except for bone marrow transplants, inpatient days between the admission date and the date of the transplant procedure are subject to MUMP guidelines.

217.063 Heart Transplants

~~3-15-05~~8-1-21

A. Medicaid covers the following hospital services related to heart transplantation.

1. Hospital services related to the transplantation of the heart into the receiver.
2. Post-operative services.

B. Inpatient stays for heart transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from ~~AFMC~~ medical review. (See Section 217.060, part E.)

217.064 Liver Transplants

~~3-15-05~~8-1-21

A. Medicaid covers the following hospital services related to liver transplantation.

1. Hospital services related to harvesting a partial organ from a living donor.
2. Hospital services related to the transplantation of the liver (or of a partial liver from a living donor) into the receiver.
3. Post-operative services (including those for the donor, when applicable).

B. Inpatient stays for liver transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from ~~AFMC~~ medical review. (See Section 217.060, part E.)

217.065 Liver/Bowel Transplants

~~3-15-05~~8-1-21

A. ~~Effective for dates of service on and after December 3, 2004,~~ Medicaid covers liver/bowel transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

B. The following hospital services related to liver/bowel transplants are covered:

1. Hospital services related to the transplantation of the liver/bowel into the receiver.
2. Post-operative services.

C. Inpatient stays for liver/bowel transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP). The services that are excluded from the MUMP are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from ~~AFMC~~ medical review. (See Section 217.060, part E.)

217.066 Lung Transplants

~~3-15-05~~8-1-21

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A. The following conditions and diseases are those for which it is believed patients can benefit significantly from a lung transplant when the disease has reached an end-stage cycle or level.

1. Pulmonary vascular diseases:
   a. Primary pulmonary hypertension
   b. Eisenmenger's Syndrome (ASD, VSD, PVA, truncus, other complex anomalies)
   c. Pulmonary hypertension secondary to thromboembolic disease
2. Obstructive lung diseases:
   a. Emphysema (idiopathic)
   b. Emphysema (alpha antitrypsin deficiency)
   c. Bronchopulmonary dysplasia
   d. Post-transplant obliterative bronchiolitis
   e. Bronchiolitis obliterans organizing pneumonia (BOOP)
3. Restrictive lung diseases:
   a. Idiopathic pulmonary fibrosis
   b. Sarcoidosis
   c. Asbestosis
   d. Eosinophilic granulomatosis
   e. Desquamative interstitial pneumonitis
   f. Lymphangioleiomyomatosis

B. Medicaid covers the following hospital services related to lung transplantation.

1. Hospital services related to the transplantation of the lung into the receiver.
2. Post-operative services.

C. Inpatient stays for lung transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from ~~AFMC~~ medical review. (See Section 217.060, part E.)

217.130 Hyperbaric Oxygen Therapy (HBOT) ~~10-1-15~~8-1-21

Hyperbaric Oxygen Therapy (HBOT) involves exposing the body to oxygen under pressure greater than one atmosphere. Such therapy is performed in specially constructed hyperbaric chambers holding one or more patients, although, oxygen may be administered in addition to the hyperbaric treatment itself. Patients should be assessed for contraindications such as sinus disease or claustrophobia prior to therapy. In some diagnoses, hyperbarics is only an adjunct to standard surgical therapy. These indications are taken from "The Hyperbaric Oxygen Therapy Committee Report" (2003) of The Undersea and Hyperbaric Medical Society (Kensington, MD).

HBOT prior authorizations will be issued by ~~Arkansas Foundation for Medical Care (AFMC) for all requests received on and after October 1, 2009~~DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.** All hyperbaric oxygen therapy will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which post-authorization will be allowed per protocol. See Section 242.000. Prior authorization will be issued for a specific number of treatments. Subsequent treatments will require another ~~telephone~~ review and an additional prior authorization. ~~All prior authorizations for HBOT are~~

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~~completed by telephone review.~~ **~~In order to request a prior authorization for HBOT, the provider must call the AFMC prior authorization number, (800) 426-2234.~~** The caller must be able to provide demographic and clinical information to support the medical necessity of treatment. ~~Calls for prior authorization should be placed by a staff member who can answer questions pertaining to the patient's clinical condition. Providers should gather all necessary information prior to placing a call.~~ All information that is submitted to acquire the prior authorization must be documented in the beneficiary's medical record. **View or print contact information to obtain instructions for submitting the request for prior authorization.** ~~The following information is required for prior authorization:~~

~~A. Name of caller requesting HBOT~~

~~B. Beneficiary's Medicaid ID number~~

~~C. Beneficiary's full name~~

~~D. Beneficiary's complete mailing address including zip code~~

~~E. Beneficiary's birth date~~

~~F. Treatment start date~~

~~G. Treatment facility's AR Medicaid provider number~~

~~H. Treating physician's AR Medicaid provider number~~

~~I. Treating physician's office phone number~~

~~J. CPT code for treatment~~

~~K. ICD diagnosis code that justifies HBOT~~

~~L. Number of treatments requested (see table below)~~

~~M. Clinical indications for treatment~~

~~1. Narrative diagnosis, history of illness requiring HBOT and prior treatment including information about specific treatments and length of time~~

~~2. If treatment is for a non-healing wound, a clear description of the wound is required~~

~~Refer to Sections 242.000, 244.000, 252.119 and 272.404 for additional information on prior authorizations, reimbursement, and information on billing.~~

NOTE: When approved, only one authorization ~~number~~ will be issued. The prior authorization ~~number~~ and the number of approved HBOT treatments must be communicated to the physician provider so that both the facility and physician may claim reimbursement for the number of approved HBOT sessions. Additionally, if more HBOT sessions are required for the same beneficiary, a new prior authorization ~~will be~~is required ~~and the above process followed to acquire any subsequent prior authorizations~~. A new prior authorization number will be assigned for any additional sessions approved. The prior authorization information between the facility and the physician ~~is to~~must be reciprocal if the physician acquires the prior authorization.

The following table provides the diagnosis requirements, description of the problem, and number of treatments.

Diagnosis	Description	Number of Treatments
(View ICD Codes.)	Air or Gas Embolism	10

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Diagnosis	Description	Number of Treatments
(View ICD Codes.)	Decompression Sickness	10
(View ICD Codes.)	Carbon Monoxide Poisoning	5
(View ICD Codes.)	Clostridial Myositis and Myonecrosis (Gas Gangrene)	10
(View ICD Codes.)	Crush injuries, compartment syndrome, other acute traumatic peripheral ischemias	6
(View ICD Codes.)	Enhancement of healing in selected problem wounds; diabetic foot ulcers, pressure ulcers, venous stasis ulcers; only in severe and limb or life-threatening wounds that have not responded to other treatments, particularly if ischemia that cannot be corrected by vascular procedures is present	30
(View ICD Codes.)	Intracranial abscess, multiple abscesses, immune compromise, unresponsive	20
(View ICD Codes.)	Necrotizing Soft Tissue Infections, immune compromise	30
(View ICD Codes.)	Refractory osteomyelitis after aggressive surgical debridement	40
(View ICD Codes.)	Delayed Radiation Injury	60
(View ICD Codes.)	Compromised skin grafts and flaps	20
(View ICD Codes.)	Thermal burns>20% TSBA +/or involvement of hands, face, feet or perineum that are deep, partial or full thickness injury	40
(View ICD Codes.)	Compartment syndrome, impending stage fasciotomy not required.	1
(View ICD Codes.)	Problem wounds after primary management	14

Refer to Section 272.404 of this manual for billing instructions.

218.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services

~~7-1-15~~8-1-21

~~The Quality Improvement Organization (QIO), under contract with the Arkansas Medicaid Program,~~DHS or its designated vendor performs retrospective reviews of medical records to determine the medical necessity of services paid for by Medicaid. **View or print contact information to obtain the DHS or designated vendor retrospective reviews.~~View or print AFMC contact information.~~**

Specific guidelines have been developed for retrospective review of occupational, physical and speech-language therapy services furnished to Medicaid beneficiaries under the age of twenty-one (21). These guidelines are included in this manual to assist providers in determining and documenting the medical necessity of occupational, physical and speech-language therapy services and are found in Sections 218.100 through 218.110

218.250 Process for Requesting Extended Therapy Services for Beneficiaries Under Age 21

~~1-1-09~~8-1-21

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A. Requests for extended therapy services for beneficiaries under age twenty-one (21) must be ~~mailed~~ submitted to DHS or its designated vendor. ~~the Arkansas Foundation for Medical Care, Inc. (AFMC~~**View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services for beneficiaries under age twenty-one (21).**~~).~~ **~~View or print the Arkansas Foundation for Medical Care, Inc. contact information~~**. The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits exceeded.

2. The request must be received ~~by AFMC~~ within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.

3. Submit ~~with the request~~ a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

~~4. AFMC will not accept requests sent via electronic facsimile (FAX).~~

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. **View or print form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials and date the request form. An electronic signature is accepted provided it ~~is in compliance~~complies with Arkansas Code 25-31-103. All applicable records that support the medical necessity of the request ~~should~~ must be attached.

C. ~~AFMC~~ DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. ~~AFMC r~~Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization ~~number that is required to be submitted with the billing for the approved services~~.

218.270 ~~AFMC~~ Extended Therapy Services Review Process ~~1-1-09~~8-1-21

View or print contact information to obtain the DHS or designated vendor step-by-step process for extended therapy services review.~~The following is a step-by-step outline of AFMC's extended services review process:~~

~~A. Requests received via mail are screened for completeness and researched to determine the beneficiary's eligibility for Medicaid when the service was provided and payment/denial status of the claim request.~~

~~B. The documentation submitted is reviewed by a registered nurse (R.N.). If, in the judgment of the R.N., the documentation supports the medical necessity, they may approve the request. An approval letter is generated and mailed to the provider the following day.~~

~~C. If the R.N. reviewer determines the documentation does not justify the service or it appears that the service is not medically necessary, they will refer the case to the appropriate physician adviser for a decision.~~

~~D. The physician adviser's rationale for approval or denial is documented and the appropriate notification is created. If services are denied for medical necessity, the physician adviser's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.~~

MARKUP

~~E. Providers may request administrative reconsideration of an adverse decision or they and/or the beneficiary may appeal as provided in Section 160.000 of this manual.~~

~~F. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to incomplete documentation, but complete documentation supporting medical necessity is submitted with the reconsideration request, the R.N. may approve the extension of benefits without referral to a physician adviser.~~

~~G. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to lack of medical necessity documentation or the documentation does not allow for approval by the R.N., the original documentation, reason for the denial and new information submitted will be referred to a different physician adviser for reconsideration.~~

~~H. All parties will be notified in writing of the outcome of the reconsideration. Reconsiderations approved generate an approval number and is mailed to the provider for inclusion with billing for the requested service. Adverse decisions that are upheld through the reconsideration remain eligible for an appeal by the provider and/or the beneficiary as provided in Section 160.000 of this manual.~~

218.280 Administrative Reconsideration

~~1-1-09~~8-1-21

A request for administrative reconsideration of the denial of services must be in writing and sent to ~~AFMC~~ DHS or its designated vendor within thirty (30) calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of ~~this~~ the manual. A request received ~~by AFMC~~ within thirty-five (35) calendar days of a denial will be deemed timely~~. Reconsideration requests must be mailed and will not be accepted via facsimile or email.~~

241.000 Procedures for Obtaining Prior Authorization

~~4-1-07~~8-1-21

There are certain medical, diagnostic and surgical procedures that are not covered without prior authorization, either because of federal requirements or because of the elective nature of a procedure. ~~Arkansas Foundation for Medical Care, Inc. (AFMC), under contract with Arkansas Medicaid,~~DHS or its designated vendor makes prior authorization (PA) determinations for most Medicaid-covered surgical procedures that require PA, and for some lab procedures that require PA.

Please refer to Section 244.000 of this manual for a list of procedures requiring prior authorization.

Prior authorization determinations are made utilizing established medical or administrative criteria combined with the professional judgment of ~~AFMC's~~ physician advisors.

View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization.

~~Written documentation is not required. However, the oral information given to AFMC when requesting prior authorization must be substantiated by medical record documentation and reports upon AFMC and/or State retrospective reviews.~~

~~It is the responsibility of the physician who will perform the procedure to initiate the prior authorization request. When requesting prior authorization, the physician or the physician's office nurse must contact AFMC.~~ **~~View or print AFMC contact information.~~** ~~The physician or the physician's office nurse must furnish the following specific information to AFMC: (All calls are tape recorded.)~~

MARKUP

~~A. Patient Name and Address~~

~~B. Beneficiary Medicaid Identification Number~~

~~C. Physician Name and License Number~~

~~D. Physician provider identification number~~

~~E. Hospital Name~~

~~F. Date of Service for Requested Procedure~~

~~G. Card Issuance Date for Retroactive Eligibility Authorizations~~

~~When you call, please provide all patient identification information and medical information related to the necessity of the procedure you need authorized.~~

~~AFMC will give approval or denial of the request by phone with follow-up in writing. If approval is granted, AFMC will assign a prior authorization control number that must be entered in the appropriate field of the claim when billing for the procedure.~~ If surgery is involved, a copy of the authorization will be ~~mailed~~ 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 physician or ~~AFMC~~ 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.

Prior authorization of service does not guarantee eligibility for a beneficiary. Coverage is contingent on the beneficiary's eligibility on the date(s) of service.

242.000 Post-authorization for Emergency Procedures and Periods of Retroactive Eligibility

~~10-13-03~~8-1-21

Post-authorization will be granted only for emergency procedures ~~and/~~or retroactively eligible beneficiaries.

A. Requests for emergency procedures must be applied for on the first working day after the procedure has been performed.

B. In cases of retroactive eligibility, ~~AFMC~~ DHS or its designated vendor must be contacted for post-authorization within sixty (60) days of the eligibility card issuance date.

C. In cases involving a hysterectomy, documentation must be provided that reflects the acknowledgement statement was signed prior to surgery or the attending physician must certify in writing.~~:~~ (Use form DMS-2606. **View or print form DMS-2606**.)

1. That the individual was already sterile, ~~stating~~ and the cause of sterility; or
2. That the hysterectomy was performed under a ~~life threatening~~life-threatening emergency ~~situation~~ in which the physician determined prior acknowledgement was not possible. The physician must also include a description ~~of the nature~~ of the emergency.

FORM DMS-2606 MUST BE ATTACHED TO THE CLAIM FOR PAYMENT.

The document must be reviewed and approved by the Medicaid Program before payment will be considered. ~~It should be stressed that a~~All guidelines must be met in order for payment to be made.

MARKUP

243.000 Post Procedural Authorization for Eligible Beneficiaries Under Age 21

~~10-13-03~~8-1-21

Providers performing surgical procedures that require prior authorization are allowed sixty 60 days from the date of service to obtain prior authorization if the beneficiary is under age twenty-one (21).

All requests for post-procedural authorizations for eligible beneficiaries are to be made to ~~the Arkansas Foundation for Medical Care, Inc., (AFMC) by telephone~~DHS or its designated vendor within sixty (60) days of the date of service. These calls will be tape-recorded. **View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits review.~~AFMC contact information.~~**

~~AFMC must be provided t~~The beneficiary and provider identifying criteria and all of the medical data necessary to justify the procedures must be provided.

~~As medical information will be exchanged for this procedure, these calls must be made by the physician or a member of his or her nursing staff.~~

~~The provider will be issued a PA number at the time of the call if the procedure requested is approved. A follow-up letter will be mailed the same day to the physician.~~

Consulting physicians are responsible for ~~calling AFMC~~contacting DHS or its designated vendor to have procedures added to the PA file. ~~They will be given the prior authorization number at the time of the call on cases that are approved. A letter verifying the PA number will be sent to the consultant upon request. When calling, all patient identification information and medical information related to the necessity of the procedure needing authorization must be provided.~~

~~The Arkansas Medicaid Program recommends p~~Providers must obtain prior authorization for procedures requiring authorization in order to prevent risk of denial due to lack of medical necessity.

This policy applies only to those Medicaid beneficiaries under age twenty-one (21). This policy does not alter prior authorization procedures applicable to retroactive eligible beneficiaries.

245.010 Organ Transplant Prior Approval in Arkansas and Bordering States

~~3-15-05~~8-1-21

The attending physician is responsible for obtaining prior approval for organ transplants.

A. The attending physician submits his or her transplant evaluation (workup) results to the Utilization Review (UR) Section, requesting approval of the transplant. **View or print the UR Section contact information.**

B. ~~UR forwards t~~The request and its supporting documentation ~~to Arkansas Foundation for Medical Care, Inc. (AFMC)~~is reviewed by DHS or its designated vendor for a determination of approval or denial.

C. ~~AFMC advises t~~The requesting physician and the beneficiary are advised of ~~its decision~~determination by letter.

D. The physician is responsible for distributing documentation of prior approval to the hospital and to the other participating providers, such as the anesthetist, assistant surgeon, etc.

245.020 Organ Transplant and Evaluation Prior Approval in Non-Bordering States

~~3-15-05~~8-1-21

A. In states that do not border Arkansas, prior approval is required for organ transplant evaluations and organ transplants.

MARKUP

B. The attending physician is responsible for obtaining prior approval for organ transplant evaluations and organ transplants.

1. The attending physician must request from the UR Section prior approval of a transplant evaluation, identifying the facility at which the evaluation is to take place and the physician who will conduct the evaluation. **View or print the UR Section contact information.**

2. UR reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.

3. The evaluation results must be forwarded to UR with a request for approval of the transplant procedure.

4. ~~UR forwards t~~The request and the supporting documentation ~~to AFMC~~is reviewed by DHS or its designated vendor for a determination of approval or denial.

5. ~~AFMC advises t~~The requesting physician and the beneficiary are advised of ~~its decision~~ the determination by letter.

245.030 Hyperbaric Oxygen Therapy (HBOT) Prior Authorization ~~10-1-09~~8-1-21

All hyperbaric oxygen therapy will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which post-authorization will be allowed per protocol. See Section 242.000. Prior authorization will be for a certain number of treatments. Further treatments will require reapplication for a prior authorization. **In order to request a prior authorization for HBOT, the provider must contact DHS or its designated vendor. View or print contact information to obtain instructions for submitting the prior authorization request.~~call the AFMC prior authorization number, (800) 426-2234.~~**

Refer to Sections 217.130, 242.000, 252.119, and 272.404 for additional information on HBOT.

250.713 Other Covered Transplants in all Hospitals Except In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals ~~3-15-05~~8-1-21

A. Hospital services (not including organ acquisition) related to other covered transplant procedures (i.e., all but bone marrow, corneal, kidney and pancreas/kidney) are reimbursed at 45% of submitted charges.

1. Reimbursement includes all medical services related to the covered transplant procedure from the date of the transplant procedure to the date of discharge.

a. Transplant hospitalization days in excess of transplant length-of-stay averages must be approved through ~~Arkansas Foundation for Medical Care, Inc. (AFMC)~~DHS or its designated vendor's medical review.

b. Transplant length-of-stay averages for each transplant type will be determined from the most current written Medicare National Coverage Decisions.

2. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

B. Medically necessary ~~(as determined by AFMC)~~ readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same methodology as the initial transplant service at 45% of submitted charges.

250.714 Other Covered Transplants in In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals ~~10-1-06~~8-1-21

MARKUP

A. Hospital services provided by in-state pediatric hospitals and Arkansas state-operated teaching hospitals related to other covered transplant procedures (does not include bone marrow, corneal, kidney or pancreas/kidney) are reimbursed in the same manner as other inpatient hospital services with interim reimbursement and final cost settlement.

B. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

C. Medically necessary ~~(as determined by AFMC)~~ readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same reimbursement methodology as the initial transplant service.

D. ~~Effective for discharge dates on and after September 1, 2006, t~~The TEFRA rate of increase limit is not applied to in-state pediatric hospitals for covered transplant procedures other than corneal, renal, pancreas/kidney and bone marrow transplants.

272.449 Molecular Pathology

~~1-15-15~~8-1-21

Molecular Pathology procedure codes require prior authorization (PA). Providers ~~are to acquire~~must receive prior authorization before a claim for molecular pathology is filed for payment. Providers may request the PA from ~~Arkansas Foundation for Medical Care (AFMC)~~DHS or its designated vendor before or after the procedure is performed as long as it is acquired in time to receive approval and file a clean claim within the 365-day claims filing deadline. **View or print contact information to obtain the DHS or designated vendor step-by-step process to request prior authorization.**~~Providers of these procedures may submit molecular pathology requests and medical record documentation to AFMC via mail, fax, or electronically through a web portal. See additional contact information for AFMC, in Section 241.000. See Section 244.000 for Molecular Pathology procedure codes.~~

Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory Services **(form DMS-841**) and ~~the attachment of~~ all pertinent clinical documentation needed to justify the procedure. ~~If the request is approved, a prior authorization number will be assigned and the provider will receive notification of the approval in writing by mail. If the request does not meet the medical necessity criteria and is denied, the requesting provider will receive notification of the denial in writing by mail.~~ Reconsideration of denied requests is allowed if new or additional information is received ~~by AFMC~~ within thirty (30) days of the initial denial. **View or print form DMS-841**. This form may ~~also~~ be found in Section V of the provider manual. ~~Copies may be made of this form. Please d~~**Do not complete the form unless you are submitting a Molecular Pathology PA request.**

Molecular Pathology procedure codes must be submitted on a red line paper claim form with the PA number listed on the claim and the itemized invoice attached that supports the charges for the test billed. See Section 244.000 for Molecular Pathology procedure codes.

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204.210 Availability of ESRD Medical Records 8-1-21

The Arkansas Department of Health and Human Services, its designees and other state and federal agencies review medical records for documentation of services provided and billed and to evaluate the medical necessity of delivered services.

A. All records must be retained in their original or legally reproduced form for at least five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.

B. Pertinent records concerning the provision of Medicaid-covered health care services are to be made available, upon request, during regular business hours to authorized representatives of the Arkansas Division of Medical Services (DMS) who are acting within the scope and course of their employment.

1. All requested documentation must be made available to DMS representatives at the time of an audit.

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

C. Pertinent records are also to be made available to DMS's contracted Quality Improvement Organization (QIO).

D. Additionally, providers are required to furnish records, when so requested, to the Office of Medicaid Inspector General (OMIG); Medicaid Fraud Control Unit (MFCU) of the Arkansas Office of the Attorney General and to representatives of the Secretary of the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS).

1. When requested records are stored off-premises or they are in active use, the provider may so certify in writing and set a date and hour within three (3) working days that the records will be available.

2. Failure to furnish medical records upon request will result in the imposition of sanctions. (See Section I of the Arkansas Medicaid provider manual.)

212.401 Inpatient Hospital Services Benefit Limit 8-1-21

A. There is no benefit limit for acute care/general and rehabilitative hospital inpatient services for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. Inpatient services must be approved by the QIO as medically necessary.

B. The benefit limit for acute care/general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged twenty-one (21) and older.

C. Included in the total of paid inpatient days are any days covered by primary third party resources (except Medicare and Railroad Retirement) for which Medicaid receives a secondary-payer claim that it adjudicates as paid. A Medicaid-secondary claim that adjudicates as a paid claim is counted toward the inpatient benefit limit.

1. Medicaid, when it is secondary to a third party resource other than Medicare or Railroad Retirement, covers only the difference between the primary resource's remittance and Medicaid's per diem or maximum allowable fee for Medicaid-covered services reimbursed by the primary resource.

2. Even when the Medicaid paid amount is $0.00 because the third party payment equals or exceeds Medicaid's per diem, the days thus paid are counted toward the benefit limit.

PROPOSED

D. Extension of the 24-day inpatient benefit is available under the Medicaid Utilization Management Program (MUMP).

E. Inpatient stays that are prior authorized for heart, liver and lung transplants are not counted toward the 24-day inpatient benefit limit.

F. See Section 272.406 regarding special billing instructions for beneficiaries who turn age 21 during an inpatient hospital stay.

212.500 Medicaid Utilization Management Program (MUMP) 8-1-21

A. DHS or its designated vendor determines covered lengths of stay in acute care/general and rehabilitative hospitals in Arkansas and states bordering Arkansas. **View or print DHS or designated vendor contact information to obtain MUMP information.** Determination are made in accordance with the guidelines of the MUMP.

B. MUMP guidelines do not apply to lengths of stay in psychiatric facilities.

Sections 212.501 through 212.507 generally set forth MUMP guidelines. Sections 212.510 through 212.550 address specific issues and procedures.

212.501 Length of Stay Determination 8-1-21

A. The *Solucient Length of Stay by Diagnosis and Operation Data Files* is used to assist non-physician reviewers in determining appropriate Arkansas Medicaid Utilization Management Program (MUMP) lengths of stay.

B. Nurse-reviewers are not authorized to deny certification requests.

1. The nurse-reviewer refers to an in-house physician adviser when:
   a. The length of stay requested is beyond that indicated by the Solucient guide or
   b. A beneficiary's medical condition does not appear to meet the guidelines or
   c. It technically meets the guidelines, but in the nurse's judgment inpatient care may not be necessary.
2. The in-house physician adviser determines, based on his or her medical judgment, whether to approve, partially approve or deny the certification request.

212.502 Reconsiderations 8-1-21

Once per admission DHS or the designated vendor will reconsider a denied extension.

A. The reconsideration request must be received by DHS or its designated vendor within thirty (30) days of the provider's receipt of the denial.

B. When requesting reconsideration, a provider must submit the complete medical record of the admission.

212.503 Paper Review After Reconsiderations: Special Cases 8-1-21

A. Infrequently, the following sequence of events may occur: An extension of days is denied or only partially approved and the determination is upheld on reconsideration; however, before the patient can be discharged, he or she becomes acutely ill and remains hospitalized for treatment of that illness.

B. In strict accordance with the regulation above in Section 212.502, the provider would be precluded from requesting certification of any of the inpatient days required for treatment of the late-appearing acute illness, because the case has already been reconsidered once.

PROPOSED

C. However, if the beneficiary had not been hospitalized when he or she became acutely ill, Medicaid would have covered up to four (4) inpatient days without certification and the beneficiary's case would have been eligible for consideration for certification if the stay for treatment had been longer than four (4) days.

D. In order to give due consideration to cases of true medical necessity while avoiding repeated reviews of the same admission, the following procedure for reviewing cases of this nature has been established.

E. After the beneficiary's discharge, the provider may submit the medical record for the entire admission and indicate in writing the dates to be considered for certification.

1. Only the dates requested by the provider will be considered for possible authorization,

2. The review and determination procedure is the same as described in Section 212.501.

F. AFMC will not reconsider denials and partial denials of these requests; however, the beneficiary may appeal the decision or the provider may appeal on behalf of the beneficiary.

212.510 MUMP Applicability 8-1-21

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer. The days are subject to retrospective review for medical necessity.

B. If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified.

C. When a patient is transferred from one hospital to another, the stay must be certified from the first day.

212.520 MUMP Certification Request Procedure 8-1-21

When a patient is transferred from another hospital (see Section 212.530 below) or when a patient's attending physician determines the patient should not be discharged by the fifth day of hospitalization, hospital utilization review or case management personnel may request an extension of inpatient days. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting MUMP certification.**

A. Additional extensions may be requested as needed.

B. The Arkansas Medicaid Utilization Management Program (MUMP) certification process is separate from prior authorization requirements.

1. Prior authorization for medical procedures must be obtained by the appropriate providers.

2. Hospital stays for restricted procedures are disallowed when required prior authorizations are not obtained.

C. Except for the exemptions listed in Section 212.511, Medicaid does not cover fifth and subsequent days of inpatient hospital admissions unless they have been certified, in accordance with applicable procedures for concurrent or retroactive MUMP certification.

212.530 Transfer Admissions 8-1-21

When a patient is transferred from one hospital to another, the receiving facility must contact DHS or designated contractor within twenty-four (24) hours of admission to certify the inpatient

PROPOSED

stay. **View or print contact information to obtain instructions for submitting the transfer request.**

212.540 Post Certification Due to Retroactive Eligibility 8-1-21

When eligibility is determined while the patient is still an inpatient, the hospital may request post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. **View or print contact information to obtain instructions for submitting the request.**

212.550 Third Party and Medicare Primary Claims 8-1-21

If a provider did not request MUMP certification of an inpatient stay because of apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted etc., post-certification required by the MUMP may be obtained. **View or print contact information to obtain instructions for submitting the request.**

215.100 Benefit Extension Requests 8-1-21

A. Requests to extend benefits for outpatient hospital visits and laboratory and X-ray services, including those for fetal ultrasounds and fetal non-stress tests, must be submitted to DHS or its designated vendor. **View or print contact information to obtain instructions for submitting the benefit extension request.**

   Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

B. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.

C. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.103 Provider Notification of Benefit Extension Determinations 8-1-21

Approvals or denials of a benefit extension request—or ask for additional information—shall be made within thirty (30) calendar days.

A. Provider notification of benefit extension approval includes:

   1. The procedure code approved,
   2. The total number of units approved for the procedure code,
   3. The benefit extension control number and
   4. The approved beginning and ending dates of service.

B. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied.

PROPOSED

215.420 CAH Coverage Restrictions 8-1-21

A. Arkansas Department of Health regulations stipulate that Critical Access Hospitals (CAH) may provide medically necessary acute inpatient care for a period not to exceed ninety-six (96) hours, unless:

1. A longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions or
2. A peer review organization or equivalent entity, upon request, waives the ninety-six (96) hour restriction on a case-by-case basis.

B. DHS or its designated vendor shall determine and certify lengths of stay in the Medicaid Utilization Management Program (MUMP). **View or print contact information to obtain the DHS or designated vendor regarding coverage restrictions.**

1. CAHs shall follow MUMP procedures to certify stays longer than four (4) days.
2. CAHs receiving inpatients by transfer from a hospital or another CAH must obtain certification of inpatient stays of any length.
3. In addition to MUMP criteria of medical necessity, DHS or its designated vendor will, when applicable, review a CAH's justification for retaining a patient instead of transferring the patient to a hospital.
   a. Inpatient stays of any length may be retrospectively reviewed for medical necessity.
   b. Inpatient stays of any length may be retrospectively reviewed to ascertain justification for retaining a patient instead of transferring the patient to a hospital.

C. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the 96-hour inpatient stay limitation and the MUMP policy for dates of service before their first birthday.

D. A CAH may provide medically necessary acute inpatient care for a period that does not exceed, as determined on an annual average basis, ninety-six (96) hours per patient.

1. Discharges and average stays are identified and calculated by the Medicare fiscal intermediary and are the same as those used for Medicare purposes.
2. The CAH's average lengths of stay will be reported to the CMS regional office by the Medicare fiscal intermediary.
   a. If a CAH exceeds the average length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS regional office.
   b. If the CAH fails to implement the corrective action plan, the CAH will be subject to termination of its Medicaid provider agreement and other sanctions established under Title XVIII of the Social Security Act.

217.060 Transplants 8-1-21

A. All transplants require prior approval.

B. Medicaid covers the following transplants for beneficiaries of all ages: bone marrow, corneal, heart, kidney, liver and lung.

C. Medicaid covers the following transplants for beneficiaries under the age of twenty-one (21) who are participating in the Child Health Services (EPSDT) Program: liver/bowel, pancreas/kidney and skin transplants for burns.

PROPOSED

D. Inpatient hospital stays for corneal, kidney, pancreas/kidney and skin transplants are subject to Medicaid Utilization Management Program (MUMP) precertification.

E. Regarding inpatient stays related to all organ transplants except bone marrow, corneal, kidney, pancreas/kidney and skin:

1. Hospital days in excess of transplant length of stay averages require medical review and approval by DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor regarding transplants.**

2. Reference sources for organ transplant length-of-stay (LOS) averages are the *Centers for Medicare and Medicaid Services (CMS) Acute Inpatient Prospective Payment System (PPS)*—using the "Arithmetic Mean LOS" method—and/or the most recently published *Medicare National Coverage Decisions*.

F. Except for cornea, kidney and pancreas/kidney acquisition, Medicaid covers hospitals' organ acquisition costs by means of the reimbursement methodologies explained in detail in Section 250.714.

G. Except for bone marrow transplants, inpatient days between the admission date and the date of the transplant procedure are subject to MUMP guidelines.

217.063 Heart Transplants 8-1-21

A. Medicaid covers the following hospital services related to heart transplantation.

1. Hospital services related to the transplantation of the heart into the receiver.

2. Post-operative services.

B. Inpatient stays for heart transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from medical review. (See Section 217.060, part E.)

217.064 Liver Transplants 8-1-21

A. Medicaid covers the following hospital services related to liver transplantation.

1. Hospital services related to harvesting a partial organ from a living donor.

2. Hospital services related to the transplantation of the liver (or of a partial liver from a living donor) into the receiver.

3. Post-operative services (including those for the donor, when applicable).

B. Inpatient stays for liver transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from medical review. (See Section 217.060, part E.)

217.065 Liver/Bowel Transplants 8-1-21

A. Medicaid covers liver/bowel transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

B. The following hospital services related to liver/bowel transplants are covered:

PROPOSED

1. Hospital services related to the transplantation of the liver/bowel into the receiver.
2. Post-operative services.

C. Inpatient stays for liver/bowel transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP). The services that are excluded from the MUMP are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from medical review. (See Section 217.060, part E.)

217.066 Lung Transplants 8-1-21

A. The following conditions and diseases are those for which it is believed patients can benefit significantly from a lung transplant when the disease has reached an end-stage cycle or level.

1. Pulmonary vascular diseases:
   a. Primary pulmonary hypertension
   b. Eisenmenger's Syndrome (ASD, VSD, PVA, truncus, other complex anomalies)
   c. Pulmonary hypertension secondary to thromboembolic disease
2. Obstructive lung diseases:
   a. Emphysema (idiopathic)
   b. Emphysema (alpha antitrypsin deficiency)
   c. Bronchopulmonary dysplasia
   d. Post-transplant obliterative bronchiolitis
   e. Bronchiolitis obliterans organizing pneumonia (BOOP)
3. Restrictive lung diseases:
   a. Idiopathic pulmonary fibrosis
   b. Sarcoidosis
   c. Asbestosis
   d. Eosinophilic granulomatosis
   e. Desquamative interstitial pneumonitis
   f. Lymphangioleiomyomatosis

B. Medicaid covers the following hospital services related to lung transplantation.

1. Hospital services related to the transplantation of the lung into the receiver.
2. Post-operative services.

C. Inpatient stays for lung transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from medical review. (See Section 217.060, part E.)

217.130 Hyperbaric Oxygen Therapy (HBOT) 8-1-21

Hyperbaric Oxygen Therapy (HBOT) involves exposing the body to oxygen under pressure greater than one atmosphere. Such therapy is performed in specially constructed hyperbaric chambers holding one or more patients, although, oxygen may be administered in addition to the hyperbaric treatment itself. Patients should be assessed for contraindications such as sinus disease or claustrophobia prior to therapy. In some diagnoses, hyperbarics is only an adjunct to

PROPOSED

standard surgical therapy. These indications are taken from "The Hyperbaric Oxygen Therapy Committee Report" (2003) of The Undersea and Hyperbaric Medical Society (Kensington, MD).

HBOT prior authorizations will be issued by DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.** All hyperbaric oxygen therapy will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which post-authorization will be allowed per protocol. See Section 242.000. Prior authorization will be issued for a specific number of treatments. Subsequent treatments will require another review and an additional prior authorization. The caller must be able to provide demographic and clinical information to support the medical necessity of treatment. All information that is submitted to acquire the prior authorization must be documented in the beneficiary's medical record. **View or print contact information to obtain instructions for submitting the request for prior authorization.**

NOTE: When approved, only one authorization will be issued. The prior authorization and the number of approved HBOT treatments must be communicated to the physician provider so that both the facility and physician may claim reimbursement for the number of approved HBOT sessions. Additionally, if more HBOT sessions are required for the same beneficiary, a new prior authorization is required. A new prior authorization number will be assigned for any additional sessions approved. The prior authorization information between the facility and the physician must be reciprocal if the physician acquires the prior authorization.

The following table provides the diagnosis requirements, description of the problem, and number of treatments.

Diagnosis	Description	Number of Treatments
(**View ICD Codes**.)	Air or Gas Embolism	10
(**View ICD Codes**.)	Decompression Sickness	10
(**View ICD Codes**.)	Carbon Monoxide Poisoning	5
(**View ICD Codes**.)	Clostridial Myositis and Myonecrosis (Gas Gangrene)	10
(**View ICD Codes**.)	Crush injuries, compartment syndrome, other acute traumatic peripheral ischemias	6
(**View ICD Codes**.)	Enhancement of healing in selected problem wounds; diabetic foot ulcers, pressure ulcers, venous stasis ulcers; only in severe and limb or life-threatening wounds that have not responded to other treatments, particularly if ischemia that cannot be corrected by vascular procedures is present	30
(**View ICD Codes**.)	Intracranial abscess, multiple abscesses, immune compromise, unresponsive	20
(**View ICD Codes**.)	Necrotizing Soft Tissue Infections, immune compromise	30
(**View ICD Codes**.)	Refractory osteomyelitis after aggressive surgical debridement	40
(**View ICD Codes**.)	Delayed Radiation Injury	60
(**View ICD Codes**.)	Compromised skin grafts and flaps	20

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Diagnosis	Description	Number of Treatments
(View ICD Codes.)	Thermal burns>20% TSBA +/or involvement of hands, face, feet or perineum that are deep, partial or full thickness injury	40
(View ICD Codes.)	Compartment syndrome, impending stage fasciotomy not required.	1
(View ICD Codes.)	Problem wounds after primary management	14

Refer to Section 272.404 of this manual for billing instructions.

218.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services 8-1-21

DHS or its designated vendor performs retrospective reviews of medical records to determine the medical necessity of services paid for by Medicaid. **View or print contact information to obtain the DHS or designated vendor retrospective reviews.**

Specific guidelines have been developed for retrospective review of occupational, physical and speech-language therapy services furnished to Medicaid beneficiaries under the age of twenty-one (21). These guidelines are included in this manual to assist providers in determining and documenting the medical necessity of occupational, physical and speech-language therapy services and are found in Sections 218.100 through 218.110

218.250 Process for Requesting Extended Therapy Services for Beneficiaries Under Age 21 8-1-21

A. Requests for extended therapy services for beneficiaries under age twenty-one (21) must be submitted to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services for beneficiaries under age twenty-one (21).**. The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits exceeded.
2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. **View or print form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials and date the request form. An electronic signature is accepted provided it complies with Arkansas Code 25-31-103. All applicable records that support the medical necessity of the request must be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization.

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218.270 Extended Therapy Services Review Process 8-1-21

View or print contact information to obtain the DHS or designated vendor step-by-step process for extended therapy services review.

218.280 Administrative Reconsideration 8-1-21

A request for administrative reconsideration of the denial of services must be in writing and sent to DHS or its designated vendor within thirty (30) calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of the manual. A request received within thirty-five (35) calendar days of a denial will be deemed timely

241.000 Procedures for Obtaining Prior Authorization 8-1-21

There are certain medical, diagnostic and surgical procedures that are not covered without prior authorization, either because of federal requirements or because of the elective nature of a procedure. DHS or its designated vendor makes prior authorization (PA) determinations for most Medicaid-covered surgical procedures that require PA, and for some lab procedures that require PA.

Please refer to Section 244.000 of this manual for a list of procedures requiring prior authorization.

Prior authorization determinations are made utilizing established medical or administrative criteria combined with the professional judgment of physician advisors.

View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization.

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 physician 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.

Prior authorization of service does not guarantee eligibility for a beneficiary. Coverage is contingent on the beneficiary's eligibility on the date(s) of service.

242.000 Post-authorization for Emergency Procedures and Periods of Retroactive Eligibility 8-1-21

Post-authorization will be granted only for emergency procedures or retroactively eligible beneficiaries.

A. Requests for emergency procedures must be applied for on the first working day after the procedure has been performed.

B. In cases of retroactive eligibility, DHS or its designated vendor must be contacted for post-authorization within sixty (60) days of the eligibility card issuance date.

C. In cases involving a hysterectomy, documentation must be provided that reflects the acknowledgement statement was signed prior to surgery or the attending physician must certify in writing. (Use form DMS-2606. **View or print form DMS-2606**.)

1. That the individual was already sterile, and the cause of sterility; or

PROPOSED

2. That the hysterectomy was performed under a life-threatening emergency in which the physician determined prior acknowledgement was not possible. The physician must also include a description of the emergency.

FORM DMS-2606 MUST BE ATTACHED TO THE CLAIM FOR PAYMENT.

The document must be reviewed and approved by the Medicaid Program before payment will be considered. All guidelines must be met in order for payment to be made.

243.000 Post Procedural Authorization for Eligible Beneficiaries Under Age 21 8-1-21

Providers performing surgical procedures that require prior authorization are allowed sixty 60 days from the date of service to obtain prior authorization if the beneficiary is under age twenty-one (21).

All requests for post-procedural authorizations for eligible beneficiaries are to be made to DHS or its designated vendor within sixty (60) days of the date of service. These calls will be tape-recorded. **View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits review.**

The beneficiary and provider identifying criteria and all of the medical data necessary to justify the procedures must be provided.

Consulting physicians are responsible for contacting DHS or its designated vendor to have procedures added to the PA file. Providers must obtain prior authorization for procedures requiring authorization in order to prevent risk of denial due to lack of medical necessity.

This policy applies only to those Medicaid beneficiaries under age twenty-one (21). This policy does not alter prior authorization procedures applicable to retroactive eligible beneficiaries.

245.010 Organ Transplant Prior Approval in Arkansas and Bordering States 8-1-21

The attending physician is responsible for obtaining prior approval for organ transplants.

A. The attending physician submits his or her transplant evaluation (workup) results to the Utilization Review (UR) Section, requesting approval of the transplant. **View or print the UR Section contact information.**

B. The request and its supporting documentation is reviewed by DHS or its designated vendor for a determination of approval or denial.

C. The requesting physician and the beneficiary are advised of determination by letter.

D. The physician is responsible for distributing documentation of prior approval to the hospital and to the other participating providers, such as the anesthetist, assistant surgeon, etc.

245.020 Organ Transplant and Evaluation Prior Approval in Non-Bordering States 8-1-21

A. In states that do not border Arkansas, prior approval is required for organ transplant evaluations and organ transplants.

B. The attending physician is responsible for obtaining prior approval for organ transplant evaluations and organ transplants.

1. The attending physician must request from the UR Section prior approval of a transplant evaluation, identifying the facility at which the evaluation is to take place and the physician who will conduct the evaluation. **View or print the UR Section contact information.**

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2. UR reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.
3. The evaluation results must be forwarded to UR with a request for approval of the transplant procedure.
4. The request and the supporting documentation is reviewed by DHS or its designated vendor for a determination of approval or denial.
5. The requesting physician and the beneficiary are advised of the determination by letter.

245.030 Hyperbaric Oxygen Therapy (HBOT) Prior Authorization 8-1-21

All hyperbaric oxygen therapy will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which post-authorization will be allowed per protocol. See Section 242.000. Prior authorization will be for a certain number of treatments. Further treatments will require reapplication for a prior authorization. **In order to request a prior authorization for HBOT, the provider must contact DHS or its designated vendor. View or print contact information to obtain instructions for submitting the prior authorization request.**

Refer to Sections 217.130, 242.000, 252.119, and 272.404 for additional information on HBOT.

250.713 Other Covered Transplants in all Hospitals Except In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals 8-1-21

A. Hospital services (not including organ acquisition) related to other covered transplant procedures (i.e., all but bone marrow, corneal, kidney and pancreas/kidney) are reimbursed at 45% of submitted charges.

1. Reimbursement includes all medical services related to the covered transplant procedure from the date of the transplant procedure to the date of discharge.
   a. Transplant hospitalization days in excess of transplant length-of-stay averages must be approved through DHS or its designated vendor's medical review.
   b. Transplant length-of-stay averages for each transplant type will be determined from the most current written Medicare National Coverage Decisions.
2. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

B. Medically necessary readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same methodology as the initial transplant service at 45% of submitted charges.

250.714 Other Covered Transplants in In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals 8-1-21

A. Hospital services provided by in-state pediatric hospitals and Arkansas state-operated teaching hospitals related to other covered transplant procedures (does not include bone marrow, corneal, kidney or pancreas/kidney) are reimbursed in the same manner as other inpatient hospital services with interim reimbursement and final cost settlement.

B. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

PROPOSED

C. Medically necessary readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same reimbursement methodology as the initial transplant service.

D. The TEFRA rate of increase limit is not applied to in-state pediatric hospitals for covered transplant procedures other than corneal, renal, pancreas/kidney and bone marrow transplants.

272.449 Molecular Pathology 8-1-21

Molecular Pathology procedure codes require prior authorization (PA). Providers must receive prior authorization before a claim for molecular pathology is filed for payment. Providers may request the PA from DHS or its designated vendor before or after the procedure is performed as long as it is acquired in time to receive approval and file a clean claim within the 365-day claims filing deadline. **View or print contact information to obtain the DHS or designated vendor step-by-step process to request prior authorization.**

Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory Services **(form DMS-841**) and all pertinent clinical documentation needed to justify the procedure. Reconsideration of denied requests is allowed if new or additional information is received within thirty (30) days of the initial denial. **View or print form DMS-841**. This form may be found in Section V of the provider manual. D**o not complete the form unless you are submitting a Molecular Pathology PA request.**

Molecular Pathology procedure codes must be submitted on a red line paper claim form with the PA number listed on the claim and the itemized invoice attached that supports the charges for the test billed. See Section 244.000 for Molecular Pathology procedure codes.

PROPOSED

TOC not required

221.000 Prior Authorization

~~6-1-08~~8-1-21

Hyperalimentation fluids, equipment and supplies must be prior authorized by the Department of Human Services (DHS) or its designated vendor. **View or print contact information to obtain the DHS or its designated vendor step-by-step process for requesting prior authorization.**~~Arkansas Foundation for Medical Care, Inc. (AFMC).~~

222.000 Request for Prior Authorization

~~10-1-06~~8-1-21

Requests for prior authorization originate with the provider. The provider is responsible for obtaining the required medical information and necessary prescription information needed for completion of the Request for Prior Authorization and Prescription Form. **View or print form DMS-2615 and instructions for completion**. This form must be signed and dated by the prescribing physician.

The request for prior authorization will be reviewed by the Department of Human Services (DHS) or its designated vendor.~~Arkansas Foundation for Medical Care, Inc., (AFMC). All requests must be submitted by mail. **AFMC will not accept prior authorization requests via FAX.**~~ The documentation submitted with the prior authorization request must support the medical necessity of the requested nutritional therapy. In some cases, ~~AFMC may request~~ additional information may be requested (i.e., original prescription, records from the hospitalization initiating nutritional therapy, nutritional assessment to establish medical necessity for nutritional therapy, etc.). ~~**View or print AFMC contact information.**~~

222.100 Approvals of Prior Authorization Requests

~~10-1-06~~8-1-21

When the PA request is approved, a prior authorization control number will be assigned~~ by AFMC. **View or print AFMC contact information.**~~ Prior authorization approvals are authorized for a maximum of six (6) months (180 days) or for the life of the prescription, whichever is shorter. If the prescribing physician documents the beneficiary's condition is chronic and unlikely to change, a prior approval may be authorized for a maximum of twelve (12) months. The effective date of the prior authorization will be the date the patient will begin therapy or the day following the last day of the previous authorization approval.

223.000 Pre-Approval of Hyperalimentation Services

~~10-1-06~~8-1-21

When an eligible Medicaid beneficiary is discharged from the inpatient setting with the continuation of hyperalimentation services in the home, a provider may request a pre-approval for hyperalimentation ~~prior to~~before the anticipated discharge date. **View or print contact information to obtain the DHS or its designated vendor step-by-step process for requesting pre-approval for hyperalimentation.**~~The request for pre-approval must be faxed to AFMC. **View or print AFMC contact information.**~~

When approved, a prior authorization number will be assigned and will be effective for thirty (30) days. The provider must not bill for hyperalimentation services prior to the date of discharge or bill for services on the same dates of service as the inpatient stay.

If the beneficiary is not discharged within the thirty (30) days, the pre-approval will be void.

When continuation of the therapy is required past the initial thirty (30) day pre-approval, the provider must submit a recertification for prior authorization request ~~for continuation of the therapy,~~ with a prescription signed by the prescribing physician, prior to the end date of the pre-approval.

MARKUP

A pre-approval of hyperalimentation services does not guarantee payment.

MARKUP

TOC not required

221.000 Prior Authorization 8-1-21

Hyperalimentation fluids, equipment and supplies must be prior authorized by the Department of Human Services (DHS) or its designated vendor. **View or print contact information to obtain the DHS or its designated vendor step-by-step process for requesting prior authorization.**

222.000 Request for Prior Authorization 8-1-21

Requests for prior authorization originate with the provider. The provider is responsible for obtaining the required medical information and necessary prescription information needed for completion of the Request for Prior Authorization and Prescription Form. **View or print form DMS-2615 and instructions for completion**. This form must be signed and dated by the prescribing physician.

The request for prior authorization will be reviewed by the Department of Human Services (DHS) or its designated vendor. The documentation submitted with the prior authorization request must support the medical necessity of the requested nutritional therapy. In some cases, additional information may be requested (i.e., original prescription, records from the hospitalization initiating nutritional therapy, nutritional assessment to establish medical necessity for nutritional therapy, etc.).

222.100 Approvals of Prior Authorization Requests 8-1-21

When the PA request is approved, a prior authorization control number will be assigned. Prior authorization approvals are authorized for a maximum of six (6) months (180 days) or for the life of the prescription, whichever is shorter. If the prescribing physician documents the beneficiary's condition is chronic and unlikely to change, a prior approval may be authorized for a maximum of twelve (12) months. The effective date of the prior authorization will be the date the patient will begin therapy or the day following the last day of the previous authorization approval.

223.000 Pre-Approval of Hyperalimentation Services 8-1-21

When an eligible Medicaid beneficiary is discharged from the inpatient setting with the continuation of hyperalimentation services in the home, a provider may request a pre-approval for hyperalimentation before the anticipated discharge date. **View or print contact information to obtain the DHS or its designated vendor step-by-step process for requesting pre-approval for hyperalimentation.**

When approved, a prior authorization number will be assigned and will be effective for thirty (30) days. The provider must not bill for hyperalimentation services prior to the date of discharge or bill for services on the same dates of service as the inpatient stay.

If the beneficiary is not discharged within the thirty (30) days, the pre-approval will be void.

When continuation of the therapy is required past the initial thirty (30) day pre-approval, the provider must submit a recertification for prior authorization request with a prescription signed by the prescribing physician, prior to the end date of the pre-approval.

A pre-approval of hyperalimentation services does not guarantee payment.

PROPOSED

TOC not required

203.100 The Nurse Practitioner's Role in the Pharmacy Program

~~2-6-17~~8-1-21

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) which was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the Arkansas Division of Medical Services (DMS) Pharmacy website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

An advanced nurse practitioner with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

Prescribers must ~~refer to the Arkansas Medicaid website at https://arkansas.magellanrx.com/provider/documents/ to~~ obtain the latest information regarding prescription drug coverage at the website listed in the contact information for DHS or its designated Pharmacy Vendor. **View or print contact information for the DHS designated Pharmacy Vendor.**

203.600 The Nurse Practitioner's Role in Hospital Services

~~1-15-16~~8-1-21

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)

B. The care and treatment of a patient must be under the direction of a licensed physician, a licensed nurse practitioner, a certified nurse-midwife or dentist with hospital staff affiliation.

C. ~~Arkansas Foundation for Medical Care, Inc., (AFMC) is the Medicaid agency's Quality Improvement Organization (QIO). AFMC performs the following services:~~

~~1.~~ ~~AFMC~~ DHS or its designated vendor reviews all inpatient hospital transfers and all inpatient stays longer than four (4) days for the Medicaid Utilization Management Program (MUMP) ~~all inpatient hospital transfers and all inpatient stays longer than four days~~.

~~2.~~ ~~AFMC~~DHS or its designated vendor also completes ~~performs~~ post-payment reviews of hospital stays for medical necessity determinations. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.**

D. Hospital claims are also subject to review by the Medicaid Peer Review Committee or the Medical Director for the Medicaid Program.

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to nurse practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.

2. Nurse practitioners and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.

MARKUP

3. Nurse practitioners and hospitals may not bill inpatient services previously denied for lack of medical necessity as outpatient services.

214.510 Laboratory and X-Ray Services Benefit Limits ~~1-15-16~~8-1-21

The Medicaid Program's laboratory and X-ray services benefit limits apply to outpatient laboratory services, radiology services and machine tests.

A. Medicaid has established a maximum paid amount (benefit limitation) of $500 per state fiscal year (July 1 through June 30) for beneficiaries aged twenty-one (21) and older, for outpatient laboratory and machine tests and outpatient radiology. Exceptions are listed below:

1. There is no lab or X-ray benefit limit for beneficiaries under age twenty-one (21).
2. There is no benefit limit on laboratory services related to family planning. Refer to Section 252.431 of this manual for the family planning-related clinical laboratory procedures.
3. There is no benefit limit on laboratory, X-ray, and machine-test services performed as emergency services, and approved by ~~Arkansas Foundation for Medical Care, Inc., (AFMC)~~DHS or its designated vendor for payment as emergency services. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.**
4. The claims processing system automatically overrides benefit limitations for services supported by the following diagnosis:
   a. Malignant Neoplasm (**View ICD Codes.**)
   b. HIV disease and AIDS (**View ICD Codes.**)
   c. Renal failure (**View ICD Codes.**)
   d. Pregnancy* (**View ICD Codes.**)

   *OB ultrasounds and fetal non-stress tests are benefit limited. See Section 214.630 for additional coverage information.

B. Extension of benefit requests are considered for clients who require supportive treatment, such as dialysis, radiation therapy or chemotherapy, for maintaining life.

C. Benefits may be extended for other conditions documented medically necessary.

214.711 Medicaid Utilization Management Program (MUMP) ~~4-1-07~~8-1-21

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care and/or general hospitals, in state and out of state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), ~~Arkansas Foundation for Medical Care, Inc., (AFMC)~~ under contract to the Arkansas Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age one (1), are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday. Refer to item "E" below for the procedure to follow when a child's first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

A. Medicaid will reimburse hospitals for up to four (4) days of inpatient service with no pre-certification requirement, except for admissions by transfer from another hospital.

MARKUP

B. If the attending nurse practitioner determines the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact ~~AFMC~~ DHS or its designated vendor and request an extension of inpatient days. ~~The following information is required:~~

~~1. Patient name and address (including zip code)~~

~~2. Patient birth date~~

~~3. Patient Medicaid number~~

~~4. Admission date~~

~~5. Hospital name~~

~~6. Hospital provider identification number~~

~~7. Attending nurse practitioner provider identification number~~

~~8. Principal diagnosis~~

~~9. Surgical procedures performed or planned~~

~~10. The number of days being requested for continued inpatient care~~

~~11. All available medical information justifying or supporting the necessity of continued stay in the hospital~~

~~C. Contact AFMC for procedure pre-certification or length of stay review.~~**View or print ~~AFMC~~ contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.**

~~D~~C. ~~AFMC will base t~~The number of days allowed for an extension will be based on ~~their~~ medical judgment utilizing Medicaid guidelines.

~~E~~D. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day (inclusive) of the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.

~~F~~E. Additional extensions may be requested as needed.

~~G. AFMC assigns an authorization number to an approved extension request and sends written notification to the hospital.~~

~~H~~F. Reconsideration reviews of denied extensions may be requested by sending the medical record to AFMC through regular mail, or expedited by overnight express. The hospital will be notified by the next working day of the decision.

~~I~~G. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However, the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable. All calls will be limited to ten (10) minutes to allow equal access to all providers.

~~J. If the fifth day of an admission falls on a Saturday, Sunday or holiday, it is recommended that the hospital provider call for an extension prior to the fifth day if the nurse practitioner has recommended a continued stay.~~

~~K~~H. Inpatient stays for bone marrow, liver, heart, lung, skin and pancreas and/or kidney transplant procedures are excluded from this review program.

MARKUP

~~I~~I. A retrospective or post-payment random sample review will be conducted for all admissions, including inpatient stays of four (4) days or less, to ensure that medical necessity for the services is substantiated.

~~M~~J. Admissions of retroactive eligible beneficiary: If eligibility is identified while the patient is still an inpatient, the hospital may ~~call for~~request retrospective review of those days already used past the original four for a determination of post-authorization and concurrent evaluation of future extended days.

If the retroactive eligible beneficiary is not identified until after discharge, and the hospital files a claim and receives a denial for any days past the original four allowed, the hospital may ~~call for~~request post-extension evaluation approval of the denied days. If granted, the claim may be refiled. If the length of stay is more than thirty (30) days, the provider ~~may~~ shall submit the entire medical record to ~~AFMC~~ DHS or its designated vendor for~~to~~ review.

~~N~~K. Claims submitted without ~~calling for~~ an extension ~~request~~ will result in automatic denials of any days billed beyond the fourth day. The only exceptions are for claims reflecting third party liability and patients with retroactive Medicaid eligibility described in items ~~I~~G and ~~M~~J above.

~~O~~L. If a patient is transferred from one facility to another, the receiving facility must contact ~~AFMC~~ DHS or its designated vendor within twenty-four (24) hours of admitting the patient to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider may contact ~~AFMC~~ DHS or its designated vendor on the first working day following the weekend or holiday.

~~P~~M. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure code in order to be reimbursed.

~~Q~~N. If a provider fails to contact ~~AFMC~~ DHS or its designated vendor for an extension of inpatient days due to the patient's having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, etc., post-certification of days past the original four days may be obtained by the following procedures:

1. Send a copy of the denial notice received from the ~~third~~ third-party payer to DHS or its designated vendor~~AFMC, attention Pre-certification Supervisor~~.
2. Include a note requesting post-certification and the full name of the requester and a phone number where the requester may be reached.

   Upon receipt of the denial copy and the provider request, a~~n AFMC~~ coordinator will call the provider and obtain certification information.

~~R~~O. If a ~~third~~ third-party insurer pays for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

214.910 Extension of Benefits for Laboratory and X-Ray Services ~~2-1-05~~8-1-21

A. Requests for extension of benefits for lab and x-ray services must be submitted to DHS or its designated vendor~~mailed to Arkansas Foundation for Medical Care, Inc. (AFMC), Attention EOB Review~~. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits. ~~View or print the Arkansas Foundation for Medical Care, Inc. contact information.~~**

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's $500 benefit limits are exhausted.

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2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

B. A request for extension of benefits must be received ~~by AFMC~~ within ninety (90) calendar days of the date of benefit limit denial.

~~1. Any requests received beyond the 90-day deadline will not be considered.~~

~~2. AFMC will consider extending benefits in cases of medical necessity if all required documentation is received timely.~~

214.920 Completion of Request Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services." ~~1-15-16~~8-1-21

Requests for extension of benefits for Clinical Services (Physician's visits, Nurse Practitioner visits), Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc.), must be submitted to ~~AFMC~~ DHS or designated vendor for consideration. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.** Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print form DMS-671.**

Complete instructions for accurate completion of form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each provider manual.

214.940 Reconsideration of Extensions of Benefits Denial ~~2-1-05~~8-1-21

A. Any reconsideration request for denial of extension of benefits must be received at AFMC within 30 days of the date of denial notice. The following information is required from providers requesting reconsideration of denial:

1. Return a copy of current NOTICE OF ACTION denial letter with re-submissions.
2. Return all previously submitted documentation as well as additional information for reconsideration.

B. Only one reconsideration is allowed. Any reconsideration request that does not include required documentation will be automatically denied.

C. ~~AFMC reserves the right to request f~~Further clinical documentation shall be requested when ~~as~~ deemed necessary to complete the medical review.

221.000 Procedure for Obtaining Prior Authorization ~~4-1-07~~8-1-21

A. Certain medical and surgical procedures are not covered without prior authorization, because of federal requirements or because of the elective nature of the surgery.

B. ~~Arkansas Foundation for Medical Care, Inc., (AFMC)~~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 to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.**

1. Prior authorization determinations are in accordance with established medical or administrative criteria combined with the professional judgment of ~~AFMC~~ physician advisors.
2. Payment for prior-authorized services is in accordance with federal regulations.

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~~C. Written documentation is not required for prior authorization. However, the patient's records must substantiate the oral information given to AFMC. Any retrospective review of a case will rely on the written record.~~

~~It is the responsibility of the nurse practitioner who will perform the procedure to initiate the prior authorization request. The nurse practitioner or an office nurse must contact AFMC. **View or print AFMC contact information**.~~

~~D. The nurse practitioner or the office nurse must furnish the following specific information to AFMC: (ALL CALLS WILL BE TAPE RECORDED.)~~

~~1. Patient Name and Address~~

~~2. Beneficiary Medicaid Identification Number~~

~~3. Nurse Practitioner Name and License Number~~

~~4. Nurse Practitioner Provider Identification Number~~

~~5. Hospital Name~~

~~6. Date of Service for Requested Procedure~~

~~7. Card Issuance Date for Retroactive Eligibility Authorizations~~

~~E. AFMC will give approval or denial of the request by phone with follow-up in writing. If approved:~~

~~1. AFMC will assign a prior authorization control number that must be entered in the appropriate field in the electronic claim format when billing for the procedure. If surgery is involved, a copy of the authorization will be mailed 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 nurse practitioner or AFMC to verify that prior authorization has been granted.~~

~~2. The Medicaid program will not pay for inpatient hospital services that require prior authorization if the prior authorization has not been requested and approved.~~

~~3. Consulting professionals are responsible for calling AFMC to have their required and/or restricted procedures added to the PA file. They will be given the prior authorization number at the time of the call on those cases that are approved. A letter verifying the PA number will be sent to the consultant upon request.~~

~~F~~C. Prior authorization of service does not guarantee eligibility for a beneficiary. Payment is ~~still~~ subject to verification that the beneficiary is Medicaid-eligible at the time services are provided.

221.100 Post-Procedural Authorization

~~1-15-16~~8-1-21

Post-procedural authorization will be granted only for emergency procedures for beneficiaries age twenty-one (21) and older. Requests for post-authorization of an emergency procedure must be applied for on the first working day after the procedure is performed.

In cases of retroactive eligibility, ~~AFMC must be contacted~~the provider must contact DHS or its designated vendor for post-authorization within sixty (60) days of the eligibility authorization ~~on~~ date displayed in the electronic eligibility verification response.

221.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21

~~1-15-16~~8-1-21

A. Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain a prior authorization number if the beneficiary is under age twenty-one (21).

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B. The following post-procedural authorization process must be followed when obtaining an authorization number.

1. All requests for post-procedural authorizations for eligible beneficiaries are to be made to ~~the Arkansas Foundation for Medical Care, Inc., (AFMC)~~DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.** ~~**View or print AFMC contact information.** These calls will be tape-recorded.~~

2. Out-of-state providers and others without electronic capability may call ~~the Provider Assistance Center~~DHS or its designated vendor to obtain the dates of eligibility. **View or print ~~the Provider Assistance Center~~ contact information to obtain dates of eligibility**.

3. ~~AFMC~~ The provider must supply ~~be given~~ the identifying criteria for the beneficiary and provider and all ~~of the~~ medical data necessary to justify the procedures. ~~As medical information will be exchanged for this procedure, the nurse practitioner or a member of his or her nursing staff must make these calls.~~

~~4. The provider will be issued a PA number at the time of the call if the procedure requested is approved. A follow-up letter will be mailed the same day to the nurse practitioner.~~

~~5~~4. Consultants are responsible for ~~calling AFMC~~DHS or its designated vendor to have their required and/or restricted procedures added to the PA file. They will be given the prior authorization number at the time of ~~the call~~contact on cases that are approved. ~~A letter verifying the PA number will be sent to the consultant upon request. During a call, all patient identification information and medical information related to the necessity of the procedure needing authorization must be provided.~~

~~The Arkansas Medicaid Program continues to recommend that p~~Providers must obtain prior authorization for procedures requiring authorization in order to prevent risk of denial due to lack of medical necessity.

221.200 Prescription Prior Authorization

~~1-15-16~~8-1-21

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a nurse practitioner with prescriptive authority. Certain prescription drugs may require prior authorization. It is the responsibility of the prescriber to request and obtain the prior authorization. Information may be obtained from DHS or its designated vendor.~~Refer to the Arkansas Medicaid Pharmacy website at~~ **~~https://arkansas.magellanrx.com/provider/documents/~~View or print contact information to obtain the DHS or designated vendor prescription drug information ~~for the following information:~~.**

The following information is available:

A. Prescription drugs requiring prior authorization.

B. Criteria for drugs requiring prior authorization.

C. Forms to be competed for prior authorization.

D. Procedures required of the prescriber to request and obtain prior authorization.

252.131 Molecular Pathology

~~1-15-16~~8-1-21

The following Molecular Pathology codes require prior authorization from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-**

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step process for requesting prior authorization.~~the Arkansas Foundation for Medical Care. See Sections 221.000 through 221.300 for prior authorization procedures.~~

81161	81200	81201	81202	81203	81205	81206	81207
81208	81209	81210	81211	81212	81213	81214	81215
81216	81217	81220	81221	81222	81223	81224	81225
81226	81227	81228	81229	81235	81240	81241	81242
81243	81244	81245	81250	81251	81252	81253	81254
81255	81256	81257	81260	81261	81262	81263	81264
81265	81266	81267	81268	81270	81275	81280	81281
81282	81290	81291	81292	81293	81294	81295	81296
81297	81298	81299	81300	81301	81302	81303	81304
81310	81315	81316	81317	81318	81319	81321	81322
81323	81324	81325	81326	81330	81331	81332	81340
81341	81342	81350	81355	81370	81371	81372	81373
81374	81375	81376	81377	81378	81379	81380	81381
81382	81383	81400	81401	81402	81403	81404	81405
81406	81407	81408					

252.453 Fluoride Varnish Treatment

~~8-1-14~~8-1-21

The American Dental Association (ADA) procedure code D1206 is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under the age of twenty-one (21). Topical fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under age twenty-one (21).

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to ~~Provider Enrollment~~DHS or its designated vendor before the specialty code will be added to their file in the MMIS. ~~**View or print the Provider Enrollment contact information.**~~ **View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.** After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code D1206, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code D1206 (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)). **View a form CMS-1500 sample form.**

252.484 Injections, Therapeutic and/or Diagnostic Agents

~~11-1-17~~8-1-21

Nurse practitioners shall administer injections, therapeutic and diagnostic agents in accordance with the rules set forth in the Arkansas Medicaid Physician's policy manual and within the scope of their practice guidelines.

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Providers must obtain prior approval, in accordance with the following procedures for special pharmacy, therapeutic agents and treatments.

A. Before treatment begins, the Medical Director for Clinical Affairs for the Division of Medical Services (DMS) must approve any drug, therapeutic agent or treatment not listed as covered in this provider manual or in official DMS correspondence. This requirement also applies to any drug, therapeutic, agent or treatment with special instructions regarding coverage in the provider manual or in an official DMS correspondence.

B. The Medical Director for Clinical Affairs' prior approval is necessary to ensure approval for medical necessity. Additionally, all other requirements must be met for reimbursement.

1. The provider must submit a history and physical examination with the treatment protocol before beginning the treatment.

2. The provider will be notified by mail of the DMS Medical Director of Clinical Affairs' decision. No prior authorization number is approved if the request is approved, but a prior approval letter is issued and must be attached to each claim. Any changes in treatment require resubmission and a new approval letter. Send requests for a prior approval letter for pharmacy and therapeutic agents to the attention of the Medical Director for Clinical Affairs for the Division of Medical Services located at Arkansas Foundation for Medical Care (AFMC). **View or print AFMC contact information.**

C. Providers billing the Arkansas Medicaid Program for covered injections should bill the appropriate CPT or HCPCS procedure code for the specific injection administered. The procedure codes and their descriptions may be found in the Current Procedure Terminology (CPT) and the Healthcare Common Procedural Coding System Level II (HCPCS) coding books.

D. Injection administration code, T1502 is payable for beneficiaries of all ages.

T1502 may be used for billing the administration of subcutaneous and/or intramuscular injections only. This procedure code cannot be billed when the medication is administered "Orally." No fee is billable for drugs administered orally. **T1502** cannot be billed separately for Influenza virus vaccines or Vaccines for Children (VFC) vaccines.

T1502 cannot be billed to administer any medication given for family planning purposes. NO other fee is billable when the provider decides not to supply family planning injectable medications. **T1502** cannot be billed when the drug administered is not FDA approved.

Most of the covered drugs can be billed electronically. However, any covered drug marked with an asterisk (*) must be billed on paper with the name of the drug and dosage listed in the "Procedures, Services, or Supplies" column Field 24D of the CMS-1500 claim form. **View a CMS-1500 sample form.** If requested, additional documentation may be required to justify medical necessity. Reimbursement for manually priced drugs is based on a percentage of the average wholesale price.

E. Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See Section 252.438.

Administration of therapeutic agents is payable only if provided in a nurse practitioner's office, place of service code "11." These procedures are not payable to the nurse practitioner if performed in any other setting. Therapeutic injections should only be provided by nurse practitioners experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim form. Reimbursement for supplies is included in the administration fee. An administration fee is not allowed when drugs are given orally.

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Use CPT code ranges **96365** through **96379** and **96401** through **96549** for therapeutic and chemotherapy administration procedure codes.

F. For consideration of payable unlisted CPT/HCPCS drug procedure codes:

1. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.

2. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.

3. All other billing requirements must be met in order for payment to be approved.

G. Immunizations

Providers may bill for immunization procedures on the CMS-1500 claim form. **View a CMS-1500 sample form.**

Coverage criteria for all immunizations and vaccines are listed in Part E of this section. Influenza virus vaccines through the Vaccines for Children (VFC) Program are determined by the age of the beneficiary and obviously which vaccine is used.

The administration fee for all vaccines is included in the reimbursement fee for the vaccine CPT procedure code.

H. Vaccines for Children (VFC)

1. The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. Arkansas Medicaid established new procedure codes for billing the administration of VFC immunizations for children under the age of 19 years of age. To enroll in the VFC Program, contact the Arkansas Department of Health. Providers may also obtain the vaccines to administer from the Arkansas Department of Health. **View or print Arkansas Department of Health contact information.**

Medicaid policy regarding immunizations for adults remains unchanged by the VFC Program.

Vaccines available through the VFC Program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ.**

2. ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or print the Department of Health contact information.**

Only a vaccine injection administration fee is reimbursed. When filing claims for administering vaccines for ARKids First-B beneficiaries, providers must use the CPT procedure code for the vaccine administered and the required modifier **SL only** for either electronic or paper claims.

All SCHIP vaccines available to ARKids-First-B beneficiaries are through the Arkansas Department of Health.

I. Billing of Multi-Use and Single-Use Vials

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

1. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.

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2. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

a. Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.

b. Multi-Use Vials: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.

c. Documentation: The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

d. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

J. Process of Obtaining a Prior Authorization Number from Arkansas Foundation for Medical Care (AFMC).

In collaboration with AFMC, DMS is changing the process for acquiring prior approval for drug procedure codes from a prior approval letter to a Prior Authorization number (PA). Instead of attaching a prior approval letter to a paper claim, providers will now list the PA number on the claim. This will mean that effective for claims submitted on and after August 26, 2016, drug procedure codes requiring PA should be billed with the PA number listed on the claim form. These drugs may be billed electronically or on a paper claim. Additionally, these procedure codes requiring a PA will no longer require manual review during the processing of the claim.

As part of the transition, AFMC will send a letter to all providers who have approval letters spanning timeframes within the last 365 days at the times of the effective date of this policy. The letter will contain a PA number and the total remaining number of the approved units that can be billed. Any providers who have questions regarding PA numbers and/or the transition process outlined above can contact AFMC at the following:

Toll Free: 1-877-350-2362, ext. 8741 or (501) 212-8741

A PA number must be requested before treatment is initiated for any drug, therapeutic agent or treatment that indicates a PA is required in a provider manual or an official Division of Medical Services correspondence.

PA requests should be completed using the approved AFMC PA request form and must be submitted by mail, fax or **https://afmc.org/reviewpoint/**. **View or print PA form.**

A decision letter will be returned to the provider by fax or email within five (5) business days.

If approved, the PA number must be appended to all applicable claims within the scope of the approval and may be billed electronically or on a paper claim with additional documentation, when necessary.

Denials will be subject to reconsideration if received by AFMC with additional documentation within fifteen (15) business days of date of the denial letter.

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A reconsideration decision will be returned within five (5) business days of receipt of the reconsideration request.

K. Contact Information for Obtaining Prior Authorization

When obtaining a Prior Authorization from the Arkansas Foundation for Medical Care, please send your request to the following:

In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax – General	(479) 649-0799
Fax – Physician Drug Reviews Only (PDR)	(501) 212-8663
Web portal	**https://afmc.org.reviewpoint/**
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	5111 Rogers Avenue, Suite 476 Fort Smith, AR 72903
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

L. Tables of Payable Procedure Codes

The tables of payable procedure codes are designed with eight columns of information.

1. The **first** column of the list contains the CPT or HCPCS procedure codes.

2. The **second** column indicates any modifiers that must be used in conjunction with the procedure code when billed, either electronically or on paper.

3. The **third** column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years (y) or months (m).

4. The **fourth** column indicates specific ICD primary diagnosis restrictions.

5. The **fifth** column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003/103 detail.

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~~6. The **sixth** column indicates whether a procedure is subject to medical review before payment.~~

~~7. The **seventh** column indicates a procedure code requires a prior authorization before the service is provided. (See Section 220.000 for Prior Authorization instructions.)~~

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
G6015	No	No	No	No	No	No
J0120	No	No	No	003/103	No	No
J0150	No	No	No	No	No	No
NOTE: Maximum units allowed are 4 per day.						
J0151	No	No	No	No	No	No
J0171	No	No	No	No	No	No
J0190	No	No	No	003/103	No	No
J0202	No	No	No	No	No	Yes
J0205	No	No	No	003/103	No	No
J0207	No	No	No	003/103	No	No
J0210	No	No	No	003/103	No	No
J0256	No	No	**View ICD Codes**	No	No	No
J0280	No	No	No	003/103	No	No
J0285	No	No	No	003/103	No	No
J0290	No	No	No	003/103	No	No
J0295	No	No	No	003/103	No	No
J0300	No	No	No	003/103	No	No
J0330	No	No	No	003/103	No	No
J0350	No	No	No	003/103	No	No
J0360	No	No	No	003/103	No	No
J0380	No	No	No	003/103	No	No
J0390	No	No	No	003/103	No	No
J0461	No	No	No	003/103	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0470	No	No	No	003/103	No	No
J0475	No	No	No	No	No	No
J0500	No	No	No	003/103	No	No
J0515	No	No	No	003/103	No	No
J0520	No	No	No	003/103	No	No
J0558	No	No	No	003/103	No	No
J0561	No	No	No	No	No	No
J0585	No	No	No	No	Yes	No
NOTE: Botox A is reviewed for medical necessity based on ICD diagnosis code.						
J0586	No	No	No	No	Yes	No
NOTE: This procedure code is reviewed for medical necessity based on an ICD diagnosis code billed.						
J0595	No	No	No	003/103	No	No
J0600	No	No	No	003/103	No	No
J0610	No	No	No	003/103	No	No
J0620	No	No	No	003/103	No	No
J0630	No	No	No	003/103	No	No
J0636	No	No	**View ICD Codes**.	No	No	No
J0640	No	No	No	003/103	No	No
J0670	No	No	No	003/103	No	No
J0690	No	No	No	003/103	No	No
J0694	No	No	No	003/103	No	No
J0695	No	18y & up	No	No	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0696	No	No	No	003/103	No	No
J0697	No	No	No	003/103	No	No
J0698	No	No	No	003/103	No	No
J0702	No	No	Yes	003/103	No	No
NOTE: Procedure code J0702 is covered for a valid diagnosis code from range (**View ICD Codes**) for complications of pregnancy or List 003/103 for all ages.						
J0710	No	No	No	003/103	No	No
J0713	No	No	No	003/103	No	No
J0714	No	18y & up	No	No	No	No
J0715	No	No	No	003/103	No	No
J0720	No	No	No	003/103	No	No
J0725	No	No	No	003/103	No	No
J0735	No	No	No	003/103	No	No
J0740	No	No	No	003/103	No	No
J0743	No	No	No	003/103	No	No
J0745	No	No	No	003/103	No	No
J0760	No	No	No	003/103	No	No
J0770	No	No	No	003/103	No	No
J0780	No	No	No	003/103	No	No
J0800	No	No	No	003/103	No	No
J0833	No	No	No	No	No	No
J0834	No	No	No	No	No	No
J0850	No	No	No	003/103	No	No
J0875	No	18y & up	No	No	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0881 J0885	No	No	Yes; see below	No	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA

NOTE: Procedure code J0885 is payable to the Nurse Practitioner only when provided in the Nurse Practitioner's office.

For patients on dialysis, use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for a red blood cell transfusion.

When the beneficiary is not on dialysis, use ICD code (**View ICD Codes**).

For all diagnoses, use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for a red blood cell transfusion.

In addition to the primary diagnosis, an ICD diagnosis code from each column below must be billed on the claim.

Column I	Column II	
	Code	**Description**
Secondary Anemia (**View ICD Codes**)	**View ICD Codes**	Encounter for antineoplastic chemotherapy
	View ICD Codes	Following chemotherapy
	View ICD Codes	Antineoplastic and immunosuppressive drugs

Use ICD code (**View ICD Codes**) (primary) with (**View ICD Codes**) (secondary) to represent patients with anemia due to hepatitis C (patients being treated with ribavirin and interferon alfa or ribavirin and peginterferon alfa), myelodysplastic syndrome or rheumatoid arthritis.

Column I	Column II	
	Code	**Description**
Anemia of other chronic disease (**View ICD Codes**)	**View ICD Code**	Chronic Hepatitis C without mention of coma

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0882	No	No	**View ICD Codes**	No	No	No
J0885						
NOTE: See procedure code J0881 in this section for specific criteria.						
J0886	No	No	**View ICD Codes**	No	No	No
J0887	No	21y & up	Yes; see below	No	No	No

NOTE: The primary diagnosis should be (**View ICD Codes**) with a secondary diagnosis of (**View ICD Codes**). For patients with CKD **on dialysis**:

Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL.

If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera.

The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic.

Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary.

J0888	No	21y & up	Yes; see below (**View ICD Codes**)	No	No	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: For patients with CKD **not on dialysis**: Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply: The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.						
J0895	No	No	No	No	No	No
J0900	No	No	No	003/103	No	No
J0945	No	No	No	003/103	No	No
J1000	No	No	No	003/103	No	No
J1020	No	No	No	003/103	No	No
J1030	No	No	No	003/103	No	No
J1040	No	No	No	003/103	No	No
J1050	^	10y & up	^	No	No	No
^ J1050 is covered for therapeutic and family planning services for females only. For therapeutic use, a diagnosis and clinical records must justify the treatment. When billed for family planning, a FP modifier and an ICD family planning diagnosis is required. NOTE: Relative to post occlusion by placement of permanent implants; procedure codes J1050, 11976 and 58301 are payable family planning services for non-sterile females only. All visits related to post-58565 services during the six months following the procedure are included in the allowable fee for the 58565 "procedure." All facility fees for J1050 are bundled under the surgical procedure code if performed on the same date of service.						
J1050	FP	No	No	No	No	No
J1060	No	No	No	003/103	No	No
J1070	No	No	No	003/103	No	No
J1080	No	No	No	003/103	No	No
J1094	No	No	No	003/103	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1100	No	No	Yes	003/103	No	No
NOTE: Procedure code J1100 is covered for a valid diagnosis code from the following range of ICD codes (**View ICD Codes**) for complications of pregnancy or List 003/103 for all ages.						
J1110	No	No	No	003/103	No	No
J1120	No	No	No	003/103	No	No
J1160	No	No	No	003/103	No	No
J1165	No	No	No	003/103	No	No
J1170	No	No	No	003/103	No	No
J1180	No	No	No	003/103	No	No
J1190	No	No	No	003/103	No	No
J1200	No	No	No	003/103	No	No
J1205	No	No	No	003/103	No	No
J1212	No	No	No	003/103	No	No
J1230	No	No	No	003/103	No	No
J1240	No	No	No	003/103	No	No
J1245	No	No	No	003/103	No	No
J1250	No	No	No	003/103	No	No
J1260	No	No	No	003/103	No	No
J1320	No	No	No	003/103	No	No
J1325	No	No	No	003/103	No	No
J1330	No	No	No	003/103	No	No
J1335	No	No	No	003/103	No	No
J1364	No	No	No	003/103	No	No
J1380	No	No	No	003/103	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1410	No	No	No	003/103	No	No
J1435	No	No	No	003/103	No	No
J1436	No	No	No	003/103	No	No
J1442	No	No	No	No	No	No
J1443	No	No	No	No	No	Yes
J1447	No	No	No	No	No	Yes
J1455	No	No	No	003/103	No	No
J1457	No	No	No	003/103	No	No
J1460	No	No	No	No	No	No
J1559	No	4y & up	**View ICD Codes**	No	No	No
J1560	No	No	No	No	No	No
J1561	No	No	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1566	No	No	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1570	No	No	No	003/103	No	No
J1575	No	18y & up	No	No	Yes	No
J1580	No	No	No	00/1033	No	No
J1600	No	No	**View ICD Codes**	No	No	No
J1610	No	No	No	003/103	No	No
J1620	No	No	No	003/103	No	No
J1626	No	No	No	003/103	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1630	No	No	No	003/103	No	No
J1631	No	No	No	003/103	No	No
J1642	No	No	No	003/103	No	No
J1644	No	No	No	003/103	No	No
J1645	No	No	No	003/103	No	No
J1650	No	No	No	No	No	No
J1670	No	No	No	003/103	No	No
J1700	No	No	No	003/103	No	No
J1710	No	No	No	003/103	No	No
J1720	No	No	No	003/103	No	No
J1730	No	No	No	003/103	No	No
J1742	No	No	No	003/103	No	No
J1750	No	No	No	No	No	No
J1786	No	2y & up	**View ICD Codes**	No	No	No
J1790	No	No	No	003/103	No	No
J1800	No	No	No	003/103	No	No
J1810	No	No	No	003/103	No	No
J1815	No	No	No	003/103	No	No
J1830	No	No	No	003/103	No	No
J1833	No	18y & up	No	No	No	No
J1840	No	No	No	003/103	No	No
J1850	No	No	No	003/103	No	No
J1885	No	No	No	003/103	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

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See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1890	No	No	No	003/103	No	No
J1940	No	No	No	003/103	No	No
J1950	No	No	No	003/103	No	No
J1955	No	No	No	003/103	No	No
J1960	No	No	No	003/103	No	No
J1980	No	No	No	003/103	No	No
J1990	No	No	No	003/103	No	No
J2001	No	No	No	003/103	No	No
J2010	No	No	No	003/103	No	No
J2060	No	No	No	003/103	No	No
J2150	No	No	No	003/103	No	No
J2175	No	No	No	003/103	No	No
J2180	No	No	No	003/103	No	No
J2185	No	No	No	003/103	No	No
J2210	No	No	No	003/103	No	No
J2250	No	No	No	003/103	No	No
J2260	No	No	**View ICD Codes**	No	No	No
J2270	No	No	No	003/103	No	No
J2275	No	No	No	003/103	No	No
J2278	No	No	No	003/103	No	No
J2280	No	No	No	003/103	No	No
J2300	No	No	No	003/103	No	No
J2310	No	No	No	003/103	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J2320	No	No	No	003/103	No	No
J2353*	No	No	No	003/103	Yes	No
J2354*	No	No	No	003/103	Yes	No
NOTE: A Prior Approval Letter is required for a diagnosis other than a List 003/103 diagnosis.						
J2360	No	No	No	003/103	No	No
J2370	No	No	No	003/103	No	No
J2400	No	No	No	003/103	No	No
J2405	No	No	No	003/103	No	No
J2407	No	18y & up	No	No	No	No
J2410	No	No	No	003/103	No	No
J2430	No	No	No	003/103	No	No
J2440	No	No	No	003/103	No	No
J2460	No	No	No	003/103	No	No
J2502	No	No	No	No	No	Yes
J2505	No	No	Yes	003/103	Yes	No
NOTE: Procedure code J2505 is payable for beneficiaries of all ages with a detail diagnosis code (**View ICD Codes**). Diagnosis codes (**View ICD Codes**) are covered along with a diagnosis of AIDS or cancer (List 003/103). Diagnosis codes must be shown on the claim form.						
J2510	No	No	No	003/103	No	No
J2515	No	No	No	003/103	No	No
J2540	No	No	No	003/103	No	No
J2547	no	18y & up	**View ICD Codes**	No	No	No
J2550	No	No	No	003/103	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J2560	No	No	No	003/103	No	No
J2590	No	No	No	003/103	No	No
J2597	No	No	No	No	No	No
J2650	No	No	No	003/103	No	No
J2670	No	No	No	003/103	No	No
J2675	No	No	No	003/103	No	No
J2680	No	No	No	003/103	No	No
J2690	No	No	No	003/103	No	No
J2700	No	No	No	003/103	No	No
J2710	No	No	No	003/103	No	No
J2720	No	No	No	003/103	No	No
J2725	No	No	No	003/103	No	No
J2730	No	No	No	003/103	No	No
J2760	No	No	No	003/103	No	No
J2765	No	No	No	003/103	No	No
J2783	No	No	No	003/103	No	No
J2788	No	No	No	No	No	No
J2790	No	No	No	No	No	No
J2800	No	No	No	003/103	No	No
J2820	No	No	No	003/103	No	No
J2860	No	18y & up	No	No	No	Yes
J2910	No	No	View ICD Codes	No	No	No
J2916	No	No	No	No	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

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See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J2920	No	No	No	003/103	No	No
J2930	No	No	No	003/103	No	No
J2950	No	No	No	003/103	No	No
J3000	No	No	No	003/103	No	No
J3010	No	No	No	003/103	No	No
J3030	No	No	No	003/103	No	No
J3070	No	No	No	003/103	No	No
J3090	No	18y & up	No	No	No	No
J3105	No	No	No	003/103	No	No
J3120	No	No	No	003/103	No	No
J3121	No	No	Yes	003/103	No	No
Note: Covered for males only.						
J3130	No	No	No	003/103	No	No
J3140	No	No	No	003/103	No	No
J3150	No	No	No	003/103	No	No
J3230	No	No	No	003/103	No	No
J3240	No	No	No	003/103	No	No
J3250	No	No	No	003/103	No	No
J3260	No	No	No	003/103	No	No
J3265	No	No	No	003/103	No	No
J3280	No	No	No	003/103	No	No
J3301	No	No	No	003/103	No	No
J3302	No	No	No	003/103	No	No
J3303	No	No	No	003/103	No	No

MARKUP

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See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J3305	No	No	No	003/103	No	No
J3310	No	No	No	003/103	No	No
J3320	No	No	No	003/103	No	No
J3350	No	No	No	003/103	No	No
J3360	No	No	No	003/103	No	No
J3364	No	No	No	003/103	No	No
J3365	No	No	No	003/103	No	No
J3370	No	No	No	003/103	No	No
J3380	No	18y – 99y	No	No	No	Yes
J3400	No	No	No	003/103	No	No
J3410	No	No	No	003/103	No	No
J3420	No	No	**View ICD Codes**	No	No	No
J3430	No	No	No	003/103	No	No
J3465	No	No	No	No	No	No
NOTE: Procedure code J3465 is covered for non-pregnant beneficiaries.						
J3470	No	No	No	003/103	No	No
J3475	No	No	No	003/103	No	No
J3480	No	No	No	003/103	No	No
J3485	No	No	No	003/103	No	No
J3490	No	0-99y	No	003/103	No	No
J3520	No	No	No	003/103	No	No
J7121	No	No	No	No	No	No
J7188	No	No	No	No	No	Yes

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7190	No	No	No	No	No	No
J7191	No	No	No	No	No	No
J7192	No	No	No	No	No	No
J7193	No	No	No	No	No	No
J7194	No	No	No	No	No	No
J7195	No	No	No	No	No	No
J7197	No	No	No	No	No	No
J7199*	No	No	No	No	No	No
NOTE: For consideration, procedure code J7199 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.						
J7205	No	No	No	No	No	Yes
J7297*	FP	12y – 65y	No	No	No	No
J7298*	No	12y – 65y	No	**View ICD Codes**	No	No
NOTE: J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.						
J7300	FP	No	No	No	No	No
NOTE: Procedure code J7300 requires modifier FP and is billable by a non-hospital based nurse practitioner. See Section 262.430 for detailed billing information.						
J7301	FP	No	No	No	No	No
NOTE: Procedure code J7301 requires modifier FP and is billable by a non-hospital based nurse practitioner. See Section 262.430 for detailed billing information.						
J7302	No	No	**View ICD Codes**	No	No	No
NOTE: Covered for therapeutic use and treatment of heavy menstrual bleeding in women who have had a child or who have been pregnant.						

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7302	FP	No	No	No	No	No
NOTE: Procedure code J7302 requires modifier FP and is billable by a non-hospital based nurse practitioner.						
J7303	FP	No	No	No	No	No
NOTE: Procedure code J7303 requires modifier FP and is billable by a non-hospital based nurse practitioner. See Section 262.430 for detailed billing information.						
J7310	No	No	No	003/103	No	No
J7328	No	No	No	No	No	Yes
J7501	No	No	No	003/103	No	No
J7504	No	No	No	003/103	No	No
J7505	No	No	No	003/103	No	No
J7506	No	No	No	003/103	No	No
J7507	No	No	No	003/103	No	No
J7509	No	No	No	003/103	No	No
J7510	No	No	No	003/103	No	No
J7513	No	No	No	003/103	No	No
J7518	No	No	No	003/103	No	No
J7599*	No	No	No	No	No	No
NOTE: For consideration, procedure code J7599 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.						
J8530	No	No	No	003/103	No	No
J9000	No	No	No	003/103	No	No
J9010	No	No	No	003/103	No	No
J9015	No	No	No	003/103	No	No
J9017	No	No	No	003/103	No	No
J9020	No	No	No	003/103	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

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See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9031	No	No	No	003/103	No	No
J9032	No	No	No	No	No	Yes
J9035*	No	No	View ICD Codes	No	Yes	No
J9039	No	No	No	No	No	Yes
J9040	No	No	No	003/103	No	No
J9041*	No	No	View ICD Codes	No	Yes	No
J9045	No	No	No	003/103	No	No
J9050	No	No	No	003/103	No	No
J9055*	No	No	View ICD Codes	No	Yes	No
J9060	No	No	No	003/103	No	No
J9065	No	No	No	003/103	No	No
J9070	No	No	No	003/103	No	No
J9098	No	No	No	003/103	No	No
J9100	No	No	No	003/103	No	No
J9120	No	No	No	003/103	No	No
J9130	No	No	No	003/103	No	No
J9150	No	No	No	003/103	No	No
J9165	No	No	No	003/103	No	No
J9171	No	No	No	003/103	No	No
J9178*	No	No	View ICD Codes	003/103	Yes	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

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See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9181	No	No	No	003/103	No	No
J9185	No	No	No	003/103	No	No
J9190	No	No	No	003/103	No	No
J9200	No	No	No	003/103	No	No
J9201	No	No	No	003/103	No	No
J9202	No	No	No	003/103	No	No
J9206	No	No	No	003/103	No	No
J9208	No	No	No	003/103	No	No
J9209	No	No	No	003/103	No	No
J9211	No	No	No	003/103	No	No
J9212	No	No	No	003/103	No	No
J9213	No	No	No	003/103	No	No
J9214	No	No	No	003/103	No	No
J9215	No	No	No	003/103	No	No
J9216	No	No	No	003/103	No	No
J9217	No	No	No	003/103	No	No
J9218	No	No	No	003/103	No	No
J9219	No	No	**View ICD Codes**	No	No	No
NOTE: For male beneficiaries of all ages. Benefit limit is one procedure every 12 months.						
J9230	No	No	No	003/103	No	No
J9245	No	No	No	003/103	No	No
J9250	No	No	No	No	No	No
J9260	No	No	No	003/103	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9263*	No	No	**View ICD Codes**	No	Yes	No
J9265	No	No	No	003/103	No	No
J9266	No	No	No	003/103	No	No
J9267	No	No	No	003/103	No	
J9268	No	No	No	003/103	No	No
J9270	No	No	No	003/103	No	No
J9271	No	No	No	No	No	Yes
J9280	No	No	No	003/103	No	No
J9293	No	No	Yes	No	Yes	No
NOTE: Requires ICD diagnosis code for cancer or ICD diagnosis code (**View ICD Codes**).						
J9299	No	No	No	No	No	Yes
J9305*	No	No	**View ICD Codes**	No	Yes	No
J9308	No	No	No	No	No	Yes
J9320	No	No	No	003/103	No	No
J9340	No	No	No	003/103	No	No
J9355	No	No	No	003/103	No	No
J9360	No	No	No	003/103	No	No
J9370	No	No	No	003/103	No	No
J9390	No	No	No	003/103	No	No
J9600	No	No	No	003/103	No	No
J9999	No	No	No	003/103	Yes	No
NOTE: See Section 252.463 for coverage information.						

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
Q5101	No	No	No	No	No	Yes
Q9980	No	No	No	No	No	Yes
NOTE: Covered for females only						
S0108	No	No	No	003/103	No	No
S0164	No	No	No	003/103	No	No
S0177	No	No	No	003/103	No	No
S0179	No	No	No	003/103	No	No
S0187	No	No	No	003/103	No	No
90281	No	No	No	No	No	No
90283	No	No	No	No	No	No
90284	No	No	No	No	Yes	No
NOTE: 90284 will be approved for payment based on diagnosis code that proves medical necessity.						
90287	No	No	No	No	No	No
90291	No	No	No	No	No	No
90296	No	No	No	No	No	No
90371	No	No	No	No	No	No
NOTE: Hepatitis B Immune Serum Globulin (ISG). One unit equals 1/2 cc with a maximum of 10 units billable per day. Payable for eligible Medicaid beneficiaries of all ages in the nurse practitioner's office, outpatient hospital or dialysis facility.						
90375*	No	No	No	No	No	No
NOTE: Each date of service must be billed on a separate detail. The manufacturer's invoice must be attached along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration. Reimbursement rate includes administration fee.						
90376*	No	No	No	No	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Each date of service must be billed on a separate detail. The manufacturer's invoice must be attached along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration. Reimbursement rate includes administration fee.						
90386	No	No	No	No	No	No
90389	No	0-99y	No	No	No	No
90396	No	0-99y	No	No	No	No
90581*	No	18y & up	No	No	No	No
NOTE: Indicate dose and attach manufacturer's invoice.						
90585	No	0-99y	No	No	No	No
90586	No	18y & up	No	No	No	No
90632	No	19y & up	No	No	No	No
90633	EP, TJ	1y – 18y	No	No	No	No
90633	SL	0 – 18y	No	No	No	No
90633	No	19y – 20y	No	No	No	No
90634	EP, TJ	1y – 18y	No	No	No	No
90634	SL	1y – 18y	No	No	No	No
90634	No	19y – 20y	No	No	No	No
90636	EP, TJ	18y	No	No	No	No
90636	SL	18y	No	No	No	No
90636	No	19y & up	No	No	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

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See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90645	EP, TJ	0 – 18y	No	No	No	No
90645	SL	0 – 18y	No	No	No	No
90645	No	19y & up	No	No	No	No
90646	EP, TJ	0 – 18y	No	No	No	No
90646	SL	0 – 18y	No	No	No	No
90646	No	19y & up	No	No	No	No
90647	EP, TJ	0 – 18y	No	No	No	No
90647	SL	0 – 18y	No	No	No	No
90647	No	19y & up	No	No	No	No
90648	EP, TJ	0 – 18y	No	No	No	No
90648	SL	0 – 18y	No	No	No	No
90649	EP, TJ	9y – 18y	No	No	No	No
90649	SL	9y – 18y	No	No	No	No
90650	EP, TJ	9y – 18y	No	No	No	No
90650	SL	9y – 18y	No	No	No	No
90654	EP, TJ	18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90654	SL	18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

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See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90654	No	19y – 64y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90655	EP, TJ	6m – 35m	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						
90655	SL	6m – 35m	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						
90656	EP, TJ	3y – 18y	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						
90656	SL	3y – 18y	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						
90656	No	19y & up	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						
90657	EP, TJ	6m – 35m	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						
90657	SL	6m – 35m	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						
90658	EP, TJ	3y – 18y	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						
90658	SL	3y – 18y	No	No	No	No

MARKUP

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List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: See Subsections A through H of this section for additional instructions.						
90658	No	19y & up	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						
90660	EP, TJ	2y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90660	SL	2y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90660	No	19y – 49y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90662	No	65y & up	No	No	No	No
90669	EP, TJ	0 – 5y	No	No	No	No
90669	SL	0 – 5y	No	No	No	No
90670	EP, TJ	0 – 5y	No	No	No	No
90670	SL	0 – 5y	No	No	No	No
90672	EP, TJ	2y – 18y	No	No	No	No
90672	SL	2y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90672	No	19y – 49y	No	No	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

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See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90673	EP, TJ	18y	No	No	No	No
90673	SL	18y	No	No	No	No
90673	No	19y – 49y	No	No	No	No
90675*	No	No	No	No	No	No
NOTE: Procedure code 90675 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in Field 24D of claim form CMS-1500 for each date of service. If date spans are used, appropriate units of service must be indicated and must be identified for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.						
90676*	No	No	No	No	No	No
NOTE: Procedure code 90676 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in Field 24D of claim form CMS-1500 for each date of service. If date spans are used, appropriate units of service must be indicated and must be identified for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.						
90680	EP, TJ	6w – 32w	No	No	No	No
90680	SL	6w – 32w	No	No	No	No
90681	EP, TJ	6w – 32w	No	No	No	No
90681	SL	6w – 32w	No	No	No	No
90685	EP, TJ	6m – 35m	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						
90685	SL	6m – 35m	No	No	No	No
NOTE: See Subsections A through H of this section for additional instructions.						

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

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List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90686	EP, TJ	3y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90686	SL	3y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90686	No	19y – 99y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90688	EP, TJ	3y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90688	SL	3y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90688	No	19y & up	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through H of this section for additional instructions.						
90690	No	6y & up	No	No	No	No
90691	No	3y & up	No	No	No	No
90692	No	No	No	No	No	No
90696	EP, TJ	4y – 6y	No	No	No	No
90696	SL	4y – 6y	No	No	No	No
90698	EP, TJ	0 – 4y	No	No	No	No

MARKUP

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See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90698	SL	0 – 4y	No	No	No	No
90703	No	No	No	No	No	No
90704	No	1y & up	No	No	No	No
90705	No	9m & up	No	No	No	No
90706	No	1y & up	No	No	No	No
90707	U1	21y – 44y	No	No	No	No
NOTE: Procedure code 90707 is payable when provided to women of childbearing age, ages 21 through 44, who may be at risk of exposure to these diseases. Coverage is limited to two (2) injections per lifetime. U1 modifier is required for this age group.						
90707	EP, TJ	0 – 18y	No	No	No	No
90707	SL	0 – 18y	No	No	No	No
90707	No	19y – 20y	No	No	No	No
90708	No	0 – 99y	No	No	No	No
90710	EP, TJ	0 – 18y	No	No	No	No
90710	SL	0 – 18y	No	No	No	No
90710	No	0 – 20y	No	No	No	No
90712	No	0 – 20y	No	No	No	No
90713	EP, TJ	0 – 18y	No	No	No	No
90713	SL	0 – 18y	No	No	No	No
90713	No	19y & up	No	No	No	No
90714	EP, TJ	7y – 18y	No	No	No	No
90714	SL	7y – 18y	No	No	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

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List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90714	No	19y & up	No	No	No	No
90715	EP, TJ	7y – 18y	No	No	No	No
90715	SL	7y – 18y	No	No	No	No
90715	No	19y & up	No	No	No	No
90716	EP, TJ	0 – 18y	No	No	No	No
90716	SL	0 – 18y	No	No	No	No
90716	No	0 – 20y	No	No	No	No
90717*	No	No	No	No	No	No
NOTE: Submit invoice with claim.						
90719	No	No	No	No	No	No
90720	EP, TJ	0 – 18y	No	No	No	No
90720	SL	0 – 18y	No	No	No	No
90721	EP, TJ	0 – 18y	No	No	No	No
90721	SL	0 – 18y	No	No	No	No
90721	No	1y – 20y	No	No	No	No
90723	EP, TJ	0 – 18y	No	No	No	No
90723	SL	0 – 18y	No	No	No	No
90725*	No	No	No	No	No	No
NOTE: Submit manufacturer's invoice.						
90727*	No	No	No	No	No	No
NOTE: Submit manufacturer's invoice.						

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

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See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90732	EP, TJ	2y – 18y	No	No	No	No
90732	SL	2y – 18y	No	No	No	No
90732	No	2y & up	No	No	No	No
NOTE: Patients age 21 years and older who receive the injection must be considered by the provider as high risk. All beneficiaries over age 65 may be considered high risk.						
90733	No	No	No	No	No	No
90734	EP, TJ	0 – 18y	No	No	No	No
90734	SL	0 – 18y	No	No	No	No
90734	No	19y & up	No	No	No	No
90735	No	0 – 20y	No	No	No	No
90736	No	60y & up	No	No	No	No
NOTE: Zoster vaccine is benefit limited to once in a lifetime.						
90740	No	No	No	No	No	No
90743	EP, TJ	0 – 18y	No	No	No	No
90743	SL	0 – 18y	No	No	No	No
90744	EP, TJ	0 – 18y	No	No	No	No
90744	SL	0 – 18y	No	No	No	No
90746	No	19y & up	No	No	No	No
90747	EP, TJ	19y & up	No	No	No	No
90747	SL	19y & up	No	No	No	No
90747	No	19y & up	No	No	No	No

MARKUP

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 252.438 for NDC protocol.)

See Section 220.000-222.000 for prior authorization procedures.

See Section 252.484 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 63 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90748	EP, TJ	0—18y	No	No	No	No
90748	SL	0—18y	No	No	No	No
90748	No	19y & up	No	No	No	No
90749*	No	No	No	No	No	No
NOTE: Claim forms for procedure code 90749 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.						
96379	No	No	No	No	No	No
NOTE: Claim forms for procedure code 96379 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.						

Procedure code **T1502** is to be used for "administration only" of IM and/or subcutaneous injections and requires a modifier **U1** when billed electronically or on paper. Procedure code **T1502** must be used when the drug is not supplied by the provider who administers the drug.

MARKUP

TOC not required

203.100 The Nurse Practitioner's Role in the Pharmacy Program 8-1-21

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) which was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the Arkansas Division of Medical Services (DMS) Pharmacy website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes**. Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

An advanced nurse practitioner with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

Prescribers must obtain the latest information regarding prescription drug coverage at the website listed in the contact information for DHS or its designated Pharmacy Vendor. **View or print contact information for the DHS designated Pharmacy Vendor.**

203.600 The Nurse Practitioner's Role in Hospital Services 8-1-21

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)

B. The care and treatment of a patient must be under the direction of a licensed physician, a licensed nurse practitioner, a certified nurse-midwife or dentist with hospital staff affiliation.

C. DHS or its designated vendor reviews all inpatient hospital transfers and all inpatient stays longer than four (4) days for the Medicaid Utilization Management Program (MUMP).

DHS or its designated vendor also completes post-payment reviews of hospital stays for medical necessity determinations. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.**

D. Hospital claims are also subject to review by the Medicaid Peer Review Committee or the Medical Director for the Medicaid Program.

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to nurse practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
2. Nurse practitioners and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
3. Nurse practitioners and hospitals may not bill inpatient services previously denied for lack of medical necessity as outpatient services.

214.510 Laboratory and X-Ray Services Benefit Limits 8-1-21

The Medicaid Program's laboratory and X-ray services benefit limits apply to outpatient laboratory services, radiology services and machine tests.

PROPOSED

A. Medicaid has established a maximum paid amount (benefit limitation) of $500 per state fiscal year (July 1 through June 30) for beneficiaries aged twenty-one (21) and older, for outpatient laboratory and machine tests and outpatient radiology. Exceptions are listed below:

1. There is no lab or X-ray benefit limit for beneficiaries under age twenty-one (21).
2. There is no benefit limit on laboratory services related to family planning. Refer to Section 252.431 of this manual for the family planning-related clinical laboratory procedures.
3. There is no benefit limit on laboratory, X-ray, and machine-test services performed as emergency services, and approved by DHS or its designated vendor for payment as emergency services. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.**
4. The claims processing system automatically overrides benefit limitations for services supported by the following diagnosis:
   a. Malignant Neoplasm (**View ICD Codes.**)
   b. HIV disease and AIDS (**View ICD Codes.**)
   c. Renal failure (**View ICD Codes.**)
   d. Pregnancy* (**View ICD Codes.**)

   *OB ultrasounds and fetal non-stress tests are benefit limited. See Section 214.630 for additional coverage information.

B. Extension of benefit requests are considered for clients who require supportive treatment, such as dialysis, radiation therapy or chemotherapy, for maintaining life.

C. Benefits may be extended for other conditions documented medically necessary.

214.711 Medicaid Utilization Management Program (MUMP) 8-1-21

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care and/or general hospitals, in state and out of state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age one (1), are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday. Refer to item “E” below for the procedure to follow when a child’s first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

A. Medicaid will reimburse hospitals for up to four (4) days of inpatient service with no pre-certification requirement, except for admissions by transfer from another hospital.

B. If the attending nurse practitioner determines the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact DHS or its designated vendor and request an extension of inpatient days.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.

C. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines.

PROPOSED

D. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day (inclusive) of the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.

E. Additional extensions may be requested as needed.

F. Reconsideration reviews of denied extensions may be requested by sending the medical record to AFMC through regular mail, or expedited by overnight express. The hospital will be notified by the next working day of the decision.

G. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However, the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable. All calls will be limited to ten (10) minutes to allow equal access to all providers.

H. Inpatient stays for bone marrow, liver, heart, lung, skin and pancreas and/or kidney transplant procedures are excluded from this review program.

I. A retrospective or post-payment random sample review will be conducted for all admissions, including inpatient stays of four (4) days or less, to ensure that medical necessity for the services is substantiated.

J. Admissions of retroactive eligible beneficiary: If eligibility is identified while the patient is still an inpatient, the hospital may request retrospective review of those days already used past the original four for a determination of post-authorization and concurrent evaluation of future extended days.

If the retroactive eligible beneficiary is not identified until after discharge, and the hospital files a claim and receives a denial for any days past the original four allowed, the hospital may request post-extension evaluation approval of the denied days. If granted, the claim may be refiled. If the length of stay is more than thirty (30) days, the provider shall submit the entire medical record to DHS or its designated vendor for review.

K. Claims submitted without an extension will result in automatic denials of any days billed beyond the fourth day. The only exceptions are for claims reflecting third party liability and patients with retroactive Medicaid eligibility described in items G and J above.

L. If a patient is transferred from one facility to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours of admitting the patient to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider may contact DHS or its designated vendor on the first working day following the weekend or holiday.

M. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure code in order to be reimbursed.

N. If a provider fails to contact DHS or its designated vendor for an extension of inpatient days due to the patient's having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, etc., post-certification of days past the original four days may be obtained by the following procedures:

1. Send a copy of the denial notice received from the third-party payer to DHS or its designated vendor.

PROPOSED

2. Include a note requesting post-certification and the full name of the requester and a phone number where the requester may be reached.

   Upon receipt of the denial copy and the provider request, a coordinator will call the provider and obtain certification information.

O. If a third-party insurer pays for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

214.910 Extension of Benefits for Laboratory and X-Ray Services 8-1-21

A. Requests for extension of benefits for lab and x-ray services must be submitted to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.**

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's $500 benefit limits are exhausted.

2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

B. A request for extension of benefits must be received within ninety (90) calendar days of the date of benefit limit denial.

214.920 Completion of Request Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services." 8-1-21

Requests for extension of benefits for Clinical Services (Physician's visits, Nurse Practitioner visits), Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc.), must be submitted to DHS or designated vendor for consideration. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.** Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print form DMS-671.**

Complete instructions for accurate completion of form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each provider manual.

214.940 Reconsideration of Extensions of Benefits Denial 8-1-21

A. Any reconsideration request for denial of extension of benefits must be received at AFMC within 30 days of the date of denial notice. The following information is required from providers requesting reconsideration of denial:

1. Return a copy of current NOTICE OF ACTION denial letter with re-submissions.

2. Return all previously submitted documentation as well as additional information for reconsideration.

B. Only one reconsideration is allowed. Any reconsideration request that does not include required documentation will be automatically denied.

C. Further clinical documentation shall be requested when deemed necessary to complete the medical review.

221.000 Procedure for Obtaining Prior Authorization 8-1-21

A. Certain medical and surgical procedures are not covered without prior authorization, because of federal requirements or because of the elective nature of the surgery.

PROPOSED

B. 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 to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.**

1. Prior authorization determinations are in accordance with established medical or administrative criteria combined with the professional judgment of physician advisors.
2. Payment for prior-authorized services is in accordance with federal regulations.

C. Prior authorization of service does not guarantee eligibility for a beneficiary. Payment is subject to verification that the beneficiary is Medicaid-eligible at the time services are provided.

221.100 Post-Procedural Authorization 8-1-21

Post-procedural authorization will be granted only for emergency procedures for beneficiaries age twenty-one (21) and older. Requests for post-authorization of an emergency procedure must be applied for on the first working day after the procedure is 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 displayed in the electronic eligibility verification response.

221.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 8-1-21

A. Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain a prior authorization number if the beneficiary is under age twenty-one (21).

B. The following post-procedural authorization process must be followed when obtaining an authorization number.

1. All requests for post-procedural authorizations for eligible beneficiaries are to be made to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**
2. Out-of-state providers and others without electronic capability may call DHS or its designated vendor to obtain the dates of eligibility. **View or print contact information to obtain dates of eligibility**.
3. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.
4. Consultants are responsible for DHS or its designated vendor to have their required and/or restricted procedures added to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

Providers must obtain prior authorization for procedures requiring authorization in order to prevent risk of denial due to lack of medical necessity.

221.200 Prescription Prior Authorization 8-1-21

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a nurse practitioner with prescriptive authority. Certain prescription drugs may require prior authorization. It is the responsibility of the prescriber to request and obtain the prior authorization. Information may be obtained from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor prescription drug information.**

PROPOSED

The following information is available:

A. Prescription drugs requiring prior authorization.

B. Criteria for drugs requiring prior authorization.

C. Forms to be competed for prior authorization.

D. Procedures required of the prescriber to request and obtain prior authorization.

252.131 Molecular Pathology 8-1-21

The following Molecular Pathology codes require prior authorization from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

81161	81200	81201	81202	81203	81205	81206	81207
81208	81209	81210	81211	81212	81213	81214	81215
81216	81217	81220	81221	81222	81223	81224	81225
81226	81227	81228	81229	81235	81240	81241	81242
81243	81244	81245	81250	81251	81252	81253	81254
81255	81256	81257	81260	81261	81262	81263	81264
81265	81266	81267	81268	81270	81275	81280	81281
81282	81290	81291	81292	81293	81294	81295	81296
81297	81298	81299	81300	81301	81302	81303	81304
81310	81315	81316	81317	81318	81319	81321	81322
81323	81324	81325	81326	81330	81331	81332	81340
81341	81342	81350	81355	81370	81371	81372	81373
81374	81375	81376	81377	81378	81379	81380	81381
81382	81383	81400	81401	81402	81403	81404	81405
81406	81407	81408					

252.453 Fluoride Varnish Treatment 8-1-21

The American Dental Association (ADA) procedure code D1206 is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under the age of twenty-one (21). Topical fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under age twenty-one (21).

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to DHS or its designated vendor before the specialty code will be added to their file in the MMIS. **View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.** After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code D1206, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is

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needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code D1206 (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)). View a form CMS-1500 sample form.

252.484 Injections, Therapeutic and/or Diagnostic Agents 8-1-21

Nurse practitioners shall administer injections, therapeutic and diagnostic agents in accordance with the rules set forth in the Arkansas Medicaid Physician's policy manual and within the scope of their practice guidelines.

PROPOSED

TOC not required

200.000 DEFINITIONS

~~1-1-19~~8-1-21

Attributed beneficiaries	The Medicaid beneficiaries for whom primary care physicians and participating practices have accountability under the PCMH program. A primary care physician's attributed beneficiaries are determined by the ConnectCare Primary Care Case Management (PCCM) program. Attributed beneficiaries do not include dual eligible beneficiaries.
Attribution	The methodology by which Medicaid determines beneficiaries for whom a participating practice may receive practice support and incentive payments.
Care coordination	The ongoing work of engaging beneficiaries and organizing their care needs across providers and care settings.
Care coordination payment	Quarterly payments made to participating practices to support care coordination services. Payment amount is calculated per attributed beneficiary, per month.
Default pool	A pool of beneficiaries who are attributed to participating practices that do not meet the requirements in Section 233.000, part A or part B.
Medical neighborhood barriers	Obstacles to the delivery of coordinated care that exist in areas of the health system external to PCMH.
Participating practice	A physician practice that is enrolled in the PCMH program, which must be one of the following: A. An individual primary care physician (Provider Type 01 or 03); B. A physician group of primary care providers who are affiliated, with a common group identification number (Provider Type 02, 04 or 81); C. A Rural Health Clinic (Provider Type 29) as defined in the Rural Health Clinic Provider Manual Section 201.000; or D. An Area Health Education Center (Provider type 69).
Patient-Centered Medical Home (PCMH)	A team-based care delivery model led by Primary Care Physicians (PCPs) who comprehensively manage beneficiaries' health needs with an emphasis on health care value.
Performance-based incentive payments	Performance-based incentive payments are payments made to a shared performance entity for delivery of economic, efficient and quality care.
Performance adjustment	An adjustment to the cost of beneficiary care to account for patient risk.
Performance period	The period of time over which performance is aggregated

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	and assessed.
Petite pool	Pool reserved for practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool.
Pool	A. The beneficiaries who are attributed to one or more participating practice(s) for the purpose of forming a shared performance entity; or B. The action of aggregating beneficiaries for the purposes of performance-based incentive payment calculations (i.e., the action of forming a shared performance entity).
Practice support	Support provided by Medicaid in the form of care coordination payments to a participating practice.
Practice transformation	The adoption, implementation and maintenance of approaches, activities, capabilities and tools that enable a participating practice to serve as a PCMH.
Primary Care Physician (PCP)	See Section 171.000 of the Arkansas Medicaid provider manual.
Provider portal	The website that participating practices use for purposes of enrollment, reporting to the Division of Medical Services (DMS) and receiving information from DMS.
Quality Improvement Plan (QIP)	QIP is a plan of improvement that practices must submit to PCMH Quality Assurance team after receiving notice of attestation failure or validation failure.
Recover	To deduct an amount from a participating practice's future Medicaid receivables, including without limitation, PCMH payments, or fee-for-service reimbursements, to recoup such amount through legal process, or both.
Remediation time	The period during which participating practices that fail to meet deadlines, targets or both on relevant activities and metrics tracked for practice support may continue to receive care coordination payments while improving performance.
Same-day appointment request	A beneficiary request to be seen by a clinician within 24 hours.
Shared performance entity	A PCMH or pooled PCMHs that, contingent on performance, may receive performance-based incentive payments.
State Health Alliance for Records Exchange (SHARE)	The Arkansas Health Information Exchange. For more information, go to ~~http://ohit.arkansas.gov~~SHARE.

212.000 Practice Enrollment

~~1-1-18~~8-1-21

Enrollment in the PCMH program is voluntary and practices must re-enroll annually. To enroll, practices must access the **Advanced Health Information Network (AHIN) provider portal** and submit a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement (DMS-844). ~~The AHIN portal can be accessed at http://www.paymentinitiative.org/enrollment.~~

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Once enrolled, a participating PCMH remains in the PCMH program until:

A. The PCMH withdraws;

B. The practice or provider changes ownership, becomes ineligible, is suspended or terminated from the Medicaid program or the PCMH program; or

C. DMS terminates the PCMH program.

A physician may be affiliated with only one participating practice. A participating practice must update the Department of Human Services (DHS) on changes to the list of physicians who are part of the practice. Physicians who are no longer participating with a practice are required to update in writing via email with the **Fiscal Contractor** ~~at **ARKPCMH@DXC.com**~~ within thirty (30) days of the change.

All practice site locations associated with a PCMH must be listed on the PCMH Program enrollment application. Each site listed on the enrollment application must complete practice support requirements as described in Section 241.000. If a site does not meet deadlines and targets for activities tracked for practice support, then the site must remediate its performance to avoid suspension or termination of practice support for the entire PCMH.

To withdraw from the PCMH program, the participating practice must email a complete and accurate Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846) to the **Fiscal Contractor** ~~**ARKPCMH@DCX.com**~~. View or print the Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846) on **the APII website**. ~~at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**~~ or download the form from the AHIN provider portal.

A practice may return to the PCMH Program beginning on the first day of the following performance year (January 1st) after suspension or termination of practice support. Such application for reinstatement is contingent on documentation of successful implementation of all previously deficient requirements and upon meeting the following requirements:

A. Submitting a complete PCMH Program enrollment application during the designated enrollment period

B. Successful implementation of the activity(s) which the practice failed and which resulted in suspension or termination from the program

Practices who withdraw while on remediation will also have to meet the re-instatement requirements. Successful implementation of the activity(s) will be determined by the Quality Assurance Team.

234.000 Requirements for Joining and Leaving Pools ~~1-1-19~~8-1-21

PCMHs may voluntarily pool for purposes described in Section 233.000 before the end of the enrollment period that precedes the start of the performance period. To pool, the participating practice must email a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form (DMS-845) to the **Fiscal Contractor**~~**ARKPCMH@DXC.com**~~. View or print the Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form on **the APII website**. ~~at **http://www.paymentinitiative.org/pcmh-manual-and-additional-resources**~~. You can also download the form from the AHIN provider portal.

The DMS-845 Pooling form must be executed by all PCMHs participating in the pool. Before the end of the enrollment period, PCMHs that are on their own or through pooling do not reach a minimum of 1,000 attributed beneficiaries will be assigned to the default pool. Practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool will be placed in the petite pool. Individual PCMHs whose attribution changes during the performance

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period will be classified as standalone, default, or petite pool members according to their attribution count at the end of the performance period.

Pooling is effective for a single performance period and must be renewed for each subsequent year.

When a PCMH has voluntarily pooled, its performance is measured in the associated shared performance entity throughout the duration of the performance period unless it withdraws from the PCMH program during the performance period. When a PCMH in a voluntary pool withdraws, is suspended, or otherwise leaves the PCMH program, any and all PCMHs in the shared performance entity will have their performance measured as if the withdrawn or suspended PCMH had never participated in the pool. This provision does not apply to PCMHs that leave the program in the last calendar quarter. If the PCMH leaves the program in the last calendar quarter, the departing PCMH, and its performance will be treated as if the PCMH has not left the program.

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TOC not required

200.000 DEFINITIONS 8-1-21

Attributed beneficiaries	The Medicaid beneficiaries for whom primary care physicians and participating practices have accountability under the PCMH program. A primary care physician's attributed beneficiaries are determined by the ConnectCare Primary Care Case Management (PCCM) program. Attributed beneficiaries do not include dual eligible beneficiaries.
Attribution	The methodology by which Medicaid determines beneficiaries for whom a participating practice may receive practice support and incentive payments.
Care coordination	The ongoing work of engaging beneficiaries and organizing their care needs across providers and care settings.
Care coordination payment	Quarterly payments made to participating practices to support care coordination services. Payment amount is calculated per attributed beneficiary, per month.
Default pool	A pool of beneficiaries who are attributed to participating practices that do not meet the requirements in Section 233.000, part A or part B.
Medical neighborhood barriers	Obstacles to the delivery of coordinated care that exist in areas of the health system external to PCMH.
Participating practice	A physician practice that is enrolled in the PCMH program, which must be one of the following: A. An individual primary care physician (Provider Type 01 or 03); B. A physician group of primary care providers who are affiliated, with a common group identification number (Provider Type 02, 04 or 81); C. A Rural Health Clinic (Provider Type 29) as defined in the Rural Health Clinic Provider Manual Section 201.000; or D. An Area Health Education Center (Provider type 69).
Patient-Centered Medical Home (PCMH)	A team-based care delivery model led by Primary Care Physicians (PCPs) who comprehensively manage beneficiaries' health needs with an emphasis on health care value.
Performance-based incentive payments	Performance-based incentive payments are payments made to a shared performance entity for delivery of economic, efficient and quality care.
Performance adjustment	An adjustment to the cost of beneficiary care to account for patient risk.
Performance period	The period of time over which performance is aggregated

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	and assessed.
Petite pool	Pool reserved for practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool.
Pool	A. The beneficiaries who are attributed to one or more participating practice(s) for the purpose of forming a shared performance entity; or B. The action of aggregating beneficiaries for the purposes of performance-based incentive payment calculations (i.e., the action of forming a shared performance entity).
Practice support	Support provided by Medicaid in the form of care coordination payments to a participating practice.
Practice transformation	The adoption, implementation and maintenance of approaches, activities, capabilities and tools that enable a participating practice to serve as a PCMH.
Primary Care Physician (PCP)	See Section 171.000 of the Arkansas Medicaid provider manual.
Provider portal	The website that participating practices use for purposes of enrollment, reporting to the Division of Medical Services (DMS) and receiving information from DMS.
Quality Improvement Plan (QIP)	QIP is a plan of improvement that practices must submit to PCMH Quality Assurance team after receiving notice of attestation failure or validation failure.
Recover	To deduct an amount from a participating practice's future Medicaid receivables, including without limitation, PCMH payments, or fee-for-service reimbursements, to recoup such amount through legal process, or both.
Remediation time	The period during which participating practices that fail to meet deadlines, targets or both on relevant activities and metrics tracked for practice support may continue to receive care coordination payments while improving performance.
Same-day appointment request	A beneficiary request to be seen by a clinician within 24 hours.
Shared performance entity	A PCMH or pooled PCMHs that, contingent on performance, may receive performance-based incentive payments.
State Health Alliance for Records Exchange (SHARE)	The Arkansas Health Information Exchange. For more information, go to **SHARE**.

212.000 Practice Enrollment 8-1-21

Enrollment in the PCMH program is voluntary and practices must re-enroll annually. To enroll, practices must access the **Advanced Health Information Network (AHIN) provider portal** and submit a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement (DMS-844).

Once enrolled, a participating PCMH remains in the PCMH program until:

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A. The PCMH withdraws;

B. The practice or provider changes ownership, becomes ineligible, is suspended or terminated from the Medicaid program or the PCMH program; or

C. DMS terminates the PCMH program.

A physician may be affiliated with only one participating practice. A participating practice must update the Department of Human Services (DHS) on changes to the list of physicians who are part of the practice. Physicians who are no longer participating with a practice are required to update in writing via email with the **Fiscal Contractor** within thirty (30) days of the change.

All practice site locations associated with a PCMH must be listed on the PCMH Program enrollment application. Each site listed on the enrollment application must complete practice support requirements as described in Section 241.000. If a site does not meet deadlines and targets for activities tracked for practice support, then the site must remediate its performance to avoid suspension or termination of practice support for the entire PCMH.

To withdraw from the PCMH program, the participating practice must email a complete and accurate Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846) to the **Fiscal Contractor**. View or print the Arkansas Patient-Centered Medical Home Withdrawal Form (DMS-846) on **the APII website.**or download the form from the AHIN provider portal.

A practice may return to the PCMH Program beginning on the first day of the following performance year (January 1st) after suspension or termination of practice support. Such application for reinstatement is contingent on documentation of successful implementation of all previously deficient requirements and upon meeting the following requirements:

A. Submitting a complete PCMH Program enrollment application during the designated enrollment period

B. Successful implementation of the activity(s) which the practice failed and which resulted in suspension or termination from the program

Practices who withdraw while on remediation will also have to meet the re-instatement requirements. Successful implementation of the activity(s) will be determined by the Quality Assurance Team.

234.000 Requirements for Joining and Leaving Pools 8-1-21

PCMHs may voluntarily pool for purposes described in Section 233.000 before the end of the enrollment period that precedes the start of the performance period. To pool, the participating practice must email a complete and accurate Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form (DMS-845) to the **Fiscal Contractor**. View or print the Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form on **the APII website**. You can also download the form from the AHIN provider portal.

The DMS-845 Pooling form must be executed by all PCMHs participating in the pool. Before the end of the enrollment period, PCMHs that are on their own or through pooling do not reach a minimum of 1,000 attributed beneficiaries will be assigned to the default pool. Practices with less than 300 attributed beneficiaries that do not wish to participate in a voluntary pool will be placed in the petite pool. Individual PCMHs whose attribution changes during the performance period will be classified as standalone, default, or petite pool members according to their attribution count at the end of the performance period.

Pooling is effective for a single performance period and must be renewed for each subsequent year.

When a PCMH has voluntarily pooled, its performance is measured in the associated shared performance entity throughout the duration of the performance period unless it withdraws from

PROPOSED

the PCMH program during the performance period. When a PCMH in a voluntary pool withdraws, is suspended, or otherwise leaves the PCMH program, any and all PCMHs in the shared performance entity will have their performance measured as if the withdrawn or suspended PCMH had never participated in the pool. This provision does not apply to PCMHs that leave the program in the last calendar quarter. If the PCMH leaves the program in the last calendar quarter, the departing PCMH, and its performance will be treated as if the PCMH has not left the program.

PROPOSED

TOC not required

212.000 Exclusions

8-1-213-14-15

A. Products manufactured by non-rebating pharmaceutical companies.

B. Effective January 1, 2006, the Medicaid agency will not cover any drug covered by Medicare Part D for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

C. The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid beneficiaries under § 1927 (d) of the Social Security Act, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses; with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 CFR § 423.104 (f) (1) (ii) (A),to full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

The following excluded drugs set forth on the **DHS Contracted Pharmacy Vendor website.** ~~on the Arkansas Medicaid Pharmacy website at **https://arkansas.magellanrx.com/provider/documents/** are covered:~~

1. Select agents when used for weight gain
2. Select agents when used for the symptomatic relief of cough and colds
3. Select prescription vitamins and mineral products, except prenatal vitamins and fluoride
4. Select nonprescription drugs
5. Select agents when used to promote smoking cessation

D. Medical accessories are not covered under the Arkansas Medicaid Pharmacy Program. Typical examples of medical accessories are atomizers, nebulizers, hot water bottles, fountain syringes, ice bags and caps, urinals, bedpans, glucose monitoring devices and supplies, cotton, gauze and bandages, wheelchairs, crutches, braces, supports, diapers, and nutritional products.

213.100 Monthly Prescription Limits

8-1-213-14-15

A. Each prescription for all Medicaid-eligible beneficiaries may be filled for up to a maximum ~~thirty-one~~31-day supply. Maintenance medications for chronic illnesses must be prescribed and dispensed in quantities sufficient (not to exceed the maximum 31-day supply per prescription) to effect optimum economy in dispensing. For drugs that are specially packaged for therapy exceeding thirty-one (31) days, the days supply limit (other than thirty one (31)), as approved by the Agency, will be allowed for claims processing. Contact DHS or its Contracted Pharmacy Vendor~~the Pharmacy Help Desk~~ to inquire about specific days supply limits on specially packaged dosage units. **View or print contact information for the DHS Contracted Pharmacy Vendor**. ~~View or print the Magellan Pharmacy Help Desk contact information.~~

B. Each Medicaid-eligible beneficiary age twenty-one (21) years and older is limited to three (3) Medicaid-paid prescriptions per calendar month.

Each prescription filled counts toward the monthly prescription limit except for the following:

1. Family planning items. This includes, but is not limited to, birth control pills, contraceptive foams, contraceptive sponges, suppositories, jellies, prophylactics and diaphragms.

MARKUP

2. Prescriptions for Medicaid-eligible long-term care facility residents. (Prescriptions must be for Medicaid-covered drugs.)

3. Prescriptions for Medicaid-eligible beneficiaries under age twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. (Prescriptions must be for Medicaid-covered drugs.)

216.200 Prescription Benefits for Long-Term Care Facility Residents

~~8-1-21~~3-14-~~15~~

Prescriptions for Medicaid-eligible LTC facility residents are not subject to a monthly prescription limit; however, the drug product must be covered under the Arkansas Medicaid Pharmacy Program. Information is available from DHS or its contracted Pharmacy Vendor. **View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.**~~Refer to the DMS Pharmacy website at **https://arkansas.magellanrx.com/provider/documents/**.~~

218.000 Participating Manufacturer/Distributor Listing

~~8-1-21~~3-14-~~15~~

Due to the importance of maintaining accurate prices in the drug master file, it is necessary that drug companies keep various drug pricing contractors informed of all product and price revisions. The Arkansas Medicaid Program's fiscal agent contracts with a national compendia to provide pricing information. It is the pharmacists' responsibility to contact the ~~Magellan~~ DHS contracted Pharmacy Vendor's Help Desk to determine if a manufacturer's products are listed in the national compendia drug file. ~~**View or print the Magellan Pharmacy Help Desk contact information**~~**View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.**

240.000 PRIOR AUTHORIZATION

~~8-1-21~~10-~~1-16~~

Prescription drugs may be reimbursed under the Arkansas Medicaid Program pursuant to an order from an authorized prescriber.

The prescriber must initiate the prior authorization (PA) for prescription drugs that require PA. The PA request must be completed and submitted by the prescriber. All PA documentation must remain in the patient's chart and will be subject to audit by the Division of Medical Services or its authorized representatives.

In addition, clinical edits will be established through a system modification enhancement, as well as limits placed on drugs based on age, gender, quantity and dosage, as approved by our Drug Utilization Review Board. Lists of all drugs subject to clinical editing and the criteria for reimbursement are~~will be~~ maintained by DHS or its contracted Pharmacy Vendor. **View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.**~~on the Arkansas Medicaid Pharmacy website at **https://arkansas.magellanrx.com/provider/documents/**, as well as the criteria for reimbursement.~~

Arkansas Medicaid Pharmacy Program will maintain a Preferred Drug List based on comparative evidence-based data from Clinical Evidence Reports (CER). Arkansas Medicaid Pharmacy Program will use the CER to identify drug class or drug classes of medications that have similar indications, efficacy, and safety. Arkansas Medicaid will negotiate state supplemental rebates with manufacturers for the identified medication(s) pursuant to a CMS approved State Supplemental Rebate Agreement. A Drug Cost Committee (DCC) will review both State Supplemental and Federal rebates to determine the final net cost to the State of the identified medication(s). A Drug Review Committee (DRC) will review the CER to determine safety and efficacy of the identified medication(s). The DCC and DRC will provide recommendations to the State for preferred and non-preferred status for the identified medication(s). Arkansas Medicaid will use these recommendations to establish and maintain a Preferred Drug List.

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In an emergency, for those drugs for which a five-day supply can be dispensed, an Arkansas Medicaid enrolled pharmacy may dispense up to a five-day supply of a drug that requires prior authorization. This provision applies only in an ***emergency*** situation when the ~~MMA Prescription Drug~~DHS Contracted Pharmacy Vendor Help Desk and the State Medicaid Pharmacy Program offices are closed, and the pharmacist is not able to contact the prescribing provider to change the prescription. The Emergency Supply Policy does not apply to drugs that are not covered by the State. Frequency of the emergency override is limited to once per year per drug class for non-LTC beneficiaries and once per sixty (60) days per drug class for LTC beneficiaries. To file a claim using this emergency provision, the pharmacy provider will submit a "03" in the Level of Service (418-DI) field.

~~Refer to the Arkansas Medicaid Pharmacy website, **https://arkansas.magellanrx.com/provider/documents/**, for the following~~ Prior Authorization information is maintained by DHS or its contracted Pharmacy Vendor. **View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.**~~:~~

The following information is available:

A. Prescription Drug Clinical Edits

B. Prescription Drug Claim Edits

C. Prescription Drug PA Forms

D. VRS System Brochure

E. Evidence-Based Prescription Drug Program

251.200 Brand Medically Necessary Override

~~4-1-17~~8-1-21

The prescriber must determine whether the Medicaid beneficiary meets the required conditions to override an Upper Limit (FUL, SAAC, Generic NADAC). The prescriber must also complete the required MedWatch (see below) documentation to allow a prior authorization (PA) for a "Brand Medically Necessary" override of the Upper Limit to reimburse at the brand name reimbursement rate.

MedWatch is the Food and Drug Administration (FDA) Safety Information and Adverse Event Reporting Program that allows healthcare professionals to report serious problems that they suspect are associated with certain drugs they prescribe.

The following criteria must be met to override the Upper Limit when calculating the allowable amount of reimbursement:

A. For MedWatch drugs, the following conditions are required for approval of a Brand Medically Necessary override:

1. The prescriber shall establish that the beneficiary's condition meets the definition provided for the medical necessity of dispensing any brand name drug when a generic equivalent is available.

   In the context of this policy, "Brand Medically Necessary" is defined as the necessity to prescribe and dispense a brand name medication when use of a generic product has resulted in adverse reaction(s) to the generic, allergic reaction(s) to the generic or therapeutic failure of the generic.

   a. Adverse reaction caused by a generic must meet one of the following criteria:

      i. Life threatening

      ii. Hospitalization

      iii. Disability

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iv. Required intervention to prevent impairment or damage

b. Allergic reaction is defined as when an allergen is present in a generic drug that is not present in a brand drug resulting in a hypersensitive reaction.

c. Therapeutic failure is defined as, clinical failure due to the beneficiary's suboptimal plasma drug concentration for the generic drug when compared to published full pharmacokinetic profiles for the brand name drug.

2. The prescriber shall submit documentation to the **DHS Contracted Pharmacy Vendor** ~~Magellan~~ using the FDA MedWatch and the MedWatch Patient Information Request forms to support dispensing a brand name medication instead of the generic equivalent. ~~The MedWatch Patient Information Request form can be found: **https://arkansas.magellanrx.com/provider/docs/rxinfo/ptrequest.pdf**~~.

3. When a MedWatch drug is approved for a Brand Medically Necessary override, the ~~Magellan~~ **DHS Contracted Pharmacy Vendor** ~~Pharmacy~~ Help Desk will contact the pharmacy provider to inform them of the prior authorization number and the date range of the approved PA.

The PA is given for up to one year for MedWatch Drugs.

All prescriptions must be on file for review by auditors from the Division of Medical Services or their designated agents.

If the criteria stated above are met and the pharmacy claim is submitted with a code of "1" in the dispense as written (DAW) field, the prescription will be priced using the Brand NADAC (or WAC when applicable) for the specific product dispensed rather than the Upper Limit rate.

B. Pharmacy providers can request a review of a specific SAAC associated to a paid claim by completing the AR Medicaid Price Research Request Form and faxing it to the number listed on the form. This form can be found on the **DHS Contracted Pharmacy Vendor website**.~~Arkansas Medicaid Pharmacy website: **https://arkansas.magellanrx.com/provider/docs/rxinfo/AR_Medicaid_SMAC_Price_Research_Request_Form.docx**~~.

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TOC not required

212.000 Exclusions 8-1-21

A. Products manufactured by non-rebating pharmaceutical companies.

B. Effective January 1, 2006, the Medicaid agency will not cover any drug covered by Medicare Part D for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

C. The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid beneficiaries under § 1927 (d) of the Social Security Act, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses; with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 CFR § 423.104 (f) (1) (ii) (A),to full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

The following excluded drugs set forth on the **DHS Contracted Pharmacy Vendor website.**

1. Select agents when used for weight gain
2. Select agents when used for the symptomatic relief of cough and colds
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5. Select agents when used to promote smoking cessation

D. Medical accessories are not covered under the Arkansas Medicaid Pharmacy Program. Typical examples of medical accessories are atomizers, nebulizers, hot water bottles, fountain syringes, ice bags and caps, urinals, bedpans, glucose monitoring devices and supplies, cotton, gauze and bandages, wheelchairs, crutches, braces, supports, diapers, and nutritional products.

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A. Each prescription for all Medicaid-eligible beneficiaries may be filled for up to a maximum 31-day supply. Maintenance medications for chronic illnesses must be prescribed and dispensed in quantities sufficient (not to exceed the maximum 31-day supply per prescription) to effect optimum economy in dispensing. For drugs that are specially packaged for therapy exceeding thirty-one (31) days, the days supply limit (other than thirty one (31)), as approved by the Agency, will be allowed for claims processing. Contact DHS or its Contracted Pharmacy Vendor to inquire about specific days supply limits on specially packaged dosage units. **View or print contact information for the DHS Contracted Pharmacy Vendor**.

B. Each Medicaid-eligible beneficiary age twenty-one (21) years and older is limited to three (3) Medicaid-paid prescriptions per calendar month.

Each prescription filled counts toward the monthly prescription limit except for the following:

1. Family planning items. This includes, but is not limited to, birth control pills, contraceptive foams, contraceptive sponges, suppositories, jellies, prophylactics and diaphragms.
2. Prescriptions for Medicaid-eligible long-term care facility residents. (Prescriptions must be for Medicaid-covered drugs.)

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3. Prescriptions for Medicaid-eligible beneficiaries under age twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. (Prescriptions must be for Medicaid-covered drugs.)

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218.000 Participating Manufacturer/Distributor Listing 8-1-21

Due to the importance of maintaining accurate prices in the drug master file, it is necessary that drug companies keep various drug pricing contractors informed of all product and price revisions. The Arkansas Medicaid Program's fiscal agent contracts with a national compendia to provide pricing information. It is the pharmacists' responsibility to contact the DHS contracted Pharmacy Vendor's Help Desk to determine if a manufacturer's products are listed in the national compendia drug file. **View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.**

240.000 PRIOR AUTHORIZATION 8-1-21

Prescription drugs may be reimbursed under the Arkansas Medicaid Program pursuant to an order from an authorized prescriber.

The prescriber must initiate the prior authorization (PA) for prescription drugs that require PA. The PA request must be completed and submitted by the prescriber. All PA documentation must remain in the patient's chart and will be subject to audit by the Division of Medical Services or its authorized representatives.

In addition, clinical edits will be established through a system modification enhancement, as well as limits placed on drugs based on age, gender, quantity and dosage, as approved by our Drug Utilization Review Board. Lists of all drugs subject to clinical editing and the criteria for reimbursement are maintained by DHS or its contracted Pharmacy Vendor **View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.**

Arkansas Medicaid Pharmacy Program will maintain a Preferred Drug List based on comparative evidence-based data from Clinical Evidence Reports (CER). Arkansas Medicaid Pharmacy Program will use the CER to identify drug class or drug classes of medications that have similar indications, efficacy, and safety. Arkansas Medicaid will negotiate state supplemental rebates with manufacturers for the identified medication(s) pursuant to a CMS approved State Supplemental Rebate Agreement. A Drug Cost Committee (DCC) will review both State Supplemental and Federal rebates to determine the final net cost to the State of the identified medication(s). A Drug Review Committee (DRC) will review the CER to determine safety and efficacy of the identified medication(s). The DCC and DRC will provide recommendations to the State for preferred and non-preferred status for the identified medication(s). Arkansas Medicaid will use these recommendations to establish and maintain a Preferred Drug List.

In an emergency, for those drugs for which a five-day supply can be dispensed, an Arkansas Medicaid enrolled pharmacy may dispense up to a five-day supply of a drug that requires prior authorization. This provision applies only in an ***emergency*** situation when the DHS Contracted Pharmacy Vendor Help Desk and the State Medicaid Pharmacy Program offices are closed, and the pharmacist is not able to contact the prescribing provider to change the prescription. The Emergency Supply Policy does not apply to drugs that are not covered by the State. Frequency of the emergency override is limited to once per year per drug class for non-LTC beneficiaries and once per sixty (60) days per drug class for LTC beneficiaries. To file a claim using this emergency provision, the pharmacy provider will submit a "03" in the Level of Service (418-DI) field.

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Prior Authorization information is maintained by DHS or its contracted Pharmacy Vendor. **View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.**

The following information is available:

A. Prescription Drug Clinical Edits

B. Prescription Drug Claim Edits

C. Prescription Drug PA Forms

D. VRS System Brochure

E. Evidence-Based Prescription Drug Program

251.200 Brand Medically Necessary Override 8-1-21

The prescriber must determine whether the Medicaid beneficiary meets the required conditions to override an Upper Limit (FUL, SAAC, Generic NADAC). The prescriber must also complete the required MedWatch (see below) documentation to allow a prior authorization (PA) for a "Brand Medically Necessary" override of the Upper Limit to reimburse at the brand name reimbursement rate.

MedWatch is the Food and Drug Administration (FDA) Safety Information and Adverse Event Reporting Program that allows healthcare professionals to report serious problems that they suspect are associated with certain drugs they prescribe.

The following criteria must be met to override the Upper Limit when calculating the allowable amount of reimbursement:

A. For MedWatch drugs, the following conditions are required for approval of a Brand Medically Necessary override:

1. The prescriber shall establish that the beneficiary's condition meets the definition provided for the medical necessity of dispensing any brand name drug when a generic equivalent is available.

   In the context of this policy, "Brand Medically Necessary" is defined as the necessity to prescribe and dispense a brand name medication when use of a generic product has resulted in adverse reaction(s) to the generic, allergic reaction(s) to the generic or therapeutic failure of the generic.

   a. Adverse reaction caused by a generic must meet one of the following criteria:
      i. Life threatening
      ii. Hospitalization
      iii. Disability
      iv. Required intervention to prevent impairment or damage

   b. Allergic reaction is defined as when an allergen is present in a generic drug that is not present in a brand drug resulting in a hypersensitive reaction.

   c. Therapeutic failure is defined as, clinical failure due to the beneficiary's suboptimal plasma drug concentration for the generic drug when compared to published full pharmacokinetic profiles for the brand name drug.

2. The prescriber shall submit documentation to the **DHS Contracted Pharmacy Vendor** using the FDA MedWatch and the MedWatch Patient Information Request forms to support dispensing a brand name medication instead of the generic equivalent.

3. When a MedWatch drug is approved for a Brand Medically Necessary override, the **DHS Contracted Pharmacy Vendor** Help Desk will contact the pharmacy provider to

PROPOSED

inform them of the prior authorization number and the date range of the approved PA.

The PA is given for up to one year for MedWatch Drugs.

All prescriptions must be on file for review by auditors from the Division of Medical Services or their designated agents.

If the criteria stated above are met and the pharmacy claim is submitted with a code of "1" in the dispense as written (DAW) field, the prescription will be priced using the Brand NADAC (or WAC when applicable) for the specific product dispensed rather than the Upper Limit rate.

B. Pharmacy providers can request a review of a specific SAAC associated to a paid claim by completing the AR Medicaid Price Research Request Form and faxing it to the number listed on the form. This form can be found on the **DHS Contracted Pharmacy Vendor website**..

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TOC required

203.170 Physician's Role in Hospital Services

~~9-15-12~~8-1-21

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations.

B. The care and treatment of a patient must be under the direction of a licensed physician or dentist with hospital staff affiliation. Most inpatient admissions require a PCP referral. (Refer to Section I of this manual.)

C. ~~Arkansas Foundation for Medical Care, Inc., (AFMC) is the Medicaid agency's Quality Improvement Organization (QIO) for physicians and hospital services.~~

~~1.~~ ~~AFMC~~ DHS or its designated vendor reviews all inpatient hospital transfers and all inpatient stays longer than four (4) days~~reviews~~ for the Medicaid Utilization Management Program~~, all inpatient hospital transfers and all inpatient stays longer than four days.~~.

~~2.~~ DHS or its designated vendor~~The QIO~~ also ~~performs~~completes post-payment reviews of hospital stays of any length for medical necessity determinations. **View or print DHS or designated vendor contact information to obtain MUMP information.**

D. Hospital claims are also subject to review by the Division of Medical Services Medical Director for Clinical Affairs for the Medicaid Program.

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
2. Practitioners and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
3. Practitioners and hospitals may not bill as outpatient services, inpatient services previously denied for lack of medical necessity.
4. Refer to Sections I and III of this manual for Medicare deductible and coinsurance information.

203.230 Physician's Role in the Pharmacy Program

8-1-21~~12-18-15~~

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the DHS or designated pharmacy vendor website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

Prescribers must obtain the latest information regarding prescription drug coverage from the~~Prescribers must refer to the website at~~ **~~https://arkansas.magellanrx.com/provider/documents/~~DHS contracted Pharmacy Vendors website. View or print DHS contracted Pharmacy vendor contact information.**~~to obtain the latest information regarding prescription drug coverage.~~

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220.000 Benefit Limits

8-1-21~~7-1-15~~

Benefit limits are the limits on the *quantity* of covered services Medicaid-eligible beneficiaries may receive. Medicaid-eligible beneficiaries are responsible for payment for services beyond the established benefit limits, unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit

If a service is denied for exceeding the benefit limit, and the Medicaid beneficiary had elected to receive the service by written informed consent prior to the delivery of the service, the Medicaid beneficiary is responsible for the payment, unless that service has been deemed not medically necessary.

Benefit extensions are considered after the service has been rendered and the provider has received a denial for "benefits exhausted." DMS considers requests for benefit extensions based on the medical necessity of the service. If a Medicaid provider chooses to file for an extension of benefits and is denied due to the service not being medically necessary, the beneficiary is not responsible for the payment. Once the extension of benefits request has been initiated on a ~~particular~~ specific service, the provider cannot abort the process before a final decision is rendered.

Please see Section 229.000 through Section 229.120 and Section 131.000 points A and C for benefit extension request procedures. DMS reviews extension of benefits requests for Home Health, personal care, diapers and medical supplies. ~~AFMC~~ DHS or its designated vendor reviews extension of benefits requests for physician, lab, radiology and machine tests, using form DMS-671. All personal care services for beneficiaries under age 21 are reviewed by the contracted Quality Improvement Organization (QIO). **~~View or print AFMC contact information.~~View or print contact information for DHS or its designated vendor regarding benefit limits.**

224.200 Medicaid Utilization Management Program (MUMP)

8-1-21~~10-13-03~~

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient, general and rehabilitative hospitals, in state and out-of-state. The MUMP does not apply to lengths of stay in psychiatric facilities.

Length-of-stay determinations are made by DHS or the Quality Improvement Organization (QIO), ~~Arkansas Foundation for Medical Care, Inc. (AFMC),~~ under contract to the Arkansas Medicaid Program.

224.210 MUMP Applicability

8-1-21~~10-13-03~~

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer (see part B, below). If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified by ~~AFMC~~DHS or its designated vendor.

B. When a patient is transferred from one hospital to another, the stay must be certified from the first day.

224.310 Direct Admissions

8-1-21~~4-1-07~~

~~A. When the attending physician determines the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact AFMC and request an extension of inpatient days. The following information is required:~~

MARKUP

~~1. Patient name and address (including zip code)~~

~~2. Patient birth date~~

~~3. Patient Medicaid number~~

~~4. Admission date~~

~~5. Hospital name~~

~~6. Hospital provider identification number~~

~~7. Attending physician provider identification number~~

~~8. Principal diagnosis and other diagnoses influencing this stay~~

~~9. Surgical procedures performed or planned~~

~~10. The number of days being requested for continued inpatient care~~

~~11. All available medical information justifying or supporting the necessity of continued stay in the hospital.~~

A. ~~B.~~ **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient days.** ~~AFMC may be contacted between 8:30 a.m. and 5:00 p.m., Monday through Friday, except holidays.~~ **~~View or print AFMC contact information.~~** ~~Calls are limited to 10 minutes to allow equal access to all providers.~~

~~C.~~ Calls for extension of days may be made at any time during the inpatient stay (except in the case of a transfer from another hospital - refer to Section 224.320).

~~1. However, p~~Providers initiating their request after the fourth day must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services.

~~2.~~ If the provider delays calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable.

~~3. If the fifth day of admission falls on a Saturday, Sunday or holiday, it is recommended that the hospital provider call for an extension prior to the fifth day if the physician has recommended a continued stay.~~

~~D~~B. When a Medicaid client reaches age one (1) during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the Medicaid Utilization Management Program (MUMP) policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day following the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.

~~E~~C. ~~AFMC~~ DHS or its designated vendor utilizes Medicaid guidelines and the medical judgment of its professional staff to determine the number of days to allow.

~~F. AFMC assigns an authorization number to an approved extension request and sends written notification to the hospital.~~

~~G~~D. Additional extensions may be requested as needed.

~~H~~E. The certification process under the MUMP is separate from prior authorization requirements. Prior authorization for medical procedures thus restricted must be obtained

MARKUP

by the appropriate providers. Hospital stays for restricted procedures may be disallowed if required prior authorizations are not obtained.

~~I~~F. Out-of-state claims (claims from providers in non-bordering states) are subject to the determination for medical necessity for out-of-state treatment. In addition, the claim and records will be reviewed retrospectively for lengths of stay beyond the four (4) days allowed.

~~J~~G. Claims submitted without ~~calling for~~ an approved extension request will result in automatic denials of any days billed beyond the fourth day. ~~There will be n~~No exceptions will be granted except for claims reflecting third party liability.

224.320 Transfer Admissions

~~8-1-21~~~~10-13-03~~

If a patient is transferred from one hospital to another, the receiving facility must contact ~~AFMC~~ DHS or its designated vendor within twenty-four (24) hours of admitting the patient to certify the inpatient stay. ~~If admission falls on a weekend or holiday, the provider may contact AFMC on the first working day following the weekend or holiday.~~**View or print contact information to obtain the DHS or designated vendor step-by-step process to request certification**.

224.330 Retroactive Eligibility

~~8-1-21~~~~10-13-03~~

A. If eligibility is determined while the patient is still an inpatient, the hospital may ~~call to~~ request post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed.

B. If eligibility is determined after discharge the hospital may ~~call AFMC~~ contact DHS or its designated vendor for post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer). If certification sought is for a stay longer than thirty (30) days, the provider must submit the entire medical record ~~to AFMC~~ for review.

224.340 Third Party and Medicare Primary Claims

~~8-1-21~~~~10-13-03~~

A. If a provider has not requested Medicaid Utilization Management Program (MUMP) certification of inpatient days because there is apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification required by the MUMP may be obtained. **View or print contact information to obtain the DHS or designated vendor step-by-step process**. ~~as follows:~~

~~1. Send a copy of the third party payer's denial notice to AFMC.~~ **~~View or print AFMC contact information.~~** ~~Include a written request for post-certification.~~

~~2. Include complete provider contact information: full name and title, telephone number and extension.~~

~~3. An AFMC coordinator will call the provider contact for the certification information.~~

B. If a third~~-~~party insurer pays the provider for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

224.350 Requests for Reconsideration

~~8-1-21~~~~10-13-03~~

Reconsideration reviews of denied extensions may be requested by sending the medical record to ~~AFMC~~ DHS or its designated vendor. ~~through regular mail or expedited by overnight express. AFMC will advise t~~The hospital will be advised of ~~its~~the reconsideration decision by the next working day.

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~~View or print AFMC contact information.~~**View or print contact information to obtain the DHS or designated vendor step-by-step process for reconsideration requests.**

229.100 Extension of Benefits for Laboratory and X-Ray, Physician Office and Outpatient Hospital Services

~~8-1-21~~~~2-1-05~~

A. Requests for extension of benefits for laboratory and x-ray, physician and outpatient services must be ~~mailed~~ submitted to ~~Arkansas Foundation for Medical Care, Inc. (AFMC), Attention EOB Review~~**~~. View or print the Arkansas Foundation for Medical Care, Inc. contact information.~~** DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.**

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit ~~with the request~~ a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.

B. A request for extension of benefits must be received ~~by AFMC~~ within ninety (90) calendar days of the date of benefits-exhausted denial.

~~1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.~~

~~2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. *Do not* send a claim.~~

229.110 Completion of Request Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services"

~~8-1-21~~~~7-1-07~~

Requests for extension of benefits for Clinical Services (Physician's Visits), Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc-), must be submitted to ~~AFMC~~ DHS or its designated vendor for consideration. **View or print contact information to obtain the DHS or designated vendor step-by-step process to complete request.** Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print form DMS-671.**

~~Complete i~~**Instructions for accurate completion of form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.**

229.130 Administrative Reconsideration of Extensions of Benefits Denial

~~8-1-21~~~~2-1-06~~

A. A request for administrative reconsideration of an extension of benefits denial must be in writing and ~~sent to AFMC~~submitted to DHS or its designated vendor within thirty (30) calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation pursuant to Section 229.120.

B. The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of ~~this~~ the manual. A request received ~~by AFMC~~ within thirty-five (35) calendar days of a denial will be deemed timely. A request received later than thirty-five (35) calendar days gives rise to a rebuttable presumption that it is not timely.

229.210 Process for Requesting Extended Therapy Services

~~8-1-21~~~~1-1-09~~

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A. Requests for extended therapy services for beneficiaries under age twenty-one (21) must be ~~mailed~~ submitted to ~~the Arkansas Foundation for Medical Care, Inc. (AFMC)~~DHS or its designated vendor. **~~View or print the Arkansas Foundation for Medical Care, Inc. contact information~~View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services.** ~~Requests must be mailed and will not be accepted via facsimile or email.~~ The request must meet the medical necessity requirement, and adequate documentation must be provided to support ~~this~~ the request.

1. Requests for extended therapy services are considered only after a claim is denied because a benefit is exceeded.
2. The request must be received ~~by AFMC~~ within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit ~~with the request~~ a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

~~4. AFMC will not accept requests sent via electronic facsimile (FAX) or e-mail.~~

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. **View or print form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted provided it ~~is in compliance with~~complies Arkansas Code 25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

C. ~~AFMC~~ DHS or its designated vendor will approve, deny, or ask for additional information within 30 calendar days of receiving the request. ~~AFMC r~~Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with information specific to the approval.~~an authorization number that is required to be submitted with the billing for the approved services.~~

229.230 ~~AFMC~~ Extended Therapy Services Review Process ~~8-1-21~~1-1-09

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services.~~The following is a step-by-step outline of AFMC's extended services review process:~~

~~A. Requests received via mail are screened for completeness and researched to determine the beneficiary's eligibility for Medicaid when the service was provided and payment/denial status of the claim request.~~

~~B. The documentation submitted is reviewed by a registered nurse (R.N.). If, in the judgment of the R.N., the documentation supports the medical necessity, they may approve the request. An approval letter is generated and mailed to the provider the following day.~~

~~C. If the R.N. reviewer determines the documentation does not justify the service or it appears the service is not medically necessary, they will refer the case to the appropriate physician adviser for a decision.~~

~~D. The physician adviser's rationale for approval or denial is entered into the system and the appropriate notification is created. If services are denied for lack of medical necessity justification, the physician adviser's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.~~

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~~E. Providers may request administrative reconsideration of an adverse decision or they may appeal as provided in Section 160.000 of this manual.~~

~~F. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the R.N. may approve the extension of benefits without referral to a physician adviser.~~

~~G. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to lack of proof of medical necessity or the documentation does not allow for approval by the R.N., the original documentation, reason for the denial and new information submitted will be referred to a different physician adviser for reconsideration.~~

~~H. All parties will be notified in writing of the outcome of the reconsideration. Reconsiderations approved generate an approval number and is mailed to the provider for inclusion with billing for the requested service. Adverse decisions that are upheld through the reconsideration remain eligible for an appeal by the provider and/or the beneficiary as provided is Section 160.000 of this manual.~~

229.240 Administrative Reconsideration

~~8-1-21 1-1-09~~

A request for administrative reconsideration of the denial of services must be in writing and sent to ~~AFMC~~ DHS or its designated vendor within thirty (30) calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of ~~this~~ the Arkansas Medicaid manual. A request received by ~~AFMC~~ DHS or its designated vendor within thirty-five (35) calendar days of a denial will be deemed timely. ~~Reconsideration requests must be mailed and will not be accepted via facsimile or email.~~

251.110 Assistant Surgery

~~8-1-21 2-1-06~~

For medical payment to be made to an assistant surgeon, the physician who wishes to use an assistant surgeon must obtain prior authorization from the ~~Arkansas Foundation for Medical Care (AFMC)~~DHS or its designated vendor. Assistant surgeon services are reimbursed only when provided by a physician. See Section 261.000 of this manual for prior authorization instructions. This provision applies to all surgery.

251.220 Elective Abortions

~~8-1-21 11-1-17~~

Only medically necessary abortions are covered by Arkansas Medicaid. Federal regulations prohibit expenditures for abortions except when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest, defined under Ark. § Code Ann. 5-14-103 and § 5-22-202, as certified in writing by the woman's attending physician.

A. All abortions require prior authorization. A Certification Statement for Abortion (DMS-2698) must be completed prior to performing the procedure and is required for requesting prior authorization and billing. **View or print form DMS-2698**.

B. Other required documentation includes patient history and physical exam records. The physician performing the abortion is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes. Refer to Section 292.410 for other billing instructions.

C. For abortions when the life of the mother would be endangered if the fetus were carried to term, prior authorization (PA) requests must be made to ~~Arkansas Foundation for Medical Care, Inc. (AFMC)~~DHS or its designated vendor. **View or print contact information to**

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obtain the DHS or designated vendor step-by-step process for requesting a review.~~View or print AFMC contact information.~~ ~~Refer to Section 261.100 for instructions for requesting PA from AFMC.~~

D. Abortions for pregnancy resulting from rape or incest must be prior authorized by the Division of Medical Services Utilization Review Section**. View or print the Utilization Review contact information.** Refer to Section 261.260 for instructions on requesting PA ~~from the Division of Medical Services Utilization Review Section~~.

E. Payable Abortion Procedure Codes

1. For Professional or Outpatient Abortion Claims, the following codes are required:

01966	59840	59841	59850
59851	59852	59855	59856
59857			

2. For inpatient hospital facility Abortion Claims, the provider must use the following codes:
   a. 10A00ZZ – Abortion of Products of Conception, Open Approach
   b. 10A03ZZ – Abortion of Products of Conception, Percutaneous Approach
   c. 10A07Z6 – Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
   d. 10A07ZW – Abortion of Products of Conception, Laminaria, Via Natural or Artificial Opening
   e. 10A07ZX – Abortion of Products of Conception, Abortifacient, Via Natural or Artificial Opening
   f. 10A07ZZ – Abortion of Products of Conception, Via Natural or Artificial Opening

251.230 Cochlear Implant and External Sound Processor Coverage Policy ~~8-1-21~~ ~~9-15-12~~

The Arkansas Medicaid Program provides coverage for cochlear implantation and the external sound processor for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. (See Section 261.120 for prior authorization requirements and Section 292.801 for billing protocol.)

A. Cochlear Implants

Cochlear Implants are covered through the Arkansas Medicaid Physician or Prosthetics Program for eligible Medicaid beneficiaries under the age of twenty-one (21) years through the Child Health Services (EPSDT) Program when prescribed by a physician.

The cochlear implant device, implantation procedure, the sound processor and other necessary devices for use with the cochlear implant device require *prior authorization* from ~~AFMC~~DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.** ~~Refer to Sections 261.100 and 261.120 of this manual for prior authorization procedures.~~

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components or a

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switch from a body worn, external sound processor to a behind-the-ear (BTE) model or technological advances in hardware, are considered not medically necessary and will not be approved.

2010 Codes	Modifier	Age Restriction	Manually Priced	Review	PA
L8627*	EP	0-20	Yes	No	Yes
L8628 *	EP	0-20	Yes	No	Yes
L8629*	EP	0-20	Yes	No	Yes

*Denotes paper claim required

B. Speech Processor

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processor will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional medical documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

C. Personal FM Systems

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available by any other source (i.e., educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

A Request for Prior Authorization may be submitted for medically necessary FM systems **(procedure code V5273 for use with cochlear implant)** that are not covered through IDEA; each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

D. Replacement, Repair, Supplies

The repair and/or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

251.300 Organ Transplants

8-1-213-15-05

A. All organ transplants require prior approval.

1. Medicaid covers bone marrow, corneal, heart, kidney, liver and lung transplants for eligible Medicaid beneficiaries of all ages.

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2. Medicaid covers pancreas/kidney transplants and skin transplants for burns for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program.

3. ~~Effective for dates of service on and after December 3, 2004,~~ Medicaid covers liver/bowel transplants for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program.

B. Medicaid covers physicians' inpatient services only on days that Medicaid covers the hospital's inpatient services; therefore, ~~it is important that physicians know that~~ inpatient hospital stays for corneal, kidney, pancreas/kidney and skin transplants are all subject to Medicaid Utilization Management Program~~—~~ (MUMP~~—~~) precertification.

C. Additionally, for inpatient stays related to all other transplants:

1. Hospital days in excess of transplant length of stay averages require medical review and approval by ~~the Quality Improvement Organization (QIO), which is AFMC~~DHS or its designated vendor.

2. ~~AFMC's r~~Reference sources for organ transplant length-of-stay (LOS) averages are the Centers for Medicare and Medicaid Services (CMS) Acute Inpatient Prospective Payment System (PPS) – using the "Arithmetic Mean LOS" method – ~~and/~~or the most recently published Medicare National Coverage Decisions.

D. ~~Physicians are reminded that p~~Post-operative care (inpatient ~~and/~~or outpatient) for ten (10) days is included in Medicaid's coverage of each transplant procedure. In the sections that follow, references to "post-operative care" and "follow-up care" ~~presume the reader's understanding of~~includes the ten (10)-day post-operative care rule.

E. Refer to Sections 261.100 and 261.230 for prior approval procedures.

F. Refer to Sections 292.820 through 292.832 for billing instructions.

251.303 Heart Transplants

~~8-1-213-15-05~~

A. Medicaid covers heart transplants for beneficiaries of all ages.

B. Covered physician services related to the transplant include:

1. Transplanting the heart into the receiver.

2. Postoperative care.

C. Heart transplants are exempt from the Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published Medicare National Coverage Decisions ~~and/~~or DHS or its designated vendor's~~AFMC~~ medical review. Refer to Section 251.300, part C.

251.304 Liver and Liver/Bowel Transplants

~~8-1-2110-1-06~~

A. Medicaid covers liver transplants for beneficiaries of all ages.

B. Medicaid covers liver/bowel transplants for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program.

C. Covered physician services related to the transplant include:

1. The surgical procedure to remove a partial liver from a living donor (when applicable).

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2. Physician services for transplanting the liver into the receiver.
3. Postoperative care (including postoperative care for the living donor of a partial liver, when applicable).

D. Liver and liver/bowel transplants are exempt from the Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published Medicare National Coverage Decisions ~~and/~~or DHS or its designated vendor's~~AFMC medical review~~. Refer to Section 251.300, part C.

251.306 Lung Transplants

~~8-1-213-15-05~~

A. Medicaid covers lung transplants for beneficiaries of all ages.

B. The following list of medical diagnoses or diseases are those in which it is believed patients could benefit significantly from a lung transplant when it has been determined the disease has reached an end-stage cycle or level:

1. Pulmonary Vascular Disease
2. Primary Pulmonary Hypertension
3. Eisenmenger's Syndrome (ASD, VSD, PVA, Truncus, Other Complex Anomalies)
4. Pulmonary Hypertension secondary to Thromboembolism
5. Obstructive Lung Disease
6. Emphysema (idiopathic)
7. Emphysema (alpha antitrypsin deficiency)
8. Bronchopulmonary Dysplasia
9. Post-~~-~~Transplant Obliterative Bronchiolitis
10. Bronchiolitis Obliterans Organizing Pneumonia (BOOP)
11. Restrictive Lung Disease
12. Idiopathic Pulmonary Fibrosis
13. Sarcoidosis
14. Asbestosis
15. Eosinophilic Granulomatosis
16. Desquamative Interstitial Pneumonitis
17. Lymphangioleiomyomatosis

C. Covered physician services related to the transplant include:

1. Transplanting the organ into the receiver.
2. Postoperative care.

D. Lung transplants are exempt from the Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published Medicare National Coverage Decisions ~~and/~~or DHS or its designated vendor's~~AFMC~~ medical review. Refer to Section 251.300, part C.

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254.000 Enterra Therapy for Treatment of Gastroparesis

8-1-21~~10-1-15~~

A. ~~Effective for dates of service on and after March 1, 2005,~~ Arkansas Medicaid covers Enterra, implantable neurostimulator therapy.

B. Coverage of Enterra therapy is limited to individuals ages eighteen (18) through sixty-nine (69) with diabetic and idiopathic gastroparesis (View ICD Codes.).

1. Service includes the implantable neurostimulator electrode(s) and the neurostimulator pulse generator.

2. Implantation procedures for neurostimulator pulse generator and the neurostimulator electrodes are covered as inpatient surgical procedures.

a. The surgical procedures require prior authorization (PA) by DHS or its designated vendor~~AFMC~~.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.

b. An approval letter from the Institutional Review Board is required. Patient's record must include documentation that further total parental nutrition (TPN) therapy is not an option.

3. Procedure for revision or removal of the peripheral neurostimulator electrodes does not require PA, but claim will be manually reviewed prior to reimbursement.

C. See Section 292.880 of this manual for procedure codes and billing instructions.

257.000 Tobacco Cessation Products and Counseling Services

8-1-21~~2-1-20~~

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **~~DHS Contracted~~ designated Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

A. Physician providers may participate by prescribing covered tobacco cessation products. Reimbursement for tobacco cessation products is available for all prescription and over the counter (OTC) products and subject to be within U.S. Food and Drug Administration prescribing guidelines.

B. Counseling by the prescriber is required to obtain initial prior authorization (PA) coverage of the products. Counseling consists of reviewing the Public Health Service (PHS) guideline-based checklist with the patient. The prescriber must retain the counseling checklist in the patient records for audit. **View or Print the Arkansas Be Well Referral Form.**

C. Counseling procedures do not count against the twelve (12) visits per state fiscal year (SFY), but they are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per SFY.

D. Counseling sessions can be billed in addition to an office visit or EPSDT. These sessions do not require a PCP referral.

E. If beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

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F. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

G. Arkansas Medicaid will provide coverage of prescription and over the counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence - 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

H. Refer to Section 292.900 for procedure codes and billing instructions.

258.000 Hyperbaric Oxygen Therapy (HBOT)

8-1-21~~10-1-15~~

Physicians may be reimbursed for attendance and supervision of hyperbaric oxygen therapy.

Hyperbaric oxygen therapy (HBOT) involves exposing the body to oxygen under pressure greater than one atmosphere. Such therapy is performed in specially constructed hyperbaric chambers holding one (1) or more patients; although oxygen may be administered in addition to the hyperbaric treatment. Patients should be assessed for contraindications such as sinus disease or claustrophobia prior to therapy. In some diagnoses, hyperbaric oxygen therapy (HBOT) is only an adjunct to standard surgical therapy. These indications are taken from "The Hyperbaric Oxygen Therapy Committee Report" (2003) of The Undersea and Hyperbaric Medical Society (Kensington, MD).

Hyperbaric oxygen therapy (HBOT) prior authorizations will be issued by ~~the Arkansas Foundation for Medical Care (AFMC) for all requests received on and after October 1, 2009~~DHS or its designated vendor. All hyperbaric oxygen therapy (HBOT) will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which case, post authorization will be allowed per protocol (See Section 261.100). Prior authorization will be for a specific number of treatments. Further treatments will require reapplication for a prior authorization. **View or print contact information to obtain the DHS or designated vendor step-by-step process for HBOT prior authorization requests.**~~In order to request a prior authorization, the provider must call AFMC at **1-800-426-2234**. The provider must be able to provide demographic clinical information to support the medical necessity of the treatment. Calls for prior authorization should be placed by a staff member who can answer questions pertaining to the patient's clinical condition. Providers should gather all necessary information prior to placing a call.~~

~~The following information is required for prior authorization:~~

~~A. Name of caller requesting HBOT~~

~~B. Beneficiary's Medicaid ID number~~

~~C. Beneficiary's full name~~

~~D. Beneficiary's complete mailing address including zip code~~

~~E. Beneficiary's birth date~~

~~F. Treatment start date~~

~~G. Treatment facility's AR Medicaid provider number~~

~~H. Treating physician's AR Medicaid provider number~~

~~I. Treating physician's office phone number~~

~~J. CPT code for treatment~~

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~~K. ICD diagnosis code justifies HBOT~~

~~L. Number of treatments requested (see table below)~~

~~M. Clinical indications for treatment~~

~~1. Narrative diagnosis, history of illness requiring HBOT and prior treatment including information about specific treatments and length of time~~

~~2. If treatment is for a non-healing wound, a clear description of the wound is required~~

~~Refer to Section 262.000 and Section 292.860 for information on prior authorizations, reimbursement, and information on billing.~~

NOTE: When approved, only one authorization ~~number~~ will be issued. The prior authorization ~~number~~ and the number of approved HBOT treatments must be shared with the facility provider so that both the physician and the facility may be reimbursed for the number of approved HBOT sessions. Additionally, if more HBOT sessions are required, a new prior authorization ~~will need to~~must be requested and the above process followed ~~to acquire any subsequent prior authorizations~~. A new prior authorization ~~number~~ will be assigned for any additional sessions approved. The prior authorization information between the physician and the facility ~~is to~~shall be reciprocal if the facility acquires the prior authorization.

The following table provides the diagnosis requirements, description of the problem, and number of treatments.

Diagnosis	Description	Number of Treatments
View ICD Codes.	Air or Gas Embolism	10
View ICD Codes.	Decompression Sickness	10
View ICD Codes.	Carbon Monoxide Poisoning	5
View ICD Codes.	Clostridial Myositis and Myonecrosis (Gas Gangrene)	10
View ICD Codes.	Crush injuries, compartment syndrome, other acute traumatic peripheral ischemias	6
View ICD Codes.	Enhancement of healing in selected problem wounds; diabetic foot ulcers, pressure ulcers, venous stasis ulcers; only in severe and limb or life-threatening wounds that have not responded to other treatments, particularly if ischemia that cannot be corrected by vascular procedures is present	30
View ICD Codes.	Intracranial abscess, multiple abscesses, immune compromise, unresponsive	20
View ICD Codes.	Necrotizing Soft Tissue Infections, immune compromise	30
View ICD Codes.	Refractory osteomyelitis after aggressive surgical debridement	40
View ICD Codes.	Delayed Radiation Injury	60
View ICD Codes.	Compromised skin grafts and flaps	20

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Diagnosis	Description	Number of Treatments
View ICD Codes.	Thermal burns > 20% TSBA +/or involvement of hands, face, feet or perineum that are deep, partial or full thickness injury	40
View ICD Codes.	Compartment syndrome, impending stage fasclotomy not required	1
View ICD Codes.	Problem wounds after primary management	14

Refer to Section 292.860 of this manual for billing instructions.

261.000 Obtaining Prior Authorization of Restricted Medical and Surgical Procedures

~~8-1-21~~11-1-~~09~~

Certain medical and surgical procedures are covered only with prior authorization (PA). ~~Most restricted procedures are prior authorized by the Arkansas Foundation for Medical Care, Inc. (AFMC).~~ Refer to sections 261.100 through 261.220 for instructions on requesting PA ~~from AFMC~~.

261.100 Obtaining Prior Authorization ~~from Arkansas Foundation of Medical Care, Inc. (AFMC)~~

~~8-1-21~~4-1-~~07~~

A. Prior authorization determinations obtained through ~~AFMC~~ DHS or its designated vendor are made in accordance with established medical and administration criteria combined with the professional judgment of ~~AFMC~~ physician advisors. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.** Payment for prior authorized services is in accordance with Federal regulations.

~~B. Written documentation is not required for prior authorization. However, the patient's records must substantiate the oral information given to AFMC. Any retrospective review of a case will rely on the written record.~~

~~C~~B. It is the responsibility of the physician who will perform the procedure to initiate the prior authorization request. ~~The physician or the physician's office nurse must contact AFMC.~~ **View or print AFMC contact information.**

~~D. The physician or his office nurse must furnish the following specific information to AFMC:~~ (IF REQUEST IS MADE BY PHONE, ALL CALLS WILL BE TAPE RECORDED)

~~1. Patient Name and Address~~

~~2. Beneficiary identification number~~

~~3. Physician Name and License Number~~

~~4. Physician provider identification number~~

~~5. Hospital Name~~

~~6. Date of Service for Requested Procedure~~

~~7. Card Issuance Date for Retroactive Eligibility Authorizations~~

~~Provide ALL patient identification information and medical information related to the necessity of the procedure you need authorized.~~

~~E. AFMC will give approval or denial of the request by phone with follow-up in writing. If approved, AFMC will assign a prior authorization control number that must be entered in the appropriate field of the claim format when billing for the procedure.~~

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1. If surgery is involved, a copy of the authorization will be ~~mailed~~ 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 physician or ~~AFMC~~ DHS or its designated vendor to verify ~~that~~ prior authorization has been granted.

2. 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 prior authorization control number must be entered in the appropriate field of the claim format when billing for the procedure.~~ The Medicaid program will not pay for inpatient hospital services that require prior authorization if the prior authorization has not been requested and approved.

~~F~~C. Consulting physicians are responsible for ~~calling AFMC~~contact DHS or its designated vendor to have their required ~~and/~~or restricted procedures added to the PA file. They will be given the prior authorization ~~number~~ information at the time of the ~~call~~ request on those cases that are approved. A letter verifying the PA ~~number~~ will be sent to the consultant upon request.

~~G~~D. Post-authorization will be granted only for emergency procedures ~~and/~~or retroactively eligible beneficiaries. Requests for emergency procedures must be ~~applied for~~requested on the first working day after the procedure has been performed. In cases of retroactive eligibility, ~~AFMC~~ DHS or its designated vendor must be contacted for post-authorization within sixty (60) days of the eligibility card issue/add date.

~~H~~E. Prior authorization is not required for services performed by an anesthesiologist. Anesthesiologists/anesthetists must continue to attach required documentation to their claims, such as sterilization consent forms for tubal ligation or vasectomy or the acknowledgment of informed consent for a hysterectomy.

~~I~~F. PRIOR AUTHORIZATION OF SERVICE DOES NOT GUARANTEE ELIGIBILITY FOR A BENEFICIARY. PAYMENT IS STILL SUBJECT TO VERIFICATION THAT THE BENEFICIARY WAS ELIGIBLE AT THE TIME SERVICES ARE PROVIDED.

~~J~~G. In cases involving a hysterectomy, documentation must be provided that reflects the acknowledgement statement was signed prior to surgery or the attending physician must certify in writing:

1. ~~That t~~The individual was already sterile, stating the cause of sterility; or

2. ~~That t~~The hysterectomy was performed under a ~~life~~ life-threatening emergency ~~situation~~ in which the physician determined prior acknowledgement was not possible. The physician must ~~also~~ include a clear description ~~of the nature~~ of the emergency.

3. THIS DOCUMENTATION MUST BE ATTACHED TO THE CLAIM FOR PAYMENT. The documentation must be reviewed and approved by the Medicaid Program before payment can be considered. ~~It should be stressed that~~ ALL guidelines must be met in order for payment to be made.

View or print Medicaid Utilization Review contact information.

261.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21

~~8-1-21~~~~10-1-06~~

A. Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain a ~~prior authorization~~PA ~~number~~ **if the beneficiary is under age twenty-one (21).**

B. The following post-procedural authorization process must be followed when ~~obtaining~~ requesting an authorization ~~number~~ for the procedures in Section 262.000.

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1. ~~All requests for post-procedural authorizations for eligible beneficiaries are to be made to the Arkansas Foundation for Medical Care (AFMC) by telephone within 60 days of the date of service. The physician or the physician's office nurse must contact AFMC.~~ **~~View or print AFMC contact information.~~** ~~These~~If requested by phone the call~~s~~ must be made by a physician or a physician's office nurse and will be ~~tape~~ recorded.

2. If the provider receives only the Medicaid identification number from the beneficiary and is unable to obtain the actual card to validate the eligibility dates, the information may be obtained by calling~~you may call~~ the Provider Assistance Center. ~~to obtain the dates of eligibility.~~ **View or print the ~~Provider Assistance Center~~ contact information for provider assistance.** ~~AFMC must be provided the beneficiary and provider identifying criteria and all of the medical data necessary to justify the procedures. As medical information will be exchanged for this procedure, the physician or a nursing member of his/her staff must make these calls.~~

3. ~~The provider will be issued a PA number at the time of the call if the procedure requested is approved. A follow-up letter will be mailed the same day to the physician.~~

4. Consulting physicians are responsible for ~~calling AFMC~~ contacting DHS or its designated vendor to have their required ~~and/~~or restricted procedures added to the PA file. They will be given the prior authorization ~~number at the time of the call~~ on cases that are approved. A letter verifying the PA ~~number~~ will be sent to the consultant upon request. ~~When calling, a~~All patient identification information and medical information related to the necessity of the procedure ~~needing~~requiring authorization must be provided.

C. ~~The Arkansas Medicaid Program continues to recommend p~~Providers must obtain prior authorization for procedures requiring ~~authorization~~ approval in order to prevent risk of denial due to lack of medical necessity.

This policy applies only to those eligible Medicaid beneficiaries under age twenty-one (21). This policy does not alter policy currently applicable to retroactive-eligible beneficiaries.

261.210 Prior Authorization of Ambulatory Infusion Device

~~8-1-21~~~~9-15-12~~

A. Arkansas Medicaid covers an ambulatory infusion device when it is provided by the physician and prior authorized. This device is covered only when services are provided to Medicaid beneficiaries receiving chemotherapy, pain management or antibiotic treatment in the home. Refer to Section 292.430 for the procedure code and billing instructions. To obtain prior authorization, the physician providing the equipment must complete and sign Form DMS-679, Medical Equipment Request for Prior Authorization and Prescription. **View or print form DMS-679 and instructions for completion.** The original and first copy of the form must be submitted to ~~the Arkansas Foundation for Medical Care (AFMC)~~DHS or its designated vendor. ~~**View or print AFMC contact information.**~~ **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.** ~~If the request is approved, a prior authorization control number will be assigned. The PA number will be indicated on the copy of the DMS-679 returned to the provider. The PA control number in Item 10 of the DMS-679 must be entered on the claim form filed for Medicaid payment of these services.~~

B. Approvals are authorized for a maximum of six (6) months (180 days). If services are needed for a longer period, a new request must be submitted.

C. The effective date of the prior authorization is the date the patient begins use of the equipment or the date following the expiration date of the previous prior authorization approval.

MARKUP

D. Denied requests are returned to the provider indicating the reason for denial.

261.220 Prior Approval of Transplant Procedures 8-1-219-15-12

A. The attending physician is responsible for obtaining a Prior Approval letter for organ transplant evaluations and for organ transplants.

1. The attending physician must request a Prior Approval Letter from the Utilization Review Section for a transplant evaluation, naming the facility at which the evaluation is to take place and the physician who will conduct the evaluation. **View or print the UR Section contact information.** This request must include the following:
   a. History and physical and supporting documentation;
   b. Previous treatment;
   c. Copy of the most recent hospitalization;
   d. Name of proposed facility where patient will be referred for transplant; and,
   e. Third-party insurance information, when applicable.
2. Utilization Review reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.
3. A request for the transplant procedure by the evaluating facility is sent to Utilization Review, including the results of the examination.
4. ~~Utilization Review forwards t~~The request and its supporting documentation ~~to AFMC~~is reviewed by DHS or its designated vendor for a determination of approval or denial.
5. ~~AFMC advises t~~The requesting physician and the beneficiary are advised of ~~its~~the ~~decision~~determination by letter.

B. The physician is responsible for distributing documentation of prior approval to the hospital and to the other participating providers, such as the anesthetist, assistant surgeon, etc.

272.830 Other Covered Transplants 8-1-213-15-05

~~Effective for dates of service on and after December 3, 2004, p~~Physician services relating to other covered transplant surgery procedures will be reimbursed at the lesser of negotiated rates or 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed.

A. Reimbursement based on billed charges is applicable from the date of the transplant procedure to the date of discharge for covered transplant procedures, subject to applicable Medicaid benefit limits, transplant length of stay averages and ~~AFMC~~ medical review.

B. Services provided during dates of readmissions to the same hospital due to complications arising from the original transplant are also reimbursed at the lesser of negotiated rates or 80% of billed charges if determined medically necessary ~~by AFMC review~~.

C. The beneficiary may not be billed for Medicaid covered charges in excess of the State's reimbursement.

292.410 Abortion Procedure Codes 8-1-2111-1-08

Abortion procedures performed when the life of the mother would be endangered if the fetus were carried to term require prior authorization from ~~the Arkansas Foundation of Medical Care, Inc. (AFMC).~~DHS or its designated vendor.

MARKUP

Abortion for pregnancy resulting from rape or incest must be prior authorized by the Division of Medical Services, Administrator, and Utilization Review.

The physician must request prior authorization for the abortion procedures and for anesthesia. Refer to Section 260.000 of this manual for prior authorization procedures. The physician is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes.

All claims must be made on paper with attached documentation. A completed Certification Statement for Abortion (form DMS-2698 Rev. 8/04), patient history and physical are required for processing of claims.

Use the following procedure codes when billing for abortions.

01966	59840	59841	59850	59851	59852
59855	59856	59857			

Refer to Section 251.220 of this manual for policies and procedures regarding coverage of abortions and Sections 261.000, 261.100, 261.200, 261.260 for prior authorization instructions.

292.470 Fluoride Varnish Treatment

8-1-21~~8-1-14~~

The American Dental Association (ADA) procedure code D1206 is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under the age of twenty-one (21). Topical fluoride varnish application benefit is covered every six (6) months plus (1) day for beneficiaries under age twenty-one (21).

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to Provider Enrollment before the specialty code will be added to their file in the MMIS. After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code D1206, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code D1206 (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20). View a ~~form~~ CMS-1500 sample form.

292.591 Molecular Pathology

8-1-21~~8-1-14~~

Molecular Pathology procedure codes, including Healthcare Common Procedural Coding System Level II (HCPCS) procedure code **G0452** requires prior authorization (PA). Providers ~~are to acquire~~must receive prior authorization before a claim for molecular pathology ~~if~~ is filed for payment. Providers may request the PA from ~~Arkansas Foundation for Medical Care (AFMC)~~DHS or its designated vendor before or after the procedure is performed as long as it is acquired in time to receive approval and file a clean claim within the 365-day filing deadline. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.**~~Providers of Molecular Pathology procedures may submit molecular pathology requests and medical record documentation to AFMC via mail, fax or electronically through a web portal. See additional contact information for AFMC in Section 261.100 of this manual.~~

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Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory services (**Form DMS-841**) and ~~the attachment of~~ all pertinent clinical documentation needed to justify the procedure. ~~If the request is approved, a prior authorization number will be assigned, and the provider will receive notification of the approval in writing by mail. If the request does not meet the medical necessity criteria and is denied, the requesting provider will receive notification of the denial in writing by mail.~~ Reconsideration of a denied request is allowed if new or additional information is received ~~by AFMC~~ within thirty (30) days of the initial denial. A copy of the **DMS-841** is ~~also~~ located in Section V of this provider manual. **View or print form DMS-841.** ~~Copies may be made of this form. Please d~~Do not complete DMS-841 unless you are submitting a Molecular Pathology Prior Authorization request. **Molecular Pathology procedure codes must be submitted on a red line CMS-1500 claim form with the Prior Authorization number listed on the claim form and the itemized invoice attached which supports the charges for the test billed.**

Use Healthcare Common Procedural Coding System Level II (HCPCS) procedure code **G0452** ~~will be used~~ for coding the Interpretation and Report of 2013 Molecular Pathology codes that allow separate Interpretation and Report. The prior authorization request for **G0452** ~~should~~ must be submitted with the Arkansas Medicaid Request for Molecular Pathology Laboratory Services (Form DMS-841). ~~When possible, p~~Prior authorization for **G0452** ~~should~~ must be obtained at the same time as the prior authorization for the CPT Molecular Pathology code. The prior authorization request for **G0452** must ~~also~~ include the CPT Molecular Pathology procedure code for which the Interpretation and Report is to be provided. **G0452** must be billed on a red line CMS-1500 paper claim form with CPT Molecular Pathology code(s) specified for which the Interpretation and Report was performed. The claim form should list the prior authorization number. ~~and t~~The invoice must be attached that reflects the cost to the provider for performing the interpretation and report of the test.

See Section 262.000 for additional information on Molecular Pathology procedure codes.

292.672 Method 2 - "Itemized Billing" ~~8-1-2111-1-17~~

Use this method only when either of the following conditions exists:

A. Less than two months of antepartum care was provided

B. The patient was NOT Medicaid eligible for at least the last two (2) months of the pregnancy.

Bill Medicaid for the antepartum care in accordance with the special billing procedures set forth in Section 292.675. The visits for antepartum care will not be counted against the patient's annual physician benefit limit. ~~Keep in mind that d~~Date-of-service spans ~~may~~ shall not include any dates for which the patient was ~~not~~ ineligible for Medicaid.

Bill Medicaid for the delivery and postpartum care with the applicable procedure code from the following table:

National Codes			
59410	59515	59614	59622

Non-emergency hysterectomy after C-section requires prior authorization from ~~the Arkansas Foundation for Medical Care (AFMC)~~DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.** Refer to Section 292.580 for billing instructions for emergency and non-emergency hysterectomy after C-section.

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If Method 2 is used to bill for OB services, ~~care should be taken to~~providers must ensure that the services are billed within the ~~12-month~~365-day filing deadline.

If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure codes **59409** or **59612** ~~should~~must be billed for vaginal delivery and procedure codes **59514** or **59620** must~~should~~ be billed for cesarean section. Procedure codes **59400**, **59410**, **59510** and **59515** shall ~~may~~ not be billed in addition to procedure codes **59409, 59612, 59514** or **59620.** These procedures will be reviewed on a post-payment basis to ensure that these procedures are not billed in addition to antepartum or postpartum care.

Laboratory and X-ray services may be billed separately using the appropriate CPT codes, if this is the physician's standard office practice for billing OB patients. If lab tests ~~and/~~or X-rays are pregnancy related, the referring physician must ~~be sure to~~ code ~~appropriately~~ correctly when these services are sent to the lab or X-ray facility. The diagnostic facilities are ~~completely~~ totally dependent on the referring physician for diagnosis information necessary for Medicaid reimbursement.

The obstetrical laboratory profile procedure code **80055** consists of four components: Complete Blood Count, VDRL, Rubella and blood typing and RH. If the ASO titer (procedure code **86060**) is performed, the test ~~should~~ must be billed separately using the individual code.

Only a collection may be filled ~~F~~for laboratory procedures, if a blood specimen is sent to an outside laboratory, only a collection fee may be billed. No additional fees ~~are to~~shall be billed for other types of specimens that are sent for testing to an outside laboratory. The outside laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 292.600 of this manual.

NOTE: Payment will not be made for emergency room physician charges on an OB patient admitted directly from the emergency room into the hospital for delivery.

292.900 Tobacco Cessation Counseling Services

~~8-1-21~~~~2-1-20~~

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the ~~**DHS Contracted**~~ **designated Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

Current Procedure Code	Current Modifier	Arkansas Medicaid Description
99406*	SE	⁂(Smoking and tobacco use cessation counseling visit; intermediate, 15-minutes)
99406*	CG	⁂ (Smoking and tobacco use cessation counseling visit, intermediate, 15-minutes provided to parents of children birth through twenty (20) years of age)
99407*	SE	⁂(Smoking and tobacco use cessation counseling visit; intensive, 30-minutes)
99407*	CG	⁂ (Smoking and tobacco use cessation counseling visit, intensive, 30-minutes provided to parents of children birth

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Current Procedure Code	Current Modifier	Arkansas Medicaid Description
		through twenty (20) years of age)

* Exempt from PCP referral.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent/legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count toward the four (4) counseling session limit described in section C above.

G. The provider must complete the counseling checklist and place in the patient records for audit. **View or Print the Arkansas Be Well Referral Form**

Oral surgeons must use procedure code **D9920** for one 15-minute unit and procedure code **D1320** for one 30-minute unit when filing claims on the American Dental Association (ADA).

See Section 257.000 of this manual for coverage and benefit limit information.

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203.170 Physician's Role in Hospital Services 8-1-21

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations.

B. The care and treatment of a patient must be under the direction of a licensed physician or dentist with hospital staff affiliation. Most inpatient admissions require a PCP referral. (Refer to Section I of this manual.)

C. DHS or its designated vendor reviews all inpatient hospital transfers and all inpatient stays longer than four (4) days for the Medicaid Utilization Management Program.

DHS or its designated vendor also completes post-payment reviews of hospital stays of any length for medical necessity determinations. **View or print DHS or designated vendor contact information to obtain MUMP information.**

D. Hospital claims are also subject to review by the Division of Medical Services Medical Director for Clinical Affairs for the Medicaid Program.

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
2. Practitioners and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
3. Practitioners and hospitals may not bill as outpatient services, inpatient services previously denied for lack of medical necessity.
4. Refer to Sections I and III of this manual for Medicare deductible and coinsurance information.

203.230 Physician's Role in the Pharmacy Program 8-1-21

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the DHS or designated pharmacy vendor website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

Prescribers must obtain the latest information regarding prescription drug coverage from the **DHS contracted Pharmacy Vendors website.** **View or print DHS contracted Pharmacy vendor contact information.**

220.000 Benefit Limits 8-1-21

Benefit limits are the limits on the *quantity* of covered services Medicaid-eligible beneficiaries may receive. Medicaid-eligible beneficiaries are responsible for payment for services beyond the established benefit limits, unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit

If a service is denied for exceeding the benefit limit, and the Medicaid beneficiary had elected to receive the service by written informed consent prior to the delivery of the service, the Medicaid

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beneficiary is responsible for the payment, unless that service has been deemed not medically necessary.

Benefit extensions are considered after the service has been rendered and the provider has received a denial for "benefits exhausted." DMS considers requests for benefit extensions based on the medical necessity of the service. If a Medicaid provider chooses to file for an extension of benefits and is denied due to the service not being medically necessary, the beneficiary is not responsible for the payment. Once the extension of benefits request has been initiated on a specific service, the provider cannot abort the process before a final decision is rendered.

Please see Section 229.000 through Section 229.120 and Section 131.000 points A and C for benefit extension request procedures. DMS reviews extension of benefits requests for Home Health, personal care, diapers and medical supplies. DHS or its designated vendor reviews extension of benefits requests for physician, lab, radiology and machine tests, using form DMS-671. All personal care services for beneficiaries under age 21 are reviewed by the contracted Quality Improvement Organization (QIO). **View or print contact information for DHS or its designated vendor regarding benefit limits.**

224.200 Medicaid Utilization Management Program (MUMP) 8-1-21

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient, general and rehabilitative hospitals, in state and out-of-state. The MUMP does not apply to lengths of stay in psychiatric facilities.

Length-of-stay determinations are made by DHS or the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

224.210 MUMP Applicability 8-1-21

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer (see part B, below). If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified by DHS or its designated vendor.

B. When a patient is transferred from one hospital to another, the stay must be certified from the first day.

224.310 Direct Admissions 8-1-21

A. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient days.**

Calls for extension of days may be made at any time during the inpatient stay (except in the case of a transfer from another hospital - refer to Section 224.320).

Providers initiating their request after the fourth day must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider delays calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable.

B. When a Medicaid client reaches age one (1) during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the Medicaid Utilization Management Program (MUMP) policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day following the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.

C. DHS or its designated vendor utilizes Medicaid guidelines and the medical judgment of its professional staff to determine the number of days to allow.

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D. Additional extensions may be requested as needed.

E. The certification process under the MUMP is separate from prior authorization requirements. Prior authorization for medical procedures thus restricted must be obtained by the appropriate providers. Hospital stays for restricted procedures may be disallowed if required prior authorizations are not obtained.

F. Out-of-state claims (claims from providers in non-bordering states) are subject to the determination for medical necessity for out-of-state treatment. In addition, the claim and records will be reviewed retrospectively for lengths of stay beyond the four (4) days allowed.

G. Claims submitted without an approved extension request will result in automatic denials of any days billed beyond the fourth day. No exceptions will be granted except for claims reflecting third party liability.

224.320 Transfer Admissions 8-1-21

If a patient is transferred from one hospital to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours of admitting the patient to certify the inpatient stay. **View or print contact information to obtain the DHS or designated vendor step-by-step process to request certification**.

224.330 Retroactive Eligibility 8-1-21

A. If eligibility is determined while the patient is still an inpatient, the hospital may request post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed.

B. If eligibility is determined after discharge the hospital may contact DHS or its designated vendor for post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer). If certification sought is for a stay longer than thirty (30) days, the provider must submit the entire medical record for review.

224.340 Third Party and Medicare Primary Claims 8-1-21

A. If a provider has not requested Medicaid Utilization Management Program (MUMP) certification of inpatient days because there is apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification required by the MUMP may be obtained. **View or print contact information to obtain the DHS or designated vendor step-by-step process**.

B. If a third-party insurer pays the provider for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

224.350 Requests for Reconsideration 8-1-21

Reconsideration reviews of denied extensions may be requested by sending the medical record to DHS or its designated vendor. The hospital will be advised of the reconsideration decision by the next working day.

View or print contact information to obtain the DHS or designated vendor step-by-step process for reconsideration requests.

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229.100 Extension of Benefits for Laboratory and X-Ray, Physician Office and Outpatient Hospital Services 8-1-21

A. Requests for extension of benefits for laboratory and x-ray, physician and outpatient services must be submitted to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.**

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.

B. A request for extension of benefits must be received within ninety (90) calendar days of the date of benefits-exhausted denial.

229.110 Completion of Request Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services" 8-1-21

Requests for extension of benefits for Clinical Services (Physician's Visits), Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc-), must be submitted to DHS or its designated vendor for consideration. **View or print contact information to obtain the DHS or designated vendor step-by-step process to complete request.** Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print form DMS-671.**

Instructions for accurate completion of form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

229.130 Administrative Reconsideration of Extensions of Benefits Denial 8-1-21

A. A request for administrative reconsideration of an extension of benefits denial must be in writing and submitted to DHS or its designated vendor within thirty (30) calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation pursuant to Section 229.120.

B. The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of the manual. A request received within thirty-five (35) calendar days of a denial will be deemed timely. A request received later than thirty-five (35) calendar days gives rise to a rebuttable presumption that it is not timely.

229.210 Process for Requesting Extended Therapy Services 8-1-21

A. Requests for extended therapy services for beneficiaries under age twenty-one (21) must be submitted to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services.** The request must meet the medical necessity requirement, and adequate documentation must be provided to support the request.

1. Requests for extended therapy services are considered only after a claim is denied because a benefit is exceeded.
2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date

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of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.

3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. **View or print form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted provided it complies Arkansas Code 25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within 30 calendar days of receiving the request. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with information specific to the approval.

229.230 Extended Therapy Services Review Process 8-1-21

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services.

229.240 Administrative Reconsideration 8-1-21

A request for administrative reconsideration of the denial of services must be in writing and sent to DHS or its designated vendor within thirty (30) calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of the Arkansas Medicaid manual. A request received by DHS or its designated vendor within thirty-five (35) calendar days of a denial will be deemed timely.

251.110 Assistant Surgery 8-1-21

For medical payment to be made to an assistant surgeon, the physician who wishes to use an assistant surgeon must obtain prior authorization from the DHS or its designated vendor. Assistant surgeon services are reimbursed only when provided by a physician. See Section 261.000 of this manual for prior authorization instructions. This provision applies to all surgery.

251.220 Elective Abortions 8-1-21

Only medically necessary abortions are covered by Arkansas Medicaid. Federal regulations prohibit expenditures for abortions except when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest, defined under Ark. § Code Ann. 5-14-103 and § 5-22-202, as certified in writing by the woman's attending physician.

A. All abortions require prior authorization. A Certification Statement for Abortion (DMS-2698) must be completed prior to performing the procedure and is required for requesting prior authorization and billing. **View or print form DMS-2698**.

B. Other required documentation includes patient history and physical exam records. The physician performing the abortion is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes. Refer to Section 292.410 for other billing instructions.

C. For abortions when the life of the mother would be endangered if the fetus were carried to term, prior authorization (PA) requests must be made to DHS or its designated vendor.

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View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting a review.

D. Abortions for pregnancy resulting from rape or incest must be prior authorized by the Division of Medical Services Utilization Review Section. **View or print the Utilization Review contact information.** Refer to Section 261.260 for instructions on requesting PA.

E. Payable Abortion Procedure Codes

1. For Professional or Outpatient Abortion Claims, the following codes are required:

01966	59840	59841	59850
59851	59852	59855	59856
59857			

2. For inpatient hospital facility Abortion Claims, the provider must use the following codes:

a. 10A00ZZ – Abortion of Products of Conception, Open Approach
b. 10A03ZZ – Abortion of Products of Conception, Percutaneous Approach
c. 10A07Z6 – Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
d. 10A07ZW – Abortion of Products of Conception, Laminaria, Via Natural or Artificial Opening
e. 10A07ZX – Abortion of Products of Conception, Abortifacient, Via Natural or Artificial Opening
f. 10A07ZZ – Abortion of Products of Conception, Via Natural or Artificial Opening

251.230 Cochlear Implant and External Sound Processor Coverage Policy 8-1-21

The Arkansas Medicaid Program provides coverage for cochlear implantation and the external sound processor for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. (See Section 261.120 for prior authorization requirements and Section 292.801 for billing protocol.)

A. Cochlear Implants

Cochlear Implants are covered through the Arkansas Medicaid Physician or Prosthetics Program for eligible Medicaid beneficiaries under the age of twenty-one (21) years through the Child Health Services (EPSDT) Program when prescribed by a physician.

The cochlear implant device, implantation procedure, the sound processor and other necessary devices for use with the cochlear implant device require *prior authorization* from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components or a switch from a body worn, external sound processor to a behind-the-ear (BTE) model or technological advances in hardware, are considered not medically necessary and will not be approved.

PROPOSED

2010 Codes	Modifier	Age Restriction	Manually Priced	Review	PA
L8627*	EP	0-20	Yes	No	Yes
L8628 *	EP	0-20	Yes	No	Yes
L8629*	EP	0-20	Yes	No	Yes

*Denotes paper claim required

B. Speech Processor

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processor will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional medical documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

C. Personal FM Systems

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available by any other source (i.e., educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

A Request for Prior Authorization may be submitted for medically necessary FM systems **(procedure code V5273 for use with cochlear implant)** that are not covered through IDEA; each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

D. Replacement, Repair, Supplies

The repair and/or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

251.300 Organ Transplants 8-1-21

A. All organ transplants require prior approval.

1. Medicaid covers bone marrow, corneal, heart, kidney, liver and lung transplants for eligible Medicaid beneficiaries of all ages.
2. Medicaid covers pancreas/kidney transplants and skin transplants for burns for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program.
3. Medicaid covers liver/bowel transplants for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program.

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B. Medicaid covers physicians' inpatient services only on days that Medicaid covers the hospital's inpatient services; therefore, inpatient hospital stays for corneal, kidney, pancreas/kidney and skin transplants are all subject to Medicaid Utilization Management Program (MUMP) precertification.

C. Additionally, for inpatient stays related to all other transplants:

1. Hospital days in excess of transplant length of stay averages require medical review and approval by DHS or its designated vendor.

2. Reference sources for organ transplant length-of-stay (LOS) averages are the Centers for Medicare and Medicaid Services (CMS) Acute Inpatient Prospective Payment System (PPS) – using the "Arithmetic Mean LOS" method – or the most recently published Medicare National Coverage Decisions.

D. Post-operative care (inpatient or outpatient) for ten (10) days is included in Medicaid's coverage of each transplant procedure. In the sections that follow, references to "post-operative care" and "follow-up care" includes the ten (10)-day post-operative care rule.

E. Refer to Sections 261.100 and 261.230 for prior approval procedures.

F. Refer to Sections 292.820 through 292.832 for billing instructions.

251.303 Heart Transplants 8-1-21

A. Medicaid covers heart transplants for beneficiaries of all ages.

B. Covered physician services related to the transplant include:

1. Transplanting the heart into the receiver.

2. Postoperative care.

C. Heart transplants are exempt from the Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published Medicare National Coverage Decisions or DHS or its designated vendor's medical review. Refer to Section 251.300, part C.

251.304 Liver and Liver/Bowel Transplants 8-1-21

A. Medicaid covers liver transplants for beneficiaries of all ages.

B. Medicaid covers liver/bowel transplants for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program.

C. Covered physician services related to the transplant include:

1. The surgical procedure to remove a partial liver from a living donor (when applicable).

2. Physician services for transplanting the liver into the receiver.

3. Postoperative care (including postoperative care for the living donor of a partial liver, when applicable).

D. Liver and liver/bowel transplants are exempt from the Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published Medicare National Coverage Decisions or DHS or its designated vendor's. Refer to Section 251.300, part C.

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251.306 Lung Transplants 8-1-21

A. Medicaid covers lung transplants for beneficiaries of all ages.

B. The following list of medical diagnoses or diseases are those in which it is believed patients could benefit significantly from a lung transplant when it has been determined the disease has reached an end-stage cycle or level:

1. Pulmonary Vascular Disease
2. Primary Pulmonary Hypertension
3. Eisenmenger's Syndrome (ASD, VSD, PVA, Truncus, Other Complex Anomalies)
4. Pulmonary Hypertension secondary to Thromboembolism
5. Obstructive Lung Disease
6. Emphysema (idiopathic)
7. Emphysema (alpha antitrypsin deficiency)
8. Bronchopulmonary Dysplasia
9. Post-Transplant Obliterative Bronchiolitis
10. Bronchiolitis Obliterans Organizing Pneumonia (BOOP)
11. Restrictive Lung Disease
12. Idiopathic Pulmonary Fibrosis
13. Sarcoidosis
14. Asbestosis
15. Eosinophilic Granulomatosis
16. Desquamative Interstitial Pneumonitis
17. Lymphangioleiomyomatosis

C. Covered physician services related to the transplant include:

1. Transplanting the organ into the receiver.
2. Postoperative care.

D. Lung transplants are exempt from the Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published Medicare National Coverage Decisions or DHS or its designated vendor's medical review. Refer to Section 251.300, part C.

254.000 Enterra Therapy for Treatment of Gastroparesis 8-1-21

A. Arkansas Medicaid covers Enterra, implantable neurostimulator therapy.

B. Coverage of Enterra therapy is limited to individuals ages eighteen (18) through sixty-nine (69) with diabetic and idiopathic gastroparesis (View ICD Codes.).

1. Service includes the implantable neurostimulator electrode(s) and the neurostimulator pulse generator.
2. Implantation procedures for neurostimulator pulse generator and the neurostimulator electrodes are covered as inpatient surgical procedures.
   a. The surgical procedures require prior authorization (PA) by DHS or its

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designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.

b. An approval letter from the Institutional Review Board is required. Patient's record must include documentation that further total parental nutrition (TPN) therapy is not an option.

3. Procedure for revision or removal of the peripheral neurostimulator electrodes does not require PA, but claim will be manually reviewed prior to reimbursement.

C. See Section 292.880 of this manual for procedure codes and billing instructions.

257.000 Tobacco Cessation Products and Counseling Services 8-1-21

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **designated Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

A. Physician providers may participate by prescribing covered tobacco cessation products. Reimbursement for tobacco cessation products is available for all prescription and over the counter (OTC) products and subject to be within U.S. Food and Drug Administration prescribing guidelines.

B. Counseling by the prescriber is required to obtain initial prior authorization (PA) coverage of the products. Counseling consists of reviewing the Public Health Service (PHS) guideline-based checklist with the patient. The prescriber must retain the counseling checklist in the patient records for audit. **View or Print the Arkansas Be Well Referral Form.**

C. Counseling procedures do not count against the twelve (12) visits per state fiscal year (SFY), but they are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per SFY.

D. Counseling sessions can be billed in addition to an office visit or EPSDT. These sessions do not require a PCP referral.

E. If beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

F. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

G. Arkansas Medicaid will provide coverage of prescription and over the counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence - 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

H. Refer to Section 292.900 for procedure codes and billing instructions.

258.000 Hyperbaric Oxygen Therapy (HBOT) 8-1-21

Physicians may be reimbursed for attendance and supervision of hyperbaric oxygen therapy.

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Hyperbaric oxygen therapy (HBOT) involves exposing the body to oxygen under pressure greater than one atmosphere. Such therapy is performed in specially constructed hyperbaric chambers holding one (1) or more patients; although oxygen may be administered in addition to the hyperbaric treatment. Patients should be assessed for contraindications such as sinus disease or claustrophobia prior to therapy. In some diagnoses, hyperbaric oxygen therapy (HBOT) is only an adjunct to standard surgical therapy. These indications are taken from "The Hyperbaric Oxygen Therapy Committee Report" (2003) of The Undersea and Hyperbaric Medical Society (Kensington, MD).

Hyperbaric oxygen therapy (HBOT) prior authorizations will be issued by DHS or its designated vendor. All hyperbaric oxygen therapy (HBOT) will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which case, post authorization will be allowed per protocol (See Section 261.100). Prior authorization will be for a specific number of treatments. Further treatments will require reapplication for a prior authorization. **View or print contact information to obtain the DHS or designated vendor step-by-step process for HBOT prior authorization requests.**

NOTE: When approved, only one authorization will be issued. The prior authorization and the number of approved HBOT treatments must be shared with the facility provider so that both the physician and the facility may be reimbursed for the number of approved HBOT sessions. Additionally, if more HBOT sessions are required, a new prior authorization must be requested and the above process followed. A new prior authorization will be assigned for any additional sessions approved. The prior authorization information between the physician and the facility shall be reciprocal if the facility acquires the prior authorization.

The following table provides the diagnosis requirements, description of the problem, and number of treatments.

Diagnosis	Description	Number of Treatments
View ICD Codes.	Air or Gas Embolism	10
View ICD Codes.	Decompression Sickness	10
View ICD Codes.	Carbon Monoxide Poisoning	5
View ICD Codes.	Clostridial Myositis and Myonecrosis (Gas Gangrene)	10
View ICD Codes.	Crush injuries, compartment syndrome, other acute traumatic peripheral ischemias	6
View ICD Codes.	Enhancement of healing in selected problem wounds; diabetic foot ulcers, pressure ulcers, venous stasis ulcers; only in severe and limb or life-threatening wounds that have not responded to other treatments, particularly if ischemia that cannot be corrected by vascular procedures is present	30
View ICD Codes.	Intracranial abscess, multiple abscesses, immune compromise, unresponsive	20
View ICD Codes.	Necrotizing Soft Tissue Infections, immune compromise	30
View ICD Codes.	Refractory osteomyelitis after aggressive surgical debridement	40
View ICD Codes.	Delayed Radiation Injury	60
View ICD Codes.	Compromised skin grafts and flaps	20

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Diagnosis	Description	Number of Treatments
View ICD Codes.	Thermal burns > 20% TSBA +/or involvement of hands, face, feet or perineum that are deep, partial or full thickness injury	40
View ICD Codes.	Compartment syndrome, impending stage fasciotomy not required	1
View ICD Codes.	Problem wounds after primary management	14

Refer to Section 292.860 of this manual for billing instructions.

261.000 Obtaining Prior Authorization of Restricted Medical and Surgical Procedures 8-1-21

Certain medical and surgical procedures are covered only with prior authorization (PA). Refer to sections 261.100 through 261.220 for instructions on requesting PA.

261.100 Obtaining Prior Authorization 8-1-21

A. Prior authorization determinations obtained through DHS or its designated vendor are made in accordance with established medical and administration criteria combined with the professional judgment of physician advisors. View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests. Payment for prior authorized services is in accordance with Federal regulations.

B. It is the responsibility of the physician who will perform the procedure to initiate the prior authorization request.

(IF REQUEST IS MADE BY PHONE, ALL CALLS WILL BE TAPE RECORDED)

1. 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 physician or DHS or its designated vendor to verify prior authorization has been granted.
2. 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.

C. Consulting physicians are responsible for contact DHS or its designated vendor to have their required or restricted procedures added to the PA file. They will be given the prior authorization information at the time of the request on those cases that are approved. A letter verifying the PA will be sent to the consultant upon request.

D. Post-authorization will be granted only for emergency procedures or retroactively eligible beneficiaries. Requests for emergency procedures must be requested on the first working day after the procedure has been performed. In cases of retroactive eligibility, DHS or its designated vendor must be contacted for post-authorization within sixty (60) days of the eligibility card issue/add date.

E. Prior authorization is not required for services performed by an anesthesiologist. Anesthesiologists/anesthetists must continue to attach required documentation to their claims, such as sterilization consent forms for tubal ligation or vasectomy or the acknowledgment of informed consent for a hysterectomy.

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F. PRIOR AUTHORIZATION OF SERVICE DOES NOT GUARANTEE ELIGIBILITY FOR A BENEFICIARY. PAYMENT IS STILL SUBJECT TO VERIFICATION THAT THE BENEFICIARY WAS ELIGIBLE AT THE TIME SERVICES ARE PROVIDED.

G. In cases involving a hysterectomy, documentation must be provided that reflects the acknowledgement statement was signed prior to surgery or the attending physician must certify in writing:

1. The individual was already sterile, stating the cause of sterility; or
2. The hysterectomy was performed under a life-threatening emergency in which the physician determined prior acknowledgement was not possible. The physician must include a clear description of the emergency.
3. THIS DOCUMENTATION MUST BE ATTACHED TO THE CLAIM FOR PAYMENT. The documentation must be reviewed and approved by the Medicaid Program before payment can be considered. ALL guidelines must be met in order for payment to be made.

View or print Medicaid Utilization Review contact information.

261.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 8-1-21

A. Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain a PA **if the beneficiary is under age twenty-one (21)**.

B. The following post-procedural authorization process must be followed when requesting an authorization for the procedures in Section 262.000.

1. If requested by phone the call must be made by a physician or a physician's office nurse and will be recorded.
2. If the provider receives only the Medicaid identification number from the beneficiary and is unable to obtain the actual card to validate the eligibility dates, the information may be obtained by calling the Provider Assistance Center. **View or print the contact information for provider assistance.**
4. Consulting physicians are responsible for contacting DHS or its designated vendor to have their required or restricted procedures added to the PA file. They will be given the prior authorization on cases that are approved. A letter verifying the PA will be sent to the consultant upon request. All patient identification information and medical information related to the necessity of the procedure requiring authorization must be provided.

C. Providers must obtain prior authorization for procedures requiring approval in order to prevent risk of denial due to lack of medical necessity.

This policy applies only to those eligible Medicaid beneficiaries under age twenty-one (21). This policy does not alter policy currently applicable to retroactive-eligible beneficiaries.

261.210 Prior Authorization of Ambulatory Infusion Device 8-1-21

A. Arkansas Medicaid covers an ambulatory infusion device when it is provided by the physician and prior authorized. This device is covered only when services are provided to Medicaid beneficiaries receiving chemotherapy, pain management or antibiotic treatment in the home. Refer to Section 292.430 for the procedure code and billing instructions. To obtain prior authorization, the physician providing the equipment must complete and sign Form DMS-679, Medical Equipment Request for Prior Authorization and Prescription. **View or print form DMS-679 and instructions for completion.** The original and first copy of the form must be submitted to DHS or its designated vendor. **View or print**

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contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.

B. Approvals are authorized for a maximum of six (6) months (180 days). If services are needed for a longer period, a new request must be submitted.

C. The effective date of the prior authorization is the date the patient begins use of the equipment or the date following the expiration date of the previous prior authorization approval.

D. Denied requests are returned to the provider indicating the reason for denial.

261.220 Prior Approval of Transplant Procedures 8-1-21

A. The attending physician is responsible for obtaining a Prior Approval letter for organ transplant evaluations and for organ transplants.

1. The attending physician must request a Prior Approval Letter from the Utilization Review Section for a transplant evaluation, naming the facility at which the evaluation is to take place and the physician who will conduct the evaluation. **View or print the UR Section contact information.** This request must include the following:
   a. History and physical and supporting documentation;
   b. Previous treatment;
   c. Copy of the most recent hospitalization;
   d. Name of proposed facility where patient will be referred for transplant; and,
   e. Third-party insurance information, when applicable.
2. Utilization Review reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.
3. A request for the transplant procedure by the evaluating facility is sent to Utilization Review, including the results of the examination.
4. The request and its supporting documentation is reviewed by DHS or its designated vendor for a determination of approval or denial.
5. The requesting physician and the beneficiary are advised of the determination by letter.

B. The physician is responsible for distributing documentation of prior approval to the hospital and to the other participating providers, such as the anesthetist, assistant surgeon, etc.

272.830 Other Covered Transplants 8-1-21

Physician services relating to other covered transplant surgery procedures will be reimbursed at the lesser of negotiated rates or 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed.

A. Reimbursement based on billed charges is applicable from the date of the transplant procedure to the date of discharge for covered transplant procedures, subject to applicable Medicaid benefit limits, transplant length of stay averages and medical review.

B. Services provided during dates of readmissions to the same hospital due to complications arising from the original transplant are also reimbursed at the lesser of negotiated rates or 80% of billed charges if determined medically necessary.

C. The beneficiary may not be billed for Medicaid covered charges in excess of the State's reimbursement.

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292.410 Abortion Procedure Codes 8-1-21

Abortion procedures performed when the life of the mother would be endangered if the fetus were carried to term require prior authorization from DHS or its designated vendor.

Abortion for pregnancy resulting from rape or incest must be prior authorized by the Division of Medical Services, Administrator, and Utilization Review.

The physician must request prior authorization for the abortion procedures and for anesthesia. Refer to Section 260.000 of this manual for prior authorization procedures. The physician is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes.

All claims must be made on paper with attached documentation. A completed Certification Statement for Abortion (form DMS-2698 Rev. 8/04), patient history and physical are required for processing of claims.

Use the following procedure codes when billing for abortions.

01966	59840	59841	59850	59851	59852
59855	59856	59857			

Refer to Section 251.220 of this manual for policies and procedures regarding coverage of abortions and Sections 261.000, 261.100, 261.200, 261.260 for prior authorization instructions.

292.470 Fluoride Varnish Treatment 8-1-21

The American Dental Association (ADA) procedure code D1206 is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under the age of twenty-one (21). Topical fluoride varnish application benefit is covered every six (6) months plus (1) day for beneficiaries under age twenty-one (21).

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to Provider Enrollment before the specialty code will be added to their file in the MMIS. After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code D1206, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code D1206 (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20). View a CMS-1500 sample form.

292.591 Molecular Pathology 8-1-21

Molecular Pathology procedure codes, including Healthcare Common Procedural Coding System Level II (HCPCS) procedure code **G0452** requires prior authorization (PA). Providers must receive prior authorization before a claim for molecular pathology is filed for payment. Providers may request the PA from DHS or its designated vendor before or after the procedure is performed as long as it is acquired in time to receive approval and file a clean claim within the 365-day filing deadline. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.**

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Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory services (**Form DMS-841**) and all pertinent clinical documentation needed to justify the procedure. Reconsideration of a denied request is allowed if new or additional information is received within thirty (30) days of the initial denial. A copy of the **DMS-841** is located in Section V of this provider manual. **View or print form DMS-841.** Do not complete DMS-841 unless you are submitting a Molecular Pathology Prior Authorization request. **Molecular Pathology procedure codes must be submitted on a red line CMS-1500 claim form with the Prior Authorization number listed on the claim form and the itemized invoice attached which supports the charges for the test billed.**

Use Healthcare Common Procedural Coding System Level II (HCPCS) procedure code **G0452** for coding the Interpretation and Report of 2013 Molecular Pathology codes that allow separate Interpretation and Report. The prior authorization request for **G0452** must be submitted with the Arkansas Medicaid Request for Molecular Pathology Laboratory Services (Form DMS-841). Prior authorization for **G0452** must be obtained at the same time as the prior authorization for the CPT Molecular Pathology code. The prior authorization request for **G0452** must include the CPT Molecular Pathology procedure code for which the Interpretation and Report is to be provided. **G0452** must be billed on a red line CMS-1500 paper claim form with CPT Molecular Pathology code(s) specified for which the Interpretation and Report was performed. The claim form should list the prior authorization number. The invoice must be attached that reflects the cost to the provider for performing the interpretation and report of the test.

See Section 262.000 for additional information on Molecular Pathology procedure codes.

292.672 Method 2 - "Itemized Billing" 8-1-21

Use this method only when either of the following conditions exists:

A. Less than two months of antepartum care was provided

B. The patient was NOT Medicaid eligible for at least the last two (2) months of the pregnancy.

Bill Medicaid for the antepartum care in accordance with the special billing procedures set forth in Section 292.675. The visits for antepartum care will not be counted against the patient's annual physician benefit limit. Date-of-service spans shall not include any dates for which the patient was ineligible for Medicaid.

Bill Medicaid for the delivery and postpartum care with the applicable procedure code from the following table:

National Codes			
59410	59515	59614	59622

Non-emergency hysterectomy after C-section requires prior authorization from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.** Refer to Section 292.580 for billing instructions for emergency and non-emergency hysterectomy after C-section.

If Method 2 is used to bill for OB services, providers must ensure that the services are billed within the 365-day filing deadline.

If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure codes **59409** or **59612** must be billed for vaginal delivery and procedure codes **59514** or **59620** must be billed for cesarean section. Procedure codes **59400**, **59410**, **59510** and **59515** shall not be billed in addition to procedure codes **59409, 59612, 59514** or **59620.** These

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procedures will be reviewed on a post-payment basis to ensure that these procedures are not billed in addition to antepartum or postpartum care.

Laboratory and X-ray services may be billed separately using the appropriate CPT codes, if this is the physician's standard office practice for billing OB patients. If lab tests or X-rays are pregnancy related, the referring physician must code correctly when these services are sent to the lab or X-ray facility. The diagnostic facilities are totally dependent on the referring physician for diagnosis information necessary for Medicaid reimbursement.

The obstetrical laboratory profile procedure code **80055** consists of four components: Complete Blood Count, VDRL, Rubella and blood typing and RH. If the ASO titer (procedure code **86060**) is performed, the test must be billed separately using the individual code.

Only a collection may be filled for laboratory procedures, if a blood specimen is sent to an outside laboratory, only a collection fee may be billed. No additional fees shall be billed for other types of specimens that are sent for testing to an outside laboratory. The outside laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 292.600 of this manual.

NOTE: Payment will not be made for emergency room physician charges on an OB patient admitted directly from the emergency room into the hospital for delivery.

292.900 Tobacco Cessation Counseling Services 8-1-21

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **designated Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

Current Procedure Code	Current Modifier	Arkansas Medicaid Description
99406*	SE	⁂(Smoking and tobacco use cessation counseling visit; intermediate, 15-minutes)
99406*	CG	⁂ (Smoking and tobacco use cessation counseling visit, intermediate, 15-minutes provided to parents of children birth through twenty (20) years of age)
99407*	SE	⁂(Smoking and tobacco use cessation counseling visit; intensive, 30-minutes)
99407*	CG	⁂ (Smoking and tobacco use cessation counseling visit, intensive, 30-minutes provided to parents of children birth through twenty (20) years of age)

* Exempt from PCP referral.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent/legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

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F. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count toward the four (4) counseling session limit described in section C above.

G. The provider must complete the counseling checklist and place in the patient records for audit. **View or Print the Arkansas Be Well Referral Form**

Oral surgeons must use procedure code **D9920** for one 15-minute unit and procedure code **D1320** for one 30-minute unit when filing claims on the American Dental Association (ADA).

See Section 257.000 of this manual for coverage and benefit limit information.

PROPOSED

TOC required

201.600 Podiatrist's Role in the Pharmacy Program

~~12-18-15~~8-1-21

PRESCRIPTION DRUG INFORMATION

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers in relation to their specialty of practice. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the DHS or designated pharmacy vendor website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

~~Prescribers may also refer to the website at~~ **~~https://arkansas.magellanrx.com/provider/documents/~~** ~~to obtain t~~The latest information regarding prescription drug coverage is available from DHS or its designated Medicaid Pharmacy vendor. **View or print contact information for the DHS contracted Pharmacy Vendor**.

214.000 Benefit Limits

8-1-21~~1-1-06~~

Medicaid-eligible patients are responsible for payment for services beyond the established benefit limits, unless ~~the Division of Medical Services (DMS) contractor~~DHS or its designated vendor authorizes an extension of a particular benefit. If a Medicaid-eligible patient elects to receive a service for which ~~DMS contractor has denied~~ a benefit extension has been denied or ~~for which DMS contractor~~is subsequently ~~denies a benefit extension~~denied, the patient is responsible for payment. ~~**View or print the AFMC contact information.**~~**View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.**

215.100 Procedure for Obtaining Extension of Benefits for Podiatry Services

8-1-21~~1-1-09~~

A. Requests for extension of benefits for podiatry services for beneficiaries over age 21 must be ~~mailed~~ submitted to DHS or its designated vendor~~the Arkansas Foundation for Medical Care, Inc. (AFMC). **View or print the Arkansas Foundation for Medical Care, Inc., contact information.**~~ A request for extension of benefits must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extension of benefits are considered only after a claim is denied because a benefit is exhausted/exceeds benefit limit.
2. The request for extension of benefits must be received ~~by AFMC~~ within ninety (90) calendar days of the date of the benefits-exhausted denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exhausted denial appears.
3. Submit ~~with the request~~ a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.
4. ~~AFMC will not accept extension of benefits requests sent via e-mail or electronic facsimile (FAX).~~

MARKUP

B. Use form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services, to request extension of benefits for podiatry services. **View or print form DMS-671.** Consideration of requests for extension of benefits requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider's signature (with his or her credentials) and the date of the request are required on the form. Stamped or electronic signatures are accepted. All applicable records that support the medical necessity of the extended benefits request should be attached.

C. ~~AFMC will approve or deny a~~An extension of benefits request will be approved, denied, or pended to ~~— or~~ ask for additional information —within thirty (30) calendar days of ~~their receiving~~ receipt of the request. ~~AFMC r~~Reviewers will simultaneously advise the provider and the beneficiary when a request is denied.

215.115 ~~AFMC~~ Extension of Benefits Review Process ~~8-1-21~~11-1-09

View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits review.

~~The following is a step-by-step outline of AFMC's extension of benefits review process:~~

~~A. Requests received via mail are screened for completeness and researched to verify the beneficiary's eligibility for Medicaid when the service was provided and to verify the claim's denial for benefits exhausted/exceeded.~~

~~B. The documentation submitted is reviewed by a registered nurse (R.N.). If, in the judgment of the R.N., the documentation supports medical necessity, they may approve the request. An approval letter is generated and mailed to the provider the following day.~~

~~C. If the R.N. review determines the documentation does not justify the service or it appears that the service is not medically necessary, they will refer the case to the appropriate physician advisor for a decision.~~

~~D. The physician advisor's rationale for approval or denial is entered into the data system and the appropriate notification is created. If services are denied for medical necessity, the physician advisor's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.~~

~~E. Providers may request administrative reconsideration of an adverse decision or appeal as provided in Section 190.003 of this manual.~~

~~F. If the denial is due to incomplete documentation, and complete documentation, that supports medical necessity, is submitted with the reconsideration request, the R.N. may approve the extension of benefits without referral to a physician advisor.~~

~~G. If the denial is due to lack of proof of medical necessity or the documentation does not allow for approval by the R.N., the original documentation, reason for denial and new information submitted will be referred to a different physician advisor for reconsideration.~~

~~H. All parties will be notified in writing of the outcome of the reconsideration.~~

220.000 PRIOR AUTHORIZATION

There are certain surgical procedures and medical services and procedures that are not reimbursable without prior authorization, either because of federal requirements or because of the nature of the service.

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~~The Arkansas Medicaid Program contracts with the Arkansas Foundation for Medical Care, Inc., (AFMC)~~DHS or its designated vendor ~~to~~ performs prior authorizations for several medical ~~and/~~or surgical procedures. Certain procedures are restricted to the outpatient setting unless prior authorized ~~by AFMC~~ for inpatient services. Other services may only be billed when performed in a nursing home or skilled nursing facility setting. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

Section 242.120 contains the list of all procedure codes that require prior authorization.

221.000 Prior Authorization ~~through the Arkansas Foundation for Medical Care, Inc. (AFMC)~~

8-1-21~~10-13-03~~

Prior authorization determinations are made ~~by the Arkansas Foundation for Medical Care, Inc., (AFMC)~~ by utilizing established medical or administrative criteria combined with the professional judgment of ~~AFMC's~~ physician advisors. Payment of services is made to participating providers in accordance with federal regulations.

~~Written documentation is not required for the prior authorization request. However, medical record documentation and reports must substantiate the oral information given to AFMC by a provider.~~

221.100 Procedure for Requesting Prior Authorization

8-1-21~~4-1-07~~

It is the responsibility of the podiatrist to initiate the prior authorization request. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

~~The podiatrist or his or her office nurse must contact AFMC to request prior authorization. **View or print AFMC contact information.** To request authorization, call AFMC at 1-800-426-2234, between the hours of 8:30 a.m. 12:00 noon and 1:00 p.m. 5:00 p.m., Monday through Friday, with the exception of holidays.~~

CPT codes that require prior authorization ~~by AFMC~~ are located in Section 242.120 of this manual.

~~A. When calling AFMC to perform a review for medical necessity of a prior authorization procedure, the following information will be required: (All calls will be tape-recorded for quality assurance purposes.)~~

~~1. Patient name and address (including ZIP code)~~

~~2. Patient birth date~~

~~3. Patient Medicaid identification number~~

~~4. Podiatrist name and license number~~

~~5. Podiatrist provider identification number~~

~~6. Hospital or ambulatory surgery center name~~

~~7. Date of service for requested procedure~~

~~8. Facility provider identification number~~

~~9. CPT code for procedure(s)~~

~~10. Principal diagnosis and any other diagnoses~~

~~11. Signs/symptoms of illness~~

~~12. Medical indication for justification of procedure(s)~~

MARKUP

~~B. All patient identification information and medical information related to the necessity of the procedure must be provided for services to be authorized.~~

221.200 Approvals and Denials of Prior Authorization Requests

~~8-1-21~~ ~~7-1-07~~

~~AFMC will give approval or denial of the PA request by phone with a follow-up in writing.~~

A. If approved, ~~AFMC will assign~~ a prior authorization control number will be assigned~~that must be entered in the appropriate field in the CMS-1500 claim format when billing for the procedure~~.

B. If surgery is involved, a copy of the prior authorization will be ~~mailed~~ 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 podiatrist ~~or AFMC~~ to verify that prior authorization has been granted.

It is the responsibility of the primary podiatrist to distribute a copy of the authorization to the anesthesiologist and the assistant podiatrist if the assistant has been requested and approved.

C. The prior authorization control number must be entered in the appropriate field in the CMS-1500 claim format when billing for the procedure. The Medicaid Program will not pay for inpatient hospital services that require prior authorization if the prior authorization has not been requested and approved.

D. Consulting podiatrists must have a separate prior authorization and are responsible for ~~calling AFMC to receive~~ obtaining the prior authorization for their procedures. They will be given a prior authorization ~~number~~ at the time of ~~the call~~ their contact on those cases that are approved. A letter verifying the PA number will be sent to the consultant upon request.

Prior authorization of a service does not guarantee eligibility for a beneficiary. Payment is subject to verification that the beneficiary was eligible at the time the services were provided.

221.300 Post-Authorization

~~8-1-21~~ ~~10-1-08~~

Post-authorization will be granted only for emergency procedures ~~and/~~or retroactively eligible beneficiaries. Requests for emergency procedures must be ~~applied for~~requested on the first working day after the procedure has been performed. In cases of retroactive eligibility, ~~AFMC~~ DHS or its designated vendor must be contacted for post-authorization within sixty (60) days of the authorization date. **View or print contact information to obtain the DHS or designated vendor step-by-step process for post-authorization.**

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TOC required

201.600 Podiatrist's Role in the Pharmacy Program 8-1-21

PRESCRIPTION DRUG INFORMATION

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers in relation to their specialty of practice. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the DHS or designated pharmacy vendor website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

The latest information regarding prescription drug coverage is available from DHS or its designated Medicaid Pharmacy vendor. **View or print contact information for the DHS contracted Pharmacy Vendor**.

214.000 Benefit Limits 8-1-21

Medicaid-eligible patients are responsible for payment for services beyond the established benefit limits, unless DHS or its designated vendor authorizes an extension of a particular benefit. If a Medicaid-eligible patient elects to receive a service for which a benefit extension has been denied or is subsequently denied, the patient is responsible for payment. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.**

215.100 Procedure for Obtaining Extension of Benefits for Podiatry Services 8-1-21

A. Requests for extension of benefits for podiatry services for beneficiaries over age 21 must be submitted to DHS or its designated vendor A request for extension of benefits must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

   1. Requests for extension of benefits are considered only after a claim is denied because a benefit is exhausted/exceeds benefit limit.
   2. The request for extension of benefits must be received within ninety (90) calendar days of the date of the benefits-exhausted denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exhausted denial appears.
   3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.

B. Use form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services, to request extension of benefits for podiatry services. **View or print form DMS-671.** Consideration of requests for extension of benefits requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider's signature (with his or her credentials) and the date of the request are required on the form. Stamped or electronic signatures are accepted. All applicable records that support the medical necessity of the extended benefits request should be attached.

PROPOSED

C. An extension of benefits request will be approved, denied, or pended to ask for additional information within thirty (30) calendar days of receipt of the request. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied.

215.115 Extension of Benefits Review Process 8-1-21

View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits review.

220.000 PRIOR AUTHORIZATION

There are certain surgical procedures and medical services and procedures that are not reimbursable without prior authorization, either because of federal requirements or because of the nature of the service.

DHS or its designated vendor performs prior authorizations for several medical or surgical procedures. Certain procedures are restricted to the outpatient setting unless prior authorized for inpatient services. Other services may only be billed when performed in a nursing home or skilled nursing facility setting. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

Section 242.120 contains the list of all procedure codes that require prior authorization.

221.000 Prior Authorization 8-1-21

Prior authorization determinations are made by utilizing established medical or administrative criteria combined with the professional judgment of physician advisors. Payment of services is made to participating providers in accordance with federal regulations.

221.100 Procedure for Requesting Prior Authorization 8-1-21

It is the responsibility of the podiatrist to initiate the prior authorization request. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

CPT codes that require prior authorization are located in Section 242.120 of this manual.

221.200 Approvals and Denials of Prior Authorization Requests 8-1-21

A. If approved, a prior authorization control number will be assigned.

B. If surgery is involved, a copy of the prior 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 podiatrist to verify that prior authorization has been granted.

It is the responsibility of the primary podiatrist to distribute a copy of the authorization to the anesthesiologist and the assistant podiatrist if the assistant has been requested and approved.

C. The prior authorization control number must be entered in the appropriate field in the CMS-1500 claim format when billing for the procedure. The Medicaid Program will not pay for inpatient hospital services that require prior authorization if the prior authorization has not been requested and approved.

D. Consulting podiatrists must have a separate prior authorization and are responsible for obtaining the prior authorization for their procedures. They will be given a prior authorization at the time of their contact on those cases that are approved. A letter verifying the PA number will be sent to the consultant upon request.

PROPOSED

Prior authorization of a service does not guarantee eligibility for a beneficiary. Payment is subject to verification that the beneficiary was eligible at the time the services were provided.

221.300 Post-Authorization 8-1-21

Post-authorization will be granted only for emergency procedures or retroactively eligible beneficiaries. Requests for emergency procedures must be requested on the first working day after the procedure has been performed. In cases of retroactive eligibility, DHS or its designated vendor must be contacted for post-authorization within sixty (60) days of the authorization date. **View or print contact information to obtain the DHS or designated vendor step-by-step process for post-authorization.**

PROPOSED

TOC not required

214.100 Extension of Benefits for X-Ray Services

~~11-1-06~~8-1-21

A. Requests for extension of benefits for x-ray services must be submitted to DHS or its designated vendor. **View or print DHS or its designated vendor contact information for extension of benefits for x-ray services.** ~~mailed to Arkansas Foundation for Medical Care, Inc. (AFMC), Attention EOB Review.~~ **~~View or print the Arkansas Foundation for Medical Care, Inc. contact information.~~**

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

B. Benefit extension requests must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.~~A request for extension of benefits must be received by AFMC within 90 calendar days of the date of benefits-exhausted denial.~~

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. *Do not* send a claim.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services"

~~7-1-07~~8-1-21

Requests for extension of benefits for Clinical Services (Physician's Visits), Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc-), must be submitted to DHS or its designated vendor. **View or print DHS or its designated vendor contact information for extension of benefits for how to obtain information regarding submission processes.** AFMC for consideration. Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print form DMS-671.**

~~Complete i~~Instructions for accurate completion of form DMS- 671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

MARKUP

TOC not required

214.100 Extension of Benefits for X-Ray Services 8-1-21

A. Requests for extension of benefits for x-ray services must be submitted to DHS or its designated vendor. **View or print DHS or its designated vendor contact information for extension of benefits for x-ray services.**

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

B. Benefit extension requests must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. *Do not* send a claim.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services" 8-1-21

Requests for extension of benefits for Clinical Services (Physician's Visits), Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc-), must be submitted to DHS or its designated vendor. **View or print DHS or its designated vendor contact information for extension of benefits for how to obtain information regarding submission processes.** AFMC for consideration. Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print form DMS-671.**

Instructions for accurate completion of form DMS- 671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

PROPOSED

TOC required

211.300 Prosthetics Service Provision

~~9-1-18~~8-1-21

At least once every six (6) months, the prosthetics provider must receive a prescription for prosthetics services from either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice and, when applicable:

A. Prepare a *Medical Equipment Request for Prior Authorization and Prescription Form* (form DMS-679) for wheelchairs, wheelchair seating systems or wheelchair repairs for beneficiaries twenty-one (21) years of age or older and for specified services for beneficiaries under age twenty-one (21). **View or print form DMS-679 and instructions for completion.**

B. Prepare a Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components for some medical supplies (i.e.: compression burn garments), orthotic appliances, prosthetic devices and durable medical equipment for beneficiaries twenty-one (21) years of age or older and for specified services for beneficiaries under age twenty-one (21). **View or print form DMS-679A and instructions for completion.**

C. Send the prepared request for prior authorization to either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice for prescriptions

D. Send the completed *Medical Equipment Request for Prior Authorization and Prescription Form* (form DMS-679) to DHS or its designated vendor. **View or print contact information for how to obtain information regarding submission processes.**~~the Arkansas Foundation for Medical Care for prior authorization. **View or print the AFMC contact information.**~~

E. Send the *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to DHS or its designated vendor. **View or print contact information for how to obtain information regarding submission processes.** ~~the Arkansas Foundation for Medical Care, Inc. (AFMC) for prior authorization. **View or print the AFMC contact information.**~~

As necessary, the provider must:

A. Deliver and set up the prescribed equipment in the beneficiary's home,

B. Teach the beneficiary, families and caregivers the correct use and maintenance of equipment,

C. Repair equipment within three (3) working days of notification,

D. Retrieve from the beneficiary's home equipment no longer prescribed for the beneficiary and

E. Provide necessary documentation.

211.800 Electronic Filing of Extension of Benefits

~~8-1-21~~4-1-~~09~~

Form DMS-699, titled *Request for Extension of Benefits*, serves as both a request form and a notification of approval or denial of extension of benefits when requesting diapers and underpads for beneficiaries age three (3) and older. If the benefit extension is approved, the form returned to the provider will contain a Benefit Extension Control Number. The approval notification will

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also list the procedure codes approved for benefit extension, the approved dates or date-of-service range and the number of units of service (or dollars, when applicable) authorized.

Upon notification of a benefit extension approval, providers may file the benefit extension claims electronically, entering the assigned Benefit Extension Control Number in the Prior Authorization (PA) number field. Subsequent benefit extension requests to the Utilization Review Section will be necessary only when the Benefit Extension Control Number expires or when a beneficiary's need for services unexpectedly exceeds the amount or number of services granted under the benefit extension.

~~Form DMS-679A, titled *Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* serves as a request form when requesting extension of benefits for the augmentative communication device. AFMC will notify providers of approval or denial by letter.~~

212.201 (DME) Apnea Monitors for Infants Under Age 1

8-1-21~~3-1-10~~

Arkansas Medicaid covers apnea monitors only for infants less than one (1) year of age. Use of the apnea monitor must be medically necessary and prescribed by a physician.

A primary care physician (PCP) is not required until an infant's Medicaid eligibility has been determined. No PCP referral for medical services is required for retroactive eligibility periods.

For the initial certification, the prescribing physician must sign form DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. The physician's signature must be an original, not a stamp. When an apnea monitor is prescribed during a hospital discharge, the physician ordering the apnea monitor must be in consultation with a neonatologist or pulmonologist.

As necessary, the primary care physician's (PCP's) name and provider number must also be indicated on DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. The PCP's signature is not required on the initial certification but he or she must sign all re-certifications.

A prior authorization request for an apnea monitor must be submitted to ~~AFMC~~ DHS or its designated vendor on form DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. **View or print form DMS-679 and instructions for completion.** **~~View or print AFMC contact information.~~View or print contact information for how to obtain information regarding submission processes.**

~~Compliance, and the download monitor report, must accompany the request for continued use of the apnea monitor following the initial sixty-day time period.~~

Prior authorization is not required for the initial sixty-day period of use of the monitor. If the apnea monitor is needed longer than an initial sixty-day period, prior authorization is required.

A new prescription, documentation of compliance during the initial sixty-day period and proof of medical necessity for the continuation of monitoring are required.

Documentation of compliance and the download monitor report must accompany the request for continued use of the apnea monitor following the initial sixty-day time period.

The following criteria, established by the *American Academy of Pediatrics*, are to be used to evaluate the need for an apnea monitor after the initial sixty-day period:

A. Evidence exists that preterm infants are at greater risk of extreme apnea episodes until approximately forty-three (43) weeks post conceptual age. Monitoring may be indicated until forty-three (43) weeks post conceptual age unless extreme episodes persist beyond that time. Home monitoring may be indicated for other selected groups of infants, as well.

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B. Home cardiorespiratory monitoring may be warranted for premature infants who are at high risk of recurrent episodes of apnea, bradycardia, and hypoxemia after hospital discharge.

The use of home cardiorespiratory monitoring in this population should be limited to approximately forty-three (43) weeks post conceptual age or after the cessation of extreme episodes, whichever comes last.

C. Home cardiorespiratory monitoring may be warranted for infants who are technology dependent (tracheostomy, supplemental oxygen, continuous positive airway pressure, etc.), have unstable airways, have rare medical conditions affecting regulation of breathing or have symptomatic chronic lung disease.

In many of these cases, the use of pulse oximetry monitoring is superior and preferred over simple cardiorespiratory monitoring.

D. Other infants who may benefit from home cardiorespiratory home monitoring include:

1. Infants who have experienced an apparent life-threatening event (ALTE)

   An ALTE is defined as “an episode that is frightening to the observer and is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking or gagging.”

2. Infants with tracheotomies or anatomic abnormalities that may compromise their airway

3. Infants with metabolic or neurological abnormalities affecting respiratory control

4. Infants with chronic lung disease of prematurity (bronchopulmonary dysplasia, BPD), especially those requiring some form of respiratory support

E. Parents or caregivers must be counseled regarding the purpose of the home cardiorespiratory monitoring and realistic expectations of what it can and cannot contribute to an infant’s well being.

1. When monitoring is used in the home, parents and other caregivers must be trained in observation techniques, operation of the monitor, and infant cardiopulmonary resuscitation prior to the use of the monitor.

2. Medical and technical support staff should always be available for direct or telephone consultation.

F. Duration and discontinuation of home cardiorespiratory monitoring

1. When home monitoring is prescribed for apnea/bradycardia in preterm infants, the physician should establish a plan for review of clinical and event (download) data at forty-three (43) weeks post conceptual age. If monitoring is to be continued beyond that time, documentation should be provided as to why it should be continued as well as a plan for reevaluation.

2. Infants whose mothers have unsure dates (uncertain post-conceptual age) may be monitored until the infants are at least forty-three (43) weeks post conceptual age.

3. When home monitoring is prescribed for indications other than apnea/bradycardia in preterm infants, continuation of monitoring will be reviewed on a case-by-case basis.

4. Discontinuation of home monitoring should be a clinical decision based on a combination of clinical data and cardiorespiratory monitor event data.

5. Decisions regarding discontinuation of home monitoring should NOT be based on single-night pneumograms, which have no proven predictive value in this setting.

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212.202 (DME) Augmentative Communication Device (ACD), All Ages 8-1-21~~4-1-09~~

The augmentative communication device (ACD) is covered for beneficiaries of all ages. Coverage for beneficiaries under twenty-one (21) years of age must result from an EPSDT screen. There is a $7,500.00 lifetime benefit for augmentative communication devices. When a beneficiary who is under age twenty-one (21) has met the lifetime benefit and it is determined that additional equipment is medically necessary, the provider may request an extension of benefits by submitting form DMS-679A. **View or print form DMS-679A.**

The ACD is also covered for Medicaid beneficiaries twenty-one (21) years old and older. Prior authorization is required on the device and on repairs of the device. For beneficiaries who are age twenty-one (21) and above, ~~there is~~ a $7,500.00 lifetime benefit without benefit extensions applies.

The Arkansas Medicaid Program will not cover ACDs that are prescribed solely for social or educational development.

Training in the use of the device is not included and is not a covered cost.

Prior authorization **must** be requested for repairs of equipment or associated items after the expiration of the initial maintenance agreement.

Form DMS-679A, titled *Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* serves as a request form when requesting extension of benefits for the augmentative communication device. **View or print contact information for how to obtain information regarding submission processes for augmentative communication device.**

~~The following information must be submitted when requesting prior authorization for ACDs for Medicaid beneficiaries.~~

~~Submit form DMS-679A, titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*.~~ **~~View or print form DMS-679A and instructions for completion.~~** The form should be accompanied by:

A. A current augmentative communication evaluation completed by a multidisciplinary team consisting of, at least, a speech/language pathologist and an occupational therapist. The team may consist of a physical therapist, regular and special educators, caregivers and parents. The speech-language pathologist must lead the team and sign the ACD evaluation report. (For the qualifications of the team members, see the Hospital/Critical Access Hospital/End Stage Renal Disease provider manual.)

   1. The team must use an interdisciplinary approach in the evaluation, incorporating the goals, objectives, skills and knowledge of various disciplines. The team must use at least three ACD systems, with written documentation of each usage included in the ACD assessment.
   2. The evaluation report must indicate the medical reason for the ACD. The report must give specific recommendations of the system and justification of why one system is more appropriate than another system.
   3. The evaluation report must be submitted to the prosthetics provider who will request prior authorization for the ACD.

B. Written denial from the insurance company if the individual has other insurance.

~~This information **must** be submitted to AFMC.~~ **~~View or print AFMC contact information.~~**

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Benefit Limit

Arkansas Medicaid limits ~~There is a $7500 lifetime benefit for~~ augmentative communication devices to a $7500 lifetime benefit.. When the beneficiary under age twenty-one (21) has met the limit and it is determined that additional equipment is necessary, the provider may request an extension of benefits. DHS or its designated vendor reviews and determines approval or denial for an extension of the lifetime benefit. **View or print contact information for how to obtain information on how to submit the request.**

~~In order to obtain an extension of the $7,500.00 lifetime benefit for beneficiaries under 21 years of age, a medical necessity determination for additional equipment is required.~~ The provider must submit a form DMS-679A, a completed Medicaid claim and medical records substantiating medical necessity that the beneficiary cannot function using his or her existing equipment and whether the equipment can be repaired or needs repair. ~~The information must be sent to AFMC.~~ **View or print form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.*** ~~**View or print the AFMC contact information.**~~

~~The provider will be notified in writing of the approval or denial of the request for extended benefits.~~

212.203 Cochlear Implants for Beneficiaries Under Age 21

~~8-1-21~~ ~~4-15-11~~

Cochlear implants are covered through the Arkansas Medicaid Physician or Prosthetics Programs for eligible Medicaid beneficiaries under the age of twenty-one (21) years through the Child Health Services (EPSDT) program when prescribed by a physician.

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components, or a switch from a body-worn, external sound processor to a behind-the-ear (BTE) model or technological advances in hardware are not considered medically necessary and will not be approved.

A. Speech Processor

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processors will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional ~~medical~~ documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

B. Personal FM (Frequency Modulation) Systems

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available from any other source (i.e., educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

A request for prior authorization may be submitted for medically necessary FM systems (procedure code **V5273** for use with cochlear implant) that are not covered through IDEA;

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each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

C. Replacement, Repair, Supplies

The repair or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics Programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

D. Prior Authorization

A request for prior authorization of a medically necessary FM system (**V5273** for use with cochlear implant) and replacement cochlear implant parts requires a paper submission to DHS or its designated vendor. **View or print contact information for how to submit the PA request** ~~the Arkansas Foundation for Medical Care (AFMC)~~ using form **DMS-679A**. All documentation supporting medical necessity should be attached to the form. The provider will be notified in writing of the approval or denial of the request for prior authorization. **View or print form DMS-679A and instructions for completion.**

Prior authorization does not guarantee payment for services or the amount of payment for services. Eligibility for, and payment of, services are subject to all terms, conditions and limitations of the Arkansas Medicaid Program. Documentation must support medical necessity. The provider must retain all documentation supporting medical necessity in the beneficiary's medical record.

The following procedure codes must be prior authorized. Providers should use the following procedure codes when requesting prior authorization for replacement parts for cochlear implant devices. Applicable manufacturer warranty options must be exhausted before coverage is considered. Most warranties include one (1) replacement for a stolen, lost or damaged piece of equipment free-of-charge by the manufacturer.

The table below contains new and existing HCPCS procedure codes for FM systems for use with cochlear implant and replacement cochlear implant parts.

NOTE: Coverage and billing requirements for the physician provider for cochlear device implantation are unchanged.

Procedure Code	M1	Age Restriction	PA	Payment Method
L8627*	EP	0-20	Y	Manually Priced
L8628*	EP	0-20	Y	Manually Priced
L8629*	EP	0-20	Y	Manually Priced

*Denotes paper claim

See Section 242.155 for information on billing and reimbursement for FM system and replacement cochlear implant parts.

MARKUP

212.204 (DME) Electronic Blood Pressure Monitor and Cuff for Beneficiaries of All Ages

~~4-1-09~~8-1-21

Arkansas Medicaid covers the automatic electronic blood pressure monitor for beneficiaries of all ages as a rental-only item. A provider must substantiate that an accurate blood pressure reading cannot be obtained by using a regular blood pressure monitor. Providers must also supply one (1) disposable blood pressure cuff each month.

Prior authorization is required for the use of this item. Providers may request prior authorization by submitting form DMS-679A, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components to ~~AFMC~~DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request.** ~~**View or print AFMC contact information.**~~

212.205 (DME) Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit for Beneficiaries Under Age 21

8-1-21~~4-1-09~~

The request for an enteral nutrition pump is covered on a case-by-case basis for beneficiaries under age twenty-one (21) who require supplemental feeding because of medical necessity. Sufficient medical documentation must be provided to establish that the enteral nutrition infusion pump is medically necessary (e.g., supplemental feeding must be given over an extended period of time due to reflux, cystic fibrosis, etc.). The PCP or appropriate physician specialist must prescribe the pump, citing the medical reason that bolus feeds are inappropriate.

Reimbursement for use in the home may be made for the pump supply kit when the feeding method involves an enteral nutrition infusion pump. The pump supply kit and the infusion pump require prior authorization from ~~AFMC~~ DHS or its designated vendor using form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.* **View or print contact information for how to submit the request.** ~~**View or print AFMC contact information.**~~ **View or print form DMS-679A and instructions for completion.**

The enteral feeding pump supply kit, necessary for the administration of the nutrients when the feeding method involves an enteral nutrition infusion pump, is reimbursed on a per-unit basis with one (1) day equaling one (1) unit of service. A maximum of one (1) unit per day is allowed. The pump supply kit includes pump sets, containers and syringes necessary for administration of the nutrients.

Reimbursement for the enteral nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid. Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized. **View or print form DMS-679A and instructions for completion.**

Requests for prior authorization for enteral pump repairs must be ~~mailed to AFMC~~submitted to DHS or its designated vendor. Form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, must be used to request prior authorization. **View or print contact information for how to submit the request.** **View or print form DMS-679A and instructions for completion.**

212.207 (DME) Insulin Pump and Supplies, All Ages

~~4-1-09~~8-1-21

Insulin pumps and supplies are covered by Arkansas Medicaid for beneficiaries of all ages.

Prior authorization is required for the insulin pump. A prescription and proof of medical necessity are required. The patient must be educated on the use of the pump, but the education is not a covered service.

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Insulin is ~~also not~~ covered through ~~because it is covered in~~ the prescription drug program.

The following criteria will be utilized in evaluating the need for the insulin pump:

A. Insulin-dependent diabetes that is difficult to control.

B. Fluctuation in blood sugars causing both high and low blood sugars in a patient on at least three (3), if not four (4), injections per day.

C. Beneficiary's motivation level in controlling diabetes and willingness to do frequent blood glucose monitoring.

D. Beneficiary's ability to learn how to use the pump effectively. This will have to be evaluated and documented by a professional with experience in the use of the pump.

E. Determination of the beneficiary's suitability to use the pump should be made by a diabetes specialist or endocrinologist.

F. Beneficiaries not included in one (1) of these categories will be considered on an individual basis.

Prior authorization requests for the insulin pump and supplies must be submitted on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, to DHS or its designated vendor.~~AFMC.~~ **View or print form DMS-679A and instructions for completion. View or print contact information for how to submit the request.~~View or print AFMC contact information.~~**

212.212 (DME) Specialized Rehabilitative Equipment, All Ages ~~8-1-21~~ ~~1-09~~

Arkansas Medicaid covers specialized rehabilitative equipment for Medicaid-eligible beneficiaries of all ages.

Some items of specialized equipment require prior authorization from ~~AFMC~~DHS or its designated vendor. **View or print form DMS-679A and instructions for completion. View or print contact information for how to submit the request.~~View or print AFMC contact information.~~**

212.213 (DME) Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult ~~8-1-21~~ ~~6-15~~

Arkansas Medicaid covers specialized wheelchairs and wheelchair seating systems for individuals age two (2) through adulthood.

Some items of specialized equipment require prior authorization from DHS or its designated vendor.~~the Arkansas Foundation for Medical Care (AFMC).~~ **View or print form DMS-679 and instructions for completion. View or print contact information for how to submit the request.~~View or print the AFMC contact information.~~**

212.600 Orthotic Appliances and Prosthetic Devices, All Ages ~~8-1-21~~ ~~5-22-19~~

A. The Arkansas Medicaid Program covers orthotic appliances and prosthetic devices for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. Providers of orthotic appliances and prosthetic devices may be reimbursed by the Arkansas Medicaid Program when the items are prescribed by a physician and documented as medically necessary for beneficiaries under age twenty-one (21) participating in the Child Health Services (EPSDT) Program.

1. No prior authorization is required to obtain these services for beneficiaries under age twenty-one (21).

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2. No benefit limits apply to orthotic appliances and prosthetic devices for beneficiaries under age twenty-one (21).

B. Arkansas Medicaid covers orthotic appliances for beneficiaries age twenty-one (21) and over. The following provisions must be met before services may be provided.

1. Prior authorization is required for orthotic appliances valued at or above the Medicaid maximum allowable reimbursement rate of $500.00 per item ~~for use by beneficiaries age 21 and over~~. Prior authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to ~~AFMC~~DHS or its designated vendor. **View or print form DMS-679A and instructions for completion. View or print contact information for how to submit the request.** ~~**View or print AFMC contact information.**~~

2. ~~For beneficiaries age 21 and over, a~~A benefit limit of $3,000 per state fiscal year (SFY; July 1 through June 30) has been established for reimbursement for orthotic appliances. No extension of benefits will be granted.

   The following restrictions apply to the coverage of orthotic appliances ~~for beneficiaries age 21 and over~~:

   a. Orthotic appliances may not be replaced for twelve (12) months from the date of purchase. If a beneficiary's condition warrants a modification or replacement and the $3,000.00 SFY benefit limit has not been met, the provider may submit documentation to ~~AFMC~~DHS or its designated vendor, to substantiate medical necessity. **View or print contact information for how to submit the request.** ~~**If approved, AFMC will issue a prior authorization number.** Section 221.000 of this provider manual may be referenced for information regarding prior authorization procedures.~~

   b. Custom-molded orthotic appliances are not covered for a diagnosis of carpal tunnel syndrome prior to surgery.

C. Arkansas Medicaid covers prosthetic devices for beneficiaries age twenty-one (21) and over; however, the following provisions must be met before services may be provided.

1. Prior authorization will be required for prosthetic device items valued at or in excess of the $1,000.00 per item Medicaid maximum allowable reimbursement rate ~~for use by beneficiaries age 21 and over~~. Prior authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to ~~AFMC~~DHS or its designated vendor. **View or print form DMS-679A and instructions for completion. View or print contact information for how to submit the request.**

2. ~~For beneficiaries age 21 and over, a~~A benefit limit of $60,000 per SFY has been established for reimbursement for prosthetic devices. No extension of benefits will be granted.

3. The following restrictions apply to coverage of prosthetic devices ~~for beneficiaries age 21 and over~~:

   a. Prosthetic devices may be replaced only after five years have elapsed from their date of purchase. If the beneficiary's condition warrants a modification or replacement, and the $60,000 per SFY benefit limit has not been met, the provider may submit documentation to ~~AFMC~~ DHS or its designated vendor to substantiate medical necessity. ~~**If approved, AFMC will issue a prior authorization number.** Section 220.000 of this provider manual may be referenced for information regarding prior authorization procedures.~~ **View or print contact information for how to submit the request.**

   b. Myoelectric prosthetic devices may be purchased only when needed to replace myoelectric devices received by beneficiaries who were under age twenty-one (21) when they received the original device.

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D. The forms, listed below, are available for evaluating the need of beneficiaries age twenty-one (21) and over for orthotic appliances and prosthetic devices, and prescribing the needed appliances and equipment. The Medicaid Program does not require providers to use the forms, but the information the forms are designed to collect is required by Medicaid to process requests for prior authorization of orthotic appliances and prosthetic devices ~~for beneficiaries aged 21 and over.~~.

The appropriate forms (or the required information in a different format) must accompany the form DMS-679A. **View or print DMS-679A *titled Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* and instructions for completion.**

The forms and their titles are as follows:

1. DMS-647 Gait Analysis: Full Body. **View or print form DMS-647.**
2. DMS-648 Upper-Limb Prosthetic Evaluation. **View or print form DMS-648**.
3. DMS-649 Upper-Limb Prosthetic Prescription. **View or print form DMS-649**.
4. DMS-650 Lower-Limb Prosthetic Evaluation. **View or print form DMS-650**.
5. DMS-651 Lower-Limb Prosthetic Prescription. **View or print form DMS-651**.

212.700 Oxygen and Oxygen Supplies, All Ages

~~8-1-21~~ ~~4-1-09~~

A prescription for oxygen must be accompanied by a current arterial blood gas (ABG) laboratory report from a certified laboratory or the beneficiary's attending physician. A current laboratory report is defined as one performed within a maximum of thirty (30) days prior to the prescription for oxygen.

A prescription for oxygen must specify the oxygen flow rate, frequency and duration of use, estimate of the period of need for oxygen and method of delivery of oxygen to the beneficiary (e.g., two liters per minute, ten (10) minutes per hour, by nasal cannula for a period of two months). A prescription containing only "oxygen PRN" is not sufficient.

The following medical criteria will be utilized in evaluating coverage of oxygen:

A. Chronic Respiratory Disease

1. Continuous oxygen therapy
   Resting Pa02 less than 55 mm Hg
2. Nocturnal oxygen therapy
   Resting Pa02 less than 60 mm Hg
3. Exercise oxygen therapy
   Pa02 with exercise less than 55 mm Hg

B. Congestive Heart Failure
Symptomatic at rest, with Pa02 less than 60 mm Hg

C. Carcinoma of the Lung
Resting Pa02 less than 60 mm Hg

D. Others
Reviewed on an individual basis

E. Children
O2 saturation below 94% by pulse oximeter with elevated PCO2 by capillary blood gas or end-tidal CO2 on two separate occasions.

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The prior authorization request for all oxygen and respiratory equipment must be submitted on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to ~~AFMC~~ DHS or its designated vendor for beneficiaries of all ages. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.

221.100 Request for Prior Authorization

~~8-1-21~~ ~~9-1-18~~

The request for prior authorization must originate with the prosthetics provider. The provider is responsible for obtaining the required medical information and prescription needed for completion of the prior authorization request form. **View or print contact information for how to submit the request**.

~~A. The *Medical Equipment Request for Prior Authorization and Prescription Form* (Form DMS-679) will be used when requesting prior authorization for wheelchairs, wheelchair seating systems and wheelchair repairs. The primary care physician or advanced practice registered nurse within the scope of practice must sign the DMS-679. The primary care physician's or advanced practice registered nurse's signature must be an original, not a stamp.~~

~~Form DMS-679 must contain a diagnosis of the disease(s) necessitating use of prosthetics services.~~ **~~View or print form DMS-679 and instructions for completion.~~**

~~B. The Arkansas Foundation for Medical Care, Inc., (AFMC) reviews requests for prior authorization for some medical supplies (i.e., compression burn garments), orthotic appliances, prosthetic devices and durable medical equipment, excluding wheelchairs, wheelchair seating systems and wheelchair repairs. Form DMS-679A, titled *Prescription and Prior Authorization Request for Medicaid Equipment Excluding Wheelchairs & Wheelchair Components* must be completed for use with those items of durable medical equipment, excluding wheelchairs, wheelchair seating systems and wheelchair repairs.~~

~~221.200 Filing for Prior Authorization~~

~~4-6-15~~

~~Requests for prior authorization will be handled by the Arkansas Foundation for Medical Care (AFMC).~~

~~A. To request prior authorization for wheelchair and wheelchair seating systems, providers must use form DMS-679 and send the information to AFMC. The original and the first copy of the *Medical Equipment Request for Prior Authorization and Prescription Form* (form DMS-679) must be forwarded to AFMC. The third copy of the form must be retained in the provider's records.~~ **~~View or print the AFMC contact information.~~**

~~B. Requests for prior authorization of some medical supplies (i.e.: compression burn garments), orthotic appliances, prosthetic devices and all durable medical equipment, excluding wheelchairs and wheelchair seating systems, must be submitted to AFMC on the *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* Form (DMS-679A).~~ **~~View or print form DMS-679A.~~**

221.300 Approvals of Prior Authorization

~~8-1-21~~ ~~4-6-15~~

A. ~~The Arkansas Foundation for Medical Care (AFMC)~~DHS or its designated vendor reviews requests for prior authorization for wheelchair and wheelchair seating systems. If necessary, ~~AFMC may request~~ additional information shall be requested to determine the medical need. **View or print contact information for how to submit the request**.

1. When a request is approved for wheelchairs, wheelchair seating systems or wheelchair repair, a prior authorization control number will be assigned ~~by AFMC~~.

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Determination of "purchase," "rental only," or "capped rental" will be made and an expiration date for "rental only" and "capped rental" items will be assigned. This information will be indicated on the copy of the form DMS-679 that is returned to the provider ~~from AFMC~~ within thirty (30) working days of receipt of the prior authorization request.

2. Prior authorization may only be approved for a maximum of six (6) months (180 days) for beneficiaries of all ages. Within thirty (30) working days before the end of currently prior authorized prosthetics services, the prosthetics provider must obtain a new prescription. If applicable, the provider must prepare and send a new *Medical Equipment Request for Prior Authorization and Prescription* Form (Form DMS-679), signed by the physician~~, to AFMC~~.

3. The effective date of the prior authorization will be the date on which the beneficiary's physician prescribed prosthetics services or the day following the last day of the previously prior authorized time period, whichever comes last.

~~B. **Consideration of prior authorization requests by AFMC requires correct completion of all fields on the request form**. The prior authorization request form must contain current medical documentation necessitating use of the required prosthetics. **If necessary, AFMC may request additional information**.~~

~~1. When a PA request is approved, a prior authorization control number will be assigned by AFMC. **View or print AFMC contact information**. Prior authorization approvals will be authorized for a maximum of six (6) months (180 days) for beneficiaries of all ages. The effective date of the prior authorization will be the date on which the beneficiary's physician prescribed prosthetics services or the day following the last day of the previously prior authorized time period, whichever comes last.~~

~~2. Within 30 working days before the end of currently authorized prosthetics services, the provider must obtain a new prescription. If applicable, the provider must prepare and submit a new *Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* (form DMS-679A) signed by the prescribing physician.~~

~~C~~B. Providers should note the following authorization process exception.

1. Prior authorization numbers for "capped rental" items will be effective for the entire "capped rental" time period of fifteen (15) months. Therefore, only one prior authorization number is needed.

   a. Providers may use the one (1) prior authorization number for billing of "capped rental" items for all fifteen (15) months.

   b. Previous prior authorization for an item will count toward the total 15-month period.

   c. Providers must resubmit a request for prior authorization after the first 180 days.

   d. Necessary information will be indicated on the copy of the notification letter sent to the provider within thirty (30) working days of receipt of the prior authorization request.

236.000 Reimbursement for Repair of the Enteral Nutrition Pump

~~8-1-21~~~~4-1-09~~

Reimbursement for repairs to the enteral nutrition infusion pump requires prior authorization. Repairs will be approved only on equipment purchased by Medicaid. Therefore, no repairs will be reimbursable prior to the equipment becoming the property of the Medicaid beneficiary.

Requests for prior authorization for enteral pump repairs must be ~~mailed to AFMC~~submitted to DHS or its designated vendor. **View or print contact information for how to submit the**

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request.~~(View or print AFMC contact information)~~ Requests must be made on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.* (**View or print form DMS-679A and instructions for completion.**)

The repair invoice and the serial number of the equipment must accompany the prior authorization request form. Total repair costs to an infusion pump may not exceed $290.93. Medicaid will not reimburse for additional repairs to an infusion pump after the provider has billed repair invoices totaling $290.93. If the equipment is still not in ~~proper~~ working order after the provider has billed the Medicaid maximum allowed for repairs, the provider must supply the beneficiary with a new infusion pump and may bill either procedure code **B9000** or **B9002** after receiving prior authorization for the new piece of equipment.

242.122 Jobst Stocking for Beneficiaries of All Ages

~~8-1-2111-1-17~~

The gradient compression stocking (Jobst) is payable for beneficiaries of all ages. However, before supplying the item, the Jobst stocking must be prior authorized by ~~AFMC~~DHS or its designated vendor. **View or print contact information for how to submit the request.** ~~**View or print form DMS-679A and instructions for completion.**~~ Documentation accompanying form DMS-679A must indicate that the beneficiary has severe varicose veins with edema, or a venous ~~statis~~stasis ulcer, unresponsive to conventional therapy such as wrappings, over-the-counter stockings and Unna boots. The documentation must include clinical medical records from a physician detailing the failure of conventional therapy. **View or print form DMS-679A and instructions for completion.**

National Procedure Code	M1	M2	Description	Maximum Units
A6530	NU EP		Gradient compression stocking, below knee, 18-30mm Hg, each	Maximum 4 units per date of service
A6549	NU		Gradient compression stocking, NOS (Jobst); 1 unit = 1 stocking	Maximum 4 units per date of service

242.152 Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit

~~8-1-2111-1-17~~

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under twenty-one (21) years of age. When a second modifier is listed, that modifier must be used in conjunction with **EP**.

The procedure codes require prior authorization from ~~AFMC~~DHS or its designated vendor. **View or print contact information for how to submit the request.**

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a “Y” in the column; if not, an “N” is shown.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

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National Procedure Code	M1	M2	Description	Maximum Units	PA	Payment Method
B4035	EP		Enteral feeding supply kit, pump fed, per day (1 unit = 1 day)	1 per day	Y	Purchase
B9000	EP		Enteral nutrition infusion pump – without alarm (1 day = 1 unit)	1 per day	Y	Rent to Purchase
B9002	EP		Enteral nutrition infusion pump – with alarm (1 day = 1 unit)	1 per day	Y	Rent to Purchase
K0739	EP	U2	⁂(Repair or non-routine service for enteral nutrition infusion pump, requiring the skill of a technician, parts and labor)		Y	

Enteral Nutrition Infusion Pump

Reimbursement for the enteral nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid.

Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized. Procedure codes **B9000** and **B9002** represent a new piece of equipment being reimbursed by Medicaid on the rent-to-purchase plan.

Codes **B9000** and **B9002** are reimbursed on a per unit basis with 1 day equaling 1 unit of service per day.

Medicaid will reimburse on the rent-to-purchase plan for a total of 304 units of service. After reimbursement has been made for 304 units, the equipment will become the property of the Medicaid beneficiary.

Prior authorization is required for codes **B9000** and **B9002**. The prior authorization request must include the serial number of the infusion pump being provided to the beneficiary.

See Section 236.000 for reimbursement when the Medicaid Program is billed for repairs made to the enteral infusion pump.

242.195 Repairs of Specialized Wheelchairs and Wheelchair Systems

8-1-21~~5-1-17~~

A. Arkansas Medicaid will cover repairs for wheelchairs and wheelchair seating.

B. Repair services must receive prior authorization from ~~AFMC~~DHS or its designated vendor. **View or print contact information for how to submit the request**.

C. Detailed documentation from the technician that supports the equipment or services being requested must be submitted. Documentation must include the following:

1. Date and place of purchase of the current chair.
2. Brand and model name of the base.
3. Brand and model name of parts and accessories needed for repairs.

D. Correct procedure codes per the current Medicaid policy must be used.

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211.300 Prosthetics Service Provision 8-1-21

At least once every six (6) months, the prosthetics provider must receive a prescription for prosthetics services from either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice and, when applicable:

A. Prepare a *Medical Equipment Request for Prior Authorization and Prescription Form* (form DMS-679) for wheelchairs, wheelchair seating systems or wheelchair repairs for beneficiaries twenty-one (21) years of age or older and for specified services for beneficiaries under age twenty-one (21). **View or print form DMS-679 and instructions for completion.**

B. Prepare a Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components for some medical supplies (i.e.: compression burn garments), orthotic appliances, prosthetic devices and durable medical equipment for beneficiaries twenty-one (21) years of age or older and for specified services for beneficiaries under age twenty-one (21). **View or print form DMS-679A and instructions for completion.**

C. Send the prepared request for prior authorization to either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice for prescriptions

D. Send the completed *Medical Equipment Request for Prior Authorization and Prescription Form* (form DMS-679) to DHS or its designated vendor. **View or print contact information for how to obtain information regarding submission processes.C:\Users\cmcrater\AppData\Local\Microsoft\Windows\INetCache\Links\afmc.doc**

E. Send the *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to DHS or its designated vendor. **View or print contact information for how to obtain information regarding submission processes.**

As necessary, the provider must:

A. Deliver and set up the prescribed equipment in the beneficiary's home,

B. Teach the beneficiary, families and caregivers the correct use and maintenance of equipment,

C. Repair equipment within three (3) working days of notification,

D. Retrieve from the beneficiary's home equipment no longer prescribed for the beneficiary and

E. Provide necessary documentation.

211.800 Electronic Filing of Extension of Benefits 8-1-21

Form DMS-699, titled *Request for Extension of Benefits*, serves as both a request form and a notification of approval or denial of extension of benefits when requesting diapers and underpads for beneficiaries age three (3) and older. If the benefit extension is approved, the form returned to the provider will contain a Benefit Extension Control Number. The approval notification will also list the procedure codes approved for benefit extension, the approved dates or date-of-service range and the number of units of service (or dollars, when applicable) authorized.

Upon notification of a benefit extension approval, providers may file the benefit extension claims electronically, entering the assigned Benefit Extension Control Number in the Prior Authorization

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(PA) number field. Subsequent benefit extension requests to the Utilization Review Section will be necessary only when the Benefit Extension Control Number expires or when a beneficiary's need for services unexpectedly exceeds the amount or number of services granted under the benefit extension.

212.201 (DME) Apnea Monitors for Infants Under Age 1 8-1-21

Arkansas Medicaid covers apnea monitors only for infants less than one (1) year of age. Use of the apnea monitor must be medically necessary and prescribed by a physician.

A primary care physician (PCP) is not required until an infant's Medicaid eligibility has been determined. No PCP referral for medical services is required for retroactive eligibility periods.

For the initial certification, the prescribing physician must sign form DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. The physician's signature must be an original, not a stamp. When an apnea monitor is prescribed during a hospital discharge, the physician ordering the apnea monitor must be in consultation with a neonatologist or pulmonologist.

As necessary, the primary care physician's (PCP's) name and provider number must also be indicated on DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. The PCP's signature is not required on the initial certification but he or she must sign all re-certifications.

A prior authorization request for an apnea monitor must be submitted to DHS or its designated vendor on form DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. **View or print form DMS-679 and instructions for completion.** **View or print contact information for how to obtain information regarding submission processes.**

Prior authorization is not required for the initial sixty-day period of use of the monitor. If the apnea monitor is needed longer than an initial sixty-day period, prior authorization is required.

A new prescription, documentation of compliance during the initial sixty-day period and proof of medical necessity for the continuation of monitoring are required.

Documentation of compliance and the download monitor report must accompany the request for continued use of the apnea monitor following the initial sixty-day time period.

The following criteria, established by the *American Academy of Pediatrics*, are to be used to evaluate the need for an apnea monitor after the initial sixty-day period:

A. Evidence exists that preterm infants are at greater risk of extreme apnea episodes until approximately forty-three (43) weeks post conceptual age. Monitoring may be indicated until forty-three (43) weeks post conceptual age unless extreme episodes persist beyond that time. Home monitoring may be indicated for other selected groups of infants, as well.

B. Home cardiorespiratory monitoring may be warranted for premature infants who are at high risk of recurrent episodes of apnea, bradycardia, and hypoxemia after hospital discharge.

   The use of home cardiorespiratory monitoring in this population should be limited to approximately forty-three (43) weeks post conceptual age or after the cessation of extreme episodes, whichever comes last.

C. Home cardiorespiratory monitoring may be warranted for infants who are technology dependent (tracheostomy, supplemental oxygen, continuous positive airway pressure, etc.), have unstable airways, have rare medical conditions affecting regulation of breathing or have symptomatic chronic lung disease.

PROPOSED

In many of these cases, the use of pulse oximetry monitoring is superior and preferred over simple cardiorespiratory monitoring.

D. Other infants who may benefit from home cardiorespiratory home monitoring include:

1. Infants who have experienced an apparent life-threatening event (ALTE)

   An ALTE is defined as "an episode that is frightening to the observer and is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking or gagging."

2. Infants with tracheotomies or anatomic abnormalities that may compromise their airway

3. Infants with metabolic or neurological abnormalities affecting respiratory control

4. Infants with chronic lung disease of prematurity (bronchopulmonary dysplasia, BPD), especially those requiring some form of respiratory support

E. Parents or caregivers must be counseled regarding the purpose of the home cardiorespiratory monitoring and realistic expectations of what it can and cannot contribute to an infant's well being.

1. When monitoring is used in the home, parents and other caregivers must be trained in observation techniques, operation of the monitor, and infant cardiopulmonary resuscitation prior to the use of the monitor.

2. Medical and technical support staff should always be available for direct or telephone consultation.

F. Duration and discontinuation of home cardiorespiratory monitoring

1. When home monitoring is prescribed for apnea/bradycardia in preterm infants, the physician should establish a plan for review of clinical and event (download) data at forty-three (43) weeks post conceptual age. If monitoring is to be continued beyond that time, documentation should be provided as to why it should be continued as well as a plan for reevaluation.

2. Infants whose mothers have unsure dates (uncertain post-conceptual age) may be monitored until the infants are at least forty-three (43) weeks post conceptual age.

3. When home monitoring is prescribed for indications other than apnea/bradycardia in preterm infants, continuation of monitoring will be reviewed on a case-by-case basis.

4. Discontinuation of home monitoring should be a clinical decision based on a combination of clinical data and cardiorespiratory monitor event data.

5. Decisions regarding discontinuation of home monitoring should NOT be based on single-night pneumograms, which have no proven predictive value in this setting.

212.202 (DME) Augmentative Communication Device (ACD), All Ages 8-1-21

The augmentative communication device (ACD) is covered for beneficiaries of all ages. Coverage for beneficiaries under twenty-one (21) years of age must result from an EPSDT screen. There is a $7,500.00 lifetime benefit for augmentative communication devices. When a beneficiary who is under age twenty-one (21) has met the lifetime benefit and it is determined that additional equipment is medically necessary, the provider may request an extension of benefits by submitting form DMS-679A. **View or print form DMS-679A.**

The ACD is also covered for Medicaid beneficiaries twenty-one (21) years old and older. Prior authorization is required on the device and on repairs of the device. For beneficiaries who are age twenty-one (21) and above, a $7,500.00 lifetime benefit without benefit extensions applies.

PROPOSED

The Arkansas Medicaid Program will not cover ACDs that are prescribed solely for social or educational development.

Training in the use of the device is not included and is not a covered cost.

Prior authorization **must** be requested for repairs of equipment or associated items after the expiration of the initial maintenance agreement.

Form DMS-679A, titled *Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* serves as a request form when requesting extension of benefits for the augmentative communication device. **View or print contact information for how to obtain information regarding submission processes for augmentative communication device.**

The form should be accompanied by:

A. A current augmentative communication evaluation completed by a multidisciplinary team consisting of, at least, a speech/language pathologist and an occupational therapist. The team may consist of a physical therapist, regular and special educators, caregivers and parents. The speech-language pathologist must lead the team and sign the ACD evaluation report. (For the qualifications of the team members, see the Hospital/Critical Access Hospital/End Stage Renal Disease provider manual.)

1. The team must use an interdisciplinary approach in the evaluation, incorporating the goals, objectives, skills and knowledge of various disciplines. The team must use at least three ACD systems, with written documentation of each usage included in the ACD assessment.
2. The evaluation report must indicate the medical reason for the ACD. The report must give specific recommendations of the system and justification of why one system is more appropriate than another system.
3. The evaluation report must be submitted to the prosthetics provider who will request prior authorization for the ACD.

B. Written denial from the insurance company if the individual has other insurance.

Benefit Limit

Arkansas Medicaid limits augmentative communication devices to a $7500 lifetime benefit. When the beneficiary under age twenty-one (21) has met the limit and it is determined that additional equipment is necessary, the provider may request an extension of benefits. DHS or its designated vendor reviews and determines approval or denial for an extension of the lifetime benefit. **View or print contact information for how to obtain information on how to submit the request.**

The provider must submit a form DMS-679A, a completed Medicaid claim and medical records substantiating medical necessity that the beneficiary cannot function using his or her existing equipment and whether the equipment can be repaired or needs repair. **View or print form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.***

212.203 Cochlear Implants for Beneficiaries Under Age 21 8-1-21

Cochlear implants are covered through the Arkansas Medicaid Physician or Prosthetics Programs for eligible Medicaid beneficiaries under the age of twenty-one (21) years through the Child Health Services (EPSDT) program when prescribed by a physician.

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

PROPOSED

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components, or a switch from a body-worn, external sound processor to a behind-the-ear (BTE) model or technological advances in hardware are not considered medically necessary and will not be approved.

A. Speech Processor

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processors will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

B. Personal FM (Frequency Modulation) Systems

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available from any other source (i.e., educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

A request for prior authorization may be submitted for medically necessary FM systems (procedure code **V5273** for use with cochlear implant) that are not covered through IDEA; each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

C. Replacement, Repair, Supplies

The repair or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics Programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

D. Prior Authorization

A request for prior authorization of a medically necessary FM system (**V5273** for use with cochlear implant) and replacement cochlear implant parts requires a paper submission to DHS or its designated vendor. **View or print contact information for how to submit the PA request** using form **DMS-679A**. All documentation supporting medical necessity should be attached to the form. The provider will be notified in writing of the approval or denial of the request for prior authorization. **View or print form DMS-679A and instructions for completion.**

Prior authorization does not guarantee payment for services or the amount of payment for services. Eligibility for, and payment of, services are subject to all terms, conditions and limitations of the Arkansas Medicaid Program. Documentation must support medical necessity. The provider must retain all documentation supporting medical necessity in the beneficiary's medical record.

The following procedure codes must be prior authorized. Providers should use the following procedure codes when requesting prior authorization for replacement parts for cochlear implant

PROPOSED

devices. Applicable manufacturer warranty options must be exhausted before coverage is considered. Most warranties include one (1) replacement for a stolen, lost or damaged piece of equipment free-of-charge by the manufacturer.

The table below contains new and existing HCPCS procedure codes for FM systems for use with cochlear implant and replacement cochlear implant parts.

NOTE: Coverage and billing requirements for the physician provider for cochlear device implantation are unchanged.

Procedure Code	M1	Age Restriction	PA	Payment Method
L8627*	EP	0-20	Y	Manually Priced
L8628*	EP	0-20	Y	Manually Priced
L8629*	EP	0-20	Y	Manually Priced

*Denotes paper claim

See Section 242.155 for information on billing and reimbursement for FM system and replacement cochlear implant parts.

212.204 (DME) Electronic Blood Pressure Monitor and Cuff for Beneficiaries of All Ages 8-1-21

Arkansas Medicaid covers the automatic electronic blood pressure monitor for beneficiaries of all ages as a rental-only item. A provider must substantiate that an accurate blood pressure reading cannot be obtained by using a regular blood pressure monitor. Providers must also supply one (1) disposable blood pressure cuff each month.

Prior authorization is required for the use of this item. Providers may request prior authorization by submitting form DMS-679A, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.

212.205 (DME) Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit for Beneficiaries Under Age 21 8-1-21

The request for an enteral nutrition pump is covered on a case-by-case basis for beneficiaries under age twenty-one (21) who require supplemental feeding because of medical necessity. Sufficient medical documentation must be provided to establish that the enteral nutrition infusion pump is medically necessary (e.g., supplemental feeding must be given over an extended period of time due to reflux, cystic fibrosis, etc.). The PCP or appropriate physician specialist must prescribe the pump, citing the medical reason that bolus feeds are inappropriate.

Reimbursement for use in the home may be made for the pump supply kit when the feeding method involves an enteral nutrition infusion pump. The pump supply kit and the infusion pump require prior authorization from DHS or its designated vendor using form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.* **View or print contact information for how to submit the request**. **View or print form DMS-679A and instructions for completion.**

The enteral feeding pump supply kit, necessary for the administration of the nutrients when the feeding method involves an enteral nutrition infusion pump, is reimbursed on a per-unit basis

PROPOSED

with one (1) day equaling one (1) unit of service. A maximum of one (1) unit per day is allowed. The pump supply kit includes pump sets, containers and syringes necessary for administration of the nutrients.

Reimbursement for the enteral nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid. Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized. **View or print form DMS-679A and instructions for completion.**

Requests for prior authorization for enteral pump repairs must be submitted to DHS or its designated vendor. Form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, must be used to request prior authorization. **View or print contact information for how to submit the request**. **View or print form DMS-679A and instructions for completion.**

212.207 (DME) Insulin Pump and Supplies, All Ages 8-1-21

Insulin pumps and supplies are covered by Arkansas Medicaid for beneficiaries of all ages.

Prior authorization is required for the insulin pump. A prescription and proof of medical necessity are required. The patient must be educated on the use of the pump, but the education is not a covered service.

Insulin is covered through the prescription drug program.

The following criteria will be utilized in evaluating the need for the insulin pump:

A. Insulin-dependent diabetes that is difficult to control.

B. Fluctuation in blood sugars causing both high and low blood sugars in a patient on at least three (3), if not four (4), injections per day.

C. Beneficiary's motivation level in controlling diabetes and willingness to do frequent blood glucose monitoring.

D. Beneficiary's ability to learn how to use the pump effectively. This will have to be evaluated and documented by a professional with experience in the use of the pump.

E. Determination of the beneficiary's suitability to use the pump should be made by a diabetes specialist or endocrinologist.

F. Beneficiaries not included in one (1) of these categories will be considered on an individual basis.

Prior authorization requests for the insulin pump and supplies must be submitted on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.

212.212 (DME) Specialized Rehabilitative Equipment, All Ages 8-1-21

Arkansas Medicaid covers specialized rehabilitative equipment for Medicaid-eligible beneficiaries of all ages.

Some items of specialized equipment require prior authorization from DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.

PROPOSED

212.213 (DME) Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult 8-1-21

Arkansas Medicaid covers specialized wheelchairs and wheelchair seating systems for individuals age two (2) through adulthood.

Some items of specialized equipment require prior authorization from DHS or its designated vendor. **View or print form DMS-679 and instructions for completion.** **View or print contact information for how to submit the request**.

212.600 Orthotic Appliances and Prosthetic Devices, All Ages 8-1-21

A. The Arkansas Medicaid Program covers orthotic appliances and prosthetic devices for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. Providers of orthotic appliances and prosthetic devices may be reimbursed by the Arkansas Medicaid Program when the items are prescribed by a physician and documented as medically necessary for beneficiaries under age twenty-one (21) participating in the Child Health Services (EPSDT) Program.

1. No prior authorization is required to obtain these services for beneficiaries under age twenty-one (21).
2. No benefit limits apply to orthotic appliances and prosthetic devices for beneficiaries under age twenty-one (21).

B. Arkansas Medicaid covers orthotic appliances for beneficiaries age twenty-one (21) and over. The following provisions must be met before services may be provided.

1. Prior authorization is required for orthotic appliances valued at or above the Medicaid maximum allowable reimbursement rate of $500.00 per item. Prior authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.
2. A benefit limit of $3,000 per state fiscal year (SFY; July 1 through June 30) has been established for reimbursement for orthotic appliances. No extension of benefits will be granted.

   The following restrictions apply to the coverage of orthotic appliances.:

   a. Orthotic appliances may not be replaced for twelve (12) months from the date of purchase. If a beneficiary's condition warrants a modification or replacement and the $3,000.00 SFY benefit limit has not been met, the provider may submit documentation to DHS or its designated vendor, to substantiate medical necessity. **View or print contact information for how to submit the request**.
   b. Custom-molded orthotic appliances are not covered for a diagnosis of carpal tunnel syndrome prior to surgery.

C. Arkansas Medicaid covers prosthetic devices for beneficiaries age twenty-one (21) and over; however, the following provisions must be met before services may be provided.

1. Prior authorization will be required for prosthetic device items valued at or in excess of the $1,000.00 per item Medicaid maximum allowable reimbursement rate. Prior authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion. View or print contact information for how to submit the request**.

PROPOSED

2. A benefit limit of $60,000 per SFY has been established for reimbursement for prosthetic devices. No extension of benefits will be granted.

3. The following restrictions apply to coverage of prosthetic devices:

   a. Prosthetic devices may be replaced only after five years have elapsed from their date of purchase. If the beneficiary's condition warrants a modification or replacement, and the $60,000 per SFY benefit limit has not been met, the provider may submit documentation to DHS or its designated vendor to substantiate medical necessity. **View or print contact information for how to submit the request**.

   b. Myoelectric prosthetic devices may be purchased only when needed to replace myoelectric devices received by beneficiaries who were under age twenty-one (21) when they received the original device.

D. The forms, listed below, are available for evaluating the need of beneficiaries age twenty-one (21) and over for orthotic appliances and prosthetic devices, and prescribing the needed appliances and equipment. The Medicaid Program does not require providers to use the forms, but the information the forms are designed to collect is required by Medicaid to process requests for prior authorization of orthotic appliances and prosthetic devices.

The appropriate forms (or the required information in a different format) must accompany the form DMS-679A. **View or print DMS-679A *titled Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* and instructions for completion.**

The forms and their titles are as follows:

1. DMS-647 Gait Analysis: Full Body. **View or print form DMS-647.**
2. DMS-648 Upper-Limb Prosthetic Evaluation. **View or print form DMS-648**.
3. DMS-649 Upper-Limb Prosthetic Prescription. **View or print form DMS-649**.
4. DMS-650 Lower-Limb Prosthetic Evaluation. **View or print form DMS-650**.
5. DMS-651 Lower-Limb Prosthetic Prescription. **View or print form DMS-651**.

212.700 Oxygen and Oxygen Supplies, All Ages 8-1-21

A prescription for oxygen must be accompanied by a current arterial blood gas (ABG) laboratory report from a certified laboratory or the beneficiary's attending physician. A current laboratory report is defined as one performed within a maximum of thirty (30) days prior to the prescription for oxygen.

A prescription for oxygen must specify the oxygen flow rate, frequency and duration of use, estimate of the period of need for oxygen and method of delivery of oxygen to the beneficiary (e.g., two liters per minute, ten (10) minutes per hour, by nasal cannula for a period of two months). A prescription containing only "oxygen PRN" is not sufficient.

The following medical criteria will be utilized in evaluating coverage of oxygen:

A. Chronic Respiratory Disease

1. Continuous oxygen therapy
   Resting Pa02 less than 55 mm Hg
2. Nocturnal oxygen therapy
   Resting Pa02 less than 60 mm Hg
3. Exercise oxygen therapy
   Pa02 with exercise less than 55 mm Hg

PROPOSED

B. Congestive Heart Failure
Symptomatic at rest, with Pa02 less than 60 mm Hg

C. Carcinoma of the Lung
Resting Pa02 less than 60 mm Hg

D. Others
Reviewed on an individual basis

E. Children
O2 saturation below 94% by pulse oximeter with elevated PCO2 by capillary blood gas or end-tidal CO2 on two separate occasions.

The prior authorization request for all oxygen and respiratory equipment must be submitted on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to DHS or its designated vendor for beneficiaries of all ages. **View or print form DMS-679A and instructions for completion. View or print contact information for how to submit the request**.

221.100 Request for Prior Authorization 8-1-21

The request for prior authorization must originate with the prosthetics provider. The provider is responsible for obtaining the required medical information and prescription needed for completion of the prior authorization request form. **View or print contact information for how to submit the request**.

221.300 Approvals of Prior Authorization 8-1-21

A. DHS or its designated vendor reviews requests for prior authorization for wheelchair and wheelchair seating systems. If necessary, additional information shall be requested to determine the medical need. **View or print contact information for how to submit the request**.

1. When a request is approved for wheelchairs, wheelchair seating systems or wheelchair repair, a prior authorization control number will be assigned. Determination of "purchase," "rental only," or "capped rental" will be made and an expiration date for "rental only" and "capped rental" items will be assigned. This information will be indicated on the copy of the form DMS-679 that is returned to the provider within thirty (30) working days of receipt of the prior authorization request.
2. Prior authorization may only be approved for a maximum of six (6) months (180 days) for beneficiaries of all ages. Within thirty (30) working days before the end of currently prior authorized prosthetics services, the prosthetics provider must obtain a new prescription. If applicable, the provider must prepare and send a new *Medical Equipment Request for Prior Authorization and Prescription* Form (Form DMS-679), signed by the physician.
3. The effective date of the prior authorization will be the date on which the beneficiary's physician prescribed prosthetics services or the day following the last day of the previously prior authorized time period, whichever comes last.

B. Providers should note the following authorization process exception.

1. Prior authorization numbers for "capped rental" items will be effective for the entire "capped rental" time period of fifteen (15) months. Therefore, only one prior authorization number is needed.
   a. Providers may use the one (1) prior authorization number for billing of "capped rental" items for all fifteen (15) months.

PROPOSED

b. Previous prior authorization for an item will count toward the total 15-month period.

c. Providers must resubmit a request for prior authorization after the first 180 days.

d. Necessary information will be indicated on the copy of the notification letter sent to the provider within thirty (30) working days of receipt of the prior authorization request.

236.000 Reimbursement for Repair of the Enteral Nutrition Pump 8-1-21

Reimbursement for repairs to the enteral nutrition infusion pump requires prior authorization. Repairs will be approved only on equipment purchased by Medicaid. Therefore, no repairs will be reimbursable prior to the equipment becoming the property of the Medicaid beneficiary.

Requests for prior authorization for enteral pump repairs must be submitted to DHS or its designated vendor. **View or print contact information for how to submit the request**. Requests must be made on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*. (**View or print form DMS-679A and instructions for completion.**)

The repair invoice and the serial number of the equipment must accompany the prior authorization request form. Total repair costs to an infusion pump may not exceed $290.93. Medicaid will not reimburse for additional repairs to an infusion pump after the provider has billed repair invoices totaling $290.93. If the equipment is still not in working order after the provider has billed the Medicaid maximum allowed for repairs, the provider must supply the beneficiary with a new infusion pump and may bill either procedure code **B9000** or **B9002** after receiving prior authorization for the new piece of equipment.

242.122 Jobst Stocking for Beneficiaries of All Ages 8-1-21

The gradient compression stocking (Jobst) is payable for beneficiaries of all ages. However, before supplying the item, the Jobst stocking must be prior authorized by DHS or its designated vendor. **View or print contact information for how to submit the request.** Documentation accompanying form DMS-679A must indicate that the beneficiary has severe varicose veins with edema, or a venous stasis ulcer, unresponsive to conventional therapy such as wrappings, over-the-counter stockings and Unna boots. The documentation must include clinical medical records from a physician detailing the failure of conventional therapy. **View or print form DMS-679A and instructions for completion.**

National Procedure Code	M1	M2	Description	Maximum Units
A6530	NU EP		Gradient compression stocking, below knee, 18-30mm Hg, each	Maximum 4 units per date of service
A6549	NU		Gradient compression stocking, NOS (Jobst); 1 unit = 1 stocking	Maximum 4 units per date of service

242.152 Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit 8-1-21

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under twenty-one (21) years of age. When a second modifier is listed, that modifier must be used in conjunction with **EP**.

PROPOSED

The procedure codes require prior authorization from DHS or its designated vendor. **View or print contact information for how to submit the request**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

National Procedure Code	M1	M2	Description	Maximum Units	PA	Payment Method
B4035	EP		Enteral feeding supply kit, pump fed, per day (1 unit = 1 day)	1 per day	Y	Purchase
B9000	EP		Enteral nutrition infusion pump – without alarm (1 day = 1 unit)	1 per day	Y	Rent to Purchase
B9002	EP		Enteral nutrition infusion pump – with alarm (1 day = 1 unit)	1 per day	Y	Rent to Purchase
K0739	EP	U2	⁂(Repair or non-routine service for enteral nutrition infusion pump, requiring the skill of a technician, parts and labor)		Y	

Enteral Nutrition Infusion Pump

Reimbursement for the enteral nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid.

Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized. Procedure codes **B9000** and **B9002** represent a new piece of equipment being reimbursed by Medicaid on the rent-to-purchase plan.

Codes **B9000** and **B9002** are reimbursed on a per unit basis with 1 day equaling 1 unit of service per day.

Medicaid will reimburse on the rent-to-purchase plan for a total of 304 units of service. After reimbursement has been made for 304 units, the equipment will become the property of the Medicaid beneficiary.

Prior authorization is required for codes **B9000** and **B9002**. The prior authorization request must include the serial number of the infusion pump being provided to the beneficiary.

See Section 236.000 for reimbursement when the Medicaid Program is billed for repairs made to the enteral infusion pump.

242.195 Repairs of Specialized Wheelchairs and Wheelchair Systems 8-1-21

A. Arkansas Medicaid will cover repairs for wheelchairs and wheelchair seating.

B. Repair services must receive prior authorization from DHS or its designated vendor. **View or print contact information for how to submit the request**.

PROPOSED

C. Detailed documentation from the technician that supports the equipment or services being requested must be submitted. Documentation must include the following:

1. Date and place of purchase of the current chair.
2. Brand and model name of the base.
3. Brand and model name of parts and accessories needed for repairs.

D. Correct procedure codes per the current Medicaid policy must be used.

E. Requests for repairs must be submitted on form DMS-679 (Prescription & Prior Authorization Request for Medical Equipment) and must be signed and dated by the beneficiary's PCP or ordering physician. **View or print form DMS-679 and instructions for completion.**

F. Repairs for previously authorized wheelchairs that the beneficiary has outgrown will not be covered if a new chair has been authorized.

G. In the event a request is submitted for repairs for a wheelchair authorized by another state agency, documentation or a delivery ticket showing that the wheelchair was authorized by another state agency must be submitted with the request.

H. Arkansas Medicaid will not cover repairs/damage due to the following:

1. Neglect.
2. Misuse.
3. Abuse.
4. Improper installation or repair by the DME provider.
5. Use of parts or changes by the DME provider or the beneficiary not authorized by Arkansas Medicaid.

I. When a request is submitted for a new wheelchair with a statement that the previous wheelchair cannot be repaired, documentation from the manufacturer of the previous chair stating the reason why the previous wheelchair cannot be repaired must be included.

J. If the previous wheelchair cannot be repaired, several color photographs taken at different angles must be included with the new request.

Miscellaneous

A. Only a physician can order a wheelchair.

B. A physician's evaluation is valid for a period of six (6) months. After six (6) months, the beneficiary must be re-evaluated by the physician to determine medical necessity for continued need based upon changes in conditions and measurements.

A DME request is considered outdated by Medicaid when it is first presented to Medicaid more than ninety (90) days from the date it was written, signed and dated by the physician.

PROPOSED

TOC required

213.010 Inpatient Hospital Services Benefit Limit

~~10-22-10~~8-1-21

A. There is no benefit limit for acute care/general and rehabilitative hospital inpatient services for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. Inpatient services must be approved by the QIO as medically necessary.

B. The benefit limit for acute care/general and rehabilitative hospital inpatient services is twenty-four (24) paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged twenty-one (21) and older.

C. When a beneficiary turns twenty-one (21) during an inpatient stay, the dates of service on or after his/her 21st birthday must be billed separately.

D. Arkansas Medicaid covers up to four (4) days of inpatient services with no certification requirement. If a beneficiary is not discharged before or during the fifth day, additional days are covered only if certified. The Medicaid Utilization Management Program (MUMP) determines covered inpatient lengths of stay in acute care/general and rehabilitative hospitals, in and out of state. See Sections 213.100 and 213.110 for MUMP certification request procedures.

E. Included in the total of paid inpatient days are any days covered by primary third-party resources (except Medicare and Railroad Retirement) for which Medicaid receives a secondary-payer claim that it adjudicates as paid. A Medicaid-secondary claim that adjudicates as a paid claim is counted toward the inpatient benefit limit.

1. Medicaid, when it is secondary to a third-party resource other than Medicare or Railroad Retirement, covers only the difference between the primary resource's remittance and Medicaid's per diem or maximum allowable fee for Medicaid-covered services reimbursed by the primary resource.

2. Even when the Medicaid paid amount is $0.00 because the third-party payment equals or exceeds Medicaid's per diem, the days thus paid are counted toward the benefit limit.

F. Extension of the 24-day inpatient benefit is ~~un~~available under the Medicaid Utilization Management Program (MUMP).

213.100 Medicaid Utilization Management Program (MUMP)

8-1-21~~10-13-03~~

The Medicaid Utilization Management Program (MUMP) determines covered inpatient lengths of stay in general and rehabilitative hospitals, in state and out-of-state. The MUMP does not apply to lengths of stay in psychiatric facilities.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), ~~Arkansas Foundation for Medical Care, Inc. (AFMC),~~ under contract to the Arkansas Medicaid Program.

213.110 MUMP Applicability

8-1-21~~10-13-03~~

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer (see part B, below). If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified by ~~AFMC~~DHS or its designated vendor. **View or print contact information for how to submit the request.**

MARKUP

B. When a patient is transferred from one hospital to another, the stay must be certified from the first day.

~~**213.130 Direct Admissions** **4-1-07**~~

~~A. When the attending physician determines the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact AFMC and request an extension of inpatient days. The following information is requested:~~

~~1. Patient name and address (including ZIP code)~~

~~2. Patient birth date~~

~~3. Patient Medicaid number~~

~~4. Admission date~~

~~5. Hospital name~~

~~6. Hospital provider identification number~~

~~7. Attending physician provider identification number~~

~~8. Principal diagnosis and other diagnoses influencing this stay~~

~~9. Surgical procedures performed or planned~~

~~10. The number of days requested for continued inpatient care~~

~~11. All available medical information justifying or supporting the necessity of continued stay in the hospital~~

~~**213.140 Transfer Admissions** **10-13-03**~~

~~If a patient is transferred from one hospital to another, the receiving facility must contact AFMC within 24 hours of admitting the patient to certify the inpatient stay. If admission falls on a weekend or holiday, the provider may contact AFMC on the first working day following the weekend or holiday.~~

213.150 Retroactive Eligibility **8-1-21**~~**10-13-03**~~

A. If eligibility is determined while the patient is still an inpatient, the hospital may ~~call~~ contact DHS or its designated vendor to request post-certification of inpatient days beyond the first four (4) days (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. **View or print contact information for how to submit the request.**

B. If eligibility is determined after discharge the hospital may ~~call AFMC~~contact DHS or its designated vendor for post-certification of inpatient days beyond the first four (4) days (or all days if the admission was by transfer). If certification sought is for a stay longer than thirty (30) days, the provider must submit the entire medical record ~~to AFMC~~ for review. **View or print contact information for how to submit the request.**

213.160 Third Party and Medicare Primary Claims **8-1-21**~~**10-13-03**~~

A. If a provider has not requested Medicaid Utilization Management Program (MUMP) certification of inpatient days because there is apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification required by the MUMP may be obtained by sending a copy of the third-party payer's denial notice to DHS or its designated vendor. **View or print contact information for how to submit the request.**~~as follows:~~

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~~1. Send a copy of the third party payer's denial notice to AFMC. **View or print AFMC contact information**. Include a written request for post certification.~~

~~2. Include complete provider contact information: full name and title, telephone number and extension.~~

~~3. An AFMC coordinator will call the provider contact for the certification information.~~

B. If a third-party insurer pays the provider for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

213.170 Requests for Reconsideration

8-1-21~~**10-13-03**~~

Reconsideration reviews of denied extensions may be expedited by ~~faxing~~ submitting the medical record to DHS or its designated vendor. **View or print contact information for how to submit the request.**~~AFMC. AFMC will advise the hospital of its decision by the next working day. **View or print AFMC contact information**.~~

215.120 Benefit Extension Requests

8-1-21~~**2-1-05**~~

A. Requests to extend benefits for outpatient rehabilitative hospital visits and laboratory and X-ray services, including those for fetal non-stress tests and fetal ultrasounds, must be mailed to DHS or its designated vendor. **View or print contact information for how to submit the request.** Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.~~Arkansas Foundation for Medical Care, Inc. (AFMC). View or print the Arkansas Foundation for Medical Care, Inc. (AFMC), contact information.~~

~~1. AFMC will not accept benefit extension requests transmitted via electronic facsimile (FAX).~~

~~2. Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.~~

B. ~~Submit with the request a~~A copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits accompany the request for review. Do not send a claim.

C. ~~AFMC reserves the right to request a~~Additional information ~~as~~ needed to process a benefit extension may be requested from the provider. Failures to ~~timely~~ provide requested additional information within the specified timeline will result in technical denials, reconsiderations of which are not available.

D. ~~AFMC must receive a~~A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

~~1. AFMC will consider extending benefits only when the extended benefits are medically necessary and all required documentation is received timely.~~

~~2. Requests received after the 90-day deadline will not be considered.~~

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

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215.123 Provider Notification of Benefit Extension Determinations 8-1-212-1-05

~~AFMC will approve or deny a~~A benefit extension ~~request~~approval or denial—or ~~ask~~ request for additional information—will be returned to the provider within thirty (30) calendar days.

A. ~~AFMC r~~Reviewers will simultaneously advise the provider and the beneficiary when a request is denied.

B. Provider notification of benefit extension approval includes:

1. The procedure code approved,
2. The total number of units approved for the procedure code,
3. The benefit extension control number and
4. The approved beginning and ending dates of service.

~~A denial notification letter is signed by a member of the benefit extension reviewing staff.~~

216.000 Retrospective Review of Occupational, Physical and Speech Therapy Services for Beneficiaries Under Age 21 8-1-217-1-15

~~The Quality Improvement Organization (QIO), under contract with the Arkansas Medicaid Program,~~DHS or its designated vendor performs retrospective reviews of medical records to determine the medical necessity of services paid for by Medicaid. . **View or print contact information for retrospective reviews.~~View or print AFMC contact information.~~**

Specific guidelines have been developed for retrospective review of occupational, physical and speech-language therapy services furnished to Medicaid beneficiaries under the age of twenty-one (21). Those guidelines are included in this manual to assist providers in determining and documenting medical necessity. The guidelines are ~~located~~ found in Sections 216.100 through 216.108.

216.112 Process for Requesting Extended Therapy Services for Beneficiaries Under Age 21 8-1-211-1-09

A. Requests for extended therapy services for beneficiaries under age twenty-one (21) must be ~~mailed~~ submitted to ~~the Arkansas Foundation for Medical Care, Inc. (AFMC)~~DHS or its designated vendor. . **View or print contact information for how to submit the request.~~View or print the Arkansas Foundation for Medical Care, Inc. contact information~~.** The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits exceeded.
2. The request must be received ~~by AFMC~~ within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit ~~with the request~~ a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

~~4. AFMC will not accept requests sent via electronic facsimile (FAX) or e-mail.~~

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. **View or print form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The

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provider must sign, include credentials and date the request form. An electronic signature is accepted provided it ~~is in compliance~~complies with Arkansas Code 25-31-103. All applicable documentation that supports the medical necessity of the request ~~should~~ must be attached.

C. ~~AFMC~~ DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. ~~AFMC r~~Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number ~~that is required to be submitted with the billing for the approved service~~.

216.114 ~~AFMC~~ Extended Therapy Services Review Process 8-1-21~~1-1-09~~

View or print contact information to obtain the DHS or designated vendor step-by-step process for an extended therapy services review.~~The following is a step-by-step outline of AFMC's extended services review process:~~

~~A. Requests received via mail are screened for completeness and researched to determine the beneficiary's eligibility for Medicaid when the service was provided and payment/denial status of the claim request.~~

~~B. The documentation submitted is reviewed by a registered nurse (R.N.). If, in the judgment of the R.N., the documentation supports the medical necessity, the R.N. may approve the request. An approval letter is generated and mailed to the provider the following day.~~

~~C. If the R.N. reviewer determines the documentation does not justify the service or it appears that the service is not medically necessary, the R.N. will refer the case to the appropriate physician adviser for a decision.~~

~~D. The physician adviser's rationale for approval or denial is documented and the appropriate notification is created. If services are denied for lack of medical necessity, the physician adviser's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.~~

~~E. Providers may request administrative reconsideration of an adverse decision or they and/or the beneficiary may appeal as provided in Section 160.000 of this manual.~~

~~F. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to incomplete documentation, but complete documentation supporting medical necessity is submitted with the reconsideration request, the R.N. may approve the extension of benefits without referral to a physician adviser.~~

~~G. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to lack of medical necessity documentation or the documentation does not allow for approval by the R.N., the original documentation, reason for the denial and new information submitted will be referred to a different physician adviser for reconsideration.~~

~~H. All parties will be notified in writing of the outcome of the reconsideration. Reconsiderations approved generate an approval number and is mailed to the provider for inclusion with billing for the requested service. Adverse decisions that are upheld through the reconsideration remain eligible for an appeal by the provider and/or the beneficiary as provided in Section 160.000 of this manual.~~

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TOC required

213.010 Inpatient Hospital Services Benefit Limit 8-1-21

A. There is no benefit limit for acute care/general and rehabilitative hospital inpatient services for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. Inpatient services must be approved by the QIO as medically necessary.

B. The benefit limit for acute care/general and rehabilitative hospital inpatient services is twenty-four (24) paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged twenty-one (21) and older.

C. When a beneficiary turns twenty-one (21) during an inpatient stay, the dates of service on or after his/her 21st birthday must be billed separately.

D. Arkansas Medicaid covers up to four (4) days of inpatient services with no certification requirement. If a beneficiary is not discharged before or during the fifth day, additional days are covered only if certified. The Medicaid Utilization Management Program (MUMP) determines covered inpatient lengths of stay in acute care/general and rehabilitative hospitals, in and out of state. See Sections 213.100 and 213.110 for MUMP certification request procedures.

E. Included in the total of paid inpatient days are any days covered by primary third-party resources (except Medicare and Railroad Retirement) for which Medicaid receives a secondary-payer claim that it adjudicates as paid. A Medicaid-secondary claim that adjudicates as a paid claim is counted toward the inpatient benefit limit.

1. Medicaid, when it is secondary to a third-party resource other than Medicare or Railroad Retirement, covers only the difference between the primary resource's remittance and Medicaid's per diem or maximum allowable fee for Medicaid-covered services reimbursed by the primary resource.

2. Even when the Medicaid paid amount is $0.00 because the third-party payment equals or exceeds Medicaid's per diem, the days thus paid are counted toward the benefit limit.

F. Extension of the 24-day inpatient benefit is available under the Medicaid Utilization Management Program (MUMP).

213.100 Medicaid Utilization Management Program (MUMP) 8-1-21

The Medicaid Utilization Management Program (MUMP) determines covered inpatient lengths of stay in general and rehabilitative hospitals, in state and out-of-state. The MUMP does not apply to lengths of stay in psychiatric facilities.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

213.110 MUMP Applicability 8-1-21

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer (see part B, below). If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified by DHS or its designated vendor. **View or print contact information for how to submit the request.**

B. When a patient is transferred from one hospital to another, the stay must be certified from the first day.

213.150 Retroactive Eligibility 8-1-21

PROPOSED

A. If eligibility is determined while the patient is still an inpatient, the hospital may contact DHS or its designated vendor to request post-certification of inpatient days beyond the first four (4) days (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. **View or print contact information for how to submit the request.**

B. If eligibility is determined after discharge the hospital may contact DHS or its designated vendor for post-certification of inpatient days beyond the first four (4) days (or all days if the admission was by transfer). If certification sought is for a stay longer than thirty (30) days, the provider must submit the entire medical record for review. **View or print contact information for how to submit the request.**

213.160 Third Party and Medicare Primary Claims 8-1-21

A. If a provider has not requested Medicaid Utilization Management Program (MUMP) certification of inpatient days because there is apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification required by the MUMP may be obtained by sending a copy of the third-party payer's denial notice to DHS or its designated vendor. **View or print contact information for how to submit the request.**

B. If a third-party insurer pays the provider for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

213.170 Requests for Reconsideration 8-1-21

Reconsideration reviews of denied extensions may be expedited by submitting the medical record to DHS or its designated vendor. **View or print contact information for how to submit the request.**

215.120 Benefit Extension Requests 8-1-21

A. Requests to extend benefits for outpatient rehabilitative hospital visits and laboratory and X-ray services, including those for fetal non-stress tests and fetal ultrasounds, must be mailed to DHS or its designated vendor. **View or print contact information for how to submit the request.** Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

B. A copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits accompany the request for review. Do not send a claim.

C. Additional information needed to process a benefit extension may be requested from the provider. Failures to provide requested additional information within the specified timeline will result in technical denials, reconsiderations of which are not available.

D. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.123 Provider Notification of Benefit Extension Determinations 8-1-21

A benefit extension approval or denial—or request for additional information—will be returned to the provider within thirty (30) calendar days.

A. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied.

PROPOSED

B. Provider notification of benefit extension approval includes:

1. The procedure code approved,
2. The total number of units approved for the procedure code,
3. The benefit extension control number and
4. The approved beginning and ending dates of service.

216.000 Retrospective Review of Occupational, Physical and Speech Therapy Services for Beneficiaries Under Age 21 8-1-21

DHS or its designated vendor performs retrospective reviews of medical records to determine the medical necessity of services paid for by Medicaid. **View or print contact information for retrospective reviews.**

Specific guidelines have been developed for retrospective review of occupational, physical and speech-language therapy services furnished to Medicaid beneficiaries under the age of twenty-one (21). Those guidelines are included in this manual to assist providers in determining and documenting medical necessity. The guidelines are found in Sections 216.100 through 216.108.

216.112 Process for Requesting Extended Therapy Services for Beneficiaries Under Age 21 8-1-21

A. Requests for extended therapy services for beneficiaries under age twenty-one (21) must be submitted to DHS or its designated vendor. **View or print contact information for how to submit the request.** The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits exceeded.
2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. **View or print form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials and date the request form. An electronic signature is accepted provided it complies with Arkansas Code 25-31-103. All applicable documentation that supports the medical necessity of the request must be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number.

216.114 Extended Therapy Services Review Process 8-1-21

View or print contact information to obtain the DHS or designated vendor step-by-step process for an extended therapy services review.

PROPOSED

TOC not required

217.100 Coverage Limitation—Medicaid Utilization Management Program

~~10-13-038~~-1-21

The Medicaid Utilization Management Program (MUMP) is designed to manage the appropriateness and duration of RSPD services. The MUMP procedures apply to all RSPD providers.

Length-of-stay determinations are performed by the Quality Improvement Organization (QIO), ~~Arkansas Foundation for Medical Care, Inc. (AFMC),~~ under contract to the Arkansas Medicaid Program.

217.110 MUMP Applicability

~~3-1-068~~-1-21

Medicaid beneficiaries are allowed up to four (4) days of RSPD services ~~as long as~~when the admission criteria (refer to Sections 213.000 through 213.300) are met. If a patient is not discharged before or during the fifth day of the residential stay, ~~*AFMC*~~ *DHS or its designated vendor must certify any additional days* ~~*beyond the initial four (4) days*~~.

When a patient is transferred from one RSPD facility to another, the stay must be certified by ~~AFMC~~ DHS or its designated vendor from the first day of transfer. (See Transfer Admissions, Section 217.132.) **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request.**

217.131 Extension of RSPD Admissions

~~4-1-078~~-1-21

A. When the RSPD provider's neuropsychologist and/or physician determines that a patient (age one (1) year or older) should not be discharged by the fifth day of residential stay due to the need for continued services, an RSPD medical staff member must contact ~~AFMC~~ DHS or its designated vendor and request an extension of the RSPD admission.

View or print contact information to obtain the DHS or its designated vendor step-by-step process for submitting the request.

~~To request an extension, an RSPD medical staff member must call AFMC.~~ ~~**View or print AFMC contact information.**~~ ~~The following information is required:~~

~~1. Patient's name and address (including ZIP code).~~

~~2. Patient's date of birth.~~

~~3. Patient's Medicaid ID number.~~

~~4. Admission date.~~

~~5. Name of the RSPD provider.~~

~~6. RSPD provider identification number.~~

~~7. Principal diagnosis and other diagnoses influencing this stay.~~

~~8. The number of days being requested for continued residential stay.~~

~~9. All available medical information justifying or supporting the necessity for continued stay in the RSPD facility.~~

~~B. AFMC may be contacted at 1-800-426-2234 between the hours of 8:30 a.m. and 12:00 noon and 1:00 and 5:00 p.m., Monday through Friday, with the exception of~~

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~~holidays. All calls are limited to 10 minutes to allow equal access to all providers and they will be monitored for quality assurance purposes.~~

~~C. Calls requesting an extension of the RSPD admission may be made at any time during the stay (except in the case of a transfer from another RSPD facility, refer to Section 217.132). However, the following will apply:~~

1. RSPD providers initiating their request after the fourth day must accept the financial liability should the stay not meet the medical criteria for continued RSPD services.
2. If the provider delays calling for an extension and the services are denied based on the lack of medical necessity, the patient will not be held liable.

~~D~~B. For a Medicaid patient under age one (1), the days from the admission date through the day before the patient's first birthday are exempt from the MUMP procedures. MUMP procedures become effective on the one-year birthday; the patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day following the patient's first birthday, the RSPD medical staff must apply for MUMP certification to extend the RSPD admission.

~~E~~C. ~~AFMC utilizes~~ Medicaid guidelines and the medical judgment of its professional staff are used to determine the number of days to extend the admission.

~~F. AFMC assigns an authorization number to an approved extension request and sends written notification to the RSPD facility.~~

~~G~~D. Additional extensions may be requested if more days are needed beyond ~~AFMC's~~ the original extension.

~~H~~E. If the extension request is denied by a physician advisor ~~with AFMC~~, the RSPD provider may request an expedited reconsideration review by sending the medical record ~~(through regular mail or by overnight express) to AFMC~~ for review and determination. The provider must specify that an expedited reconsideration is being requested. The RSPD provider will be notified of the decision by the next working day.

~~I~~F. Providers may request administrative reconsideration of an adverse decision or they can appeal as provided in Section 190.003 of ~~this~~ the Arkansas Medicaid provider manual.

~~J~~G. If the denial is because of incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the nurse may approve the extension of benefits without referral to a physician advisor.

~~K~~H. If the denial is because there is no proof of medical necessity or the documentation does not allow for approval by the nurse, the original documentation, reason for denial and new information submitted will be referred to a different physician advisor for reconsideration.

~~L~~I. All parties will be notified in writing of the outcome of the reconsideration.

~~M~~J. Medicaid claims submitted without ~~calling AFMC for~~ an approved extension ~~request~~ will result in automatic denials of any days billed beyond the fourth day. The only exception is claims involving third party liability. (See Section 217.134.)

217.132 Transfer Admissions ~~10-13-038~~ 1-21

If a patient is transferred from one RSPD facility to another, the receiving facility must contact ~~AFMC~~ DHS or its designated vendor within twenty-four (24) hours to certify the residential stay. **View or print the contact information to obtain the DHS or designated vendor step-by-step process for submitting the request.** ~~If the admission date of the transfer falls on a weekend or holiday, the provider may contact AFMC on the first working day following the weekend or holiday.~~ **~~View or print the AFMC contact information.~~**

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217.133 Retroactive Medicaid Eligibility

~~3-1-06~~8-1-21

A. If retroactive Medicaid eligibility is determined prior to discharge of the patient, the RSPD provider may ~~call AFMC~~contact DHS or its designated vendor to request post-certification of the days beyond the first four (4) days (or all days if the admission was by transfer) and a concurrent extension for additional days, if needed.

B. If the retroactive Medicaid eligibility is determined after discharge, the RSPD provider may ~~call AFMC~~contact DHS or its designated vendor to request post-certification of the days beyond the first four (4) days (or all days if the admission was by transfer). If the certification is requested for a length-of-stay longer than thirty (30) days, the provider must submit the entire medical record ~~to AFMC~~ for review. (Refer to Section 217.200 for the annual benefit limit on the length-of-stays.) **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request** ~~**View or print the AFMC contact information.**~~

217.134 Third Party and Medicare Claims

~~10-13-03~~8-1-21

~~A.~~ If a provider has not requested MUMP certification of an extension of days because there is apparent coverage by private insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification of days beyond the first four (4) days may be obtained. ~~.~~) **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request** ~~as follows:~~

~~1. Send a copy of the third party payer's denial notice to AFMC, attention Pre-Certification Supervisor.~~ ~~**View or print the AFMC contact information.**~~

~~2. Include a written request for post-certification.~~

~~3. Include complete provider contact information: full name and title, telephone number and extension.~~

~~4. An AFMC coordinator will call the provider contact for the certification information.~~

~~B. If a third party insurer pays the provider for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.~~

262.300 Billing Instructions—Paper Only

~~11-1-17~~8-1-21

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements, and regulations for claim form CMS-1450.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) **View or print NUBC contact information.**

The committee develops, maintains, and distributes to its subscribers the UB-04 Data Element Specifications Manual and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Data Element Specifications Manual (UB-04 Manual), a CMS-1450 (UB-04) claim form.

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Forward the original of the completed form to the ~~DXC Technology~~Fiscal Agent's Claims Department. ~~**View or print the DXC Technology Claims Department contact information.**~~ **View or print DHS or its designated Fiscal Agent's contact information.** One (1) copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

MARKUP

TOC not required

217.100 Coverage Limitation—Medicaid Utilization Management Program 8-1-21

The Medicaid Utilization Management Program (MUMP) is designed to manage the appropriateness and duration of RSPD services. The MUMP procedures apply to all RSPD providers.

Length-of-stay determinations are performed by the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

217.110 MUMP Applicability 8-1-21

Medicaid beneficiaries are allowed up to four (4) days of RSPD services when the admission criteria (refer to Sections 213.000 through 213.300) are met. If a patient is not discharged before or during the fifth day of the residential stay, *DHS or its designated vendor must certify any additional days.*

When a patient is transferred from one RSPD facility to another, the stay must be certified by DHS or its designated vendor from the first day of transfer. (See Transfer Admissions, Section 217.132.) **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request.**

217.131 Extension of RSPD Admissions 8-1-21

A. When the RSPD provider's neuropsychologist and/or physician determines that a patient (age one (1) year or older) should not be discharged by the fifth day of residential stay due to the need for continued services, an RSPD medical staff member must contact DHS or its designated vendor and request an extension of the RSPD admission.

   View or print contact information to obtain the DHS or its designated vendor step-by-step process for submitting the request.

   1. RSPD providers initiating their request after the fourth day must accept the financial liability should the stay not meet the medical criteria for continued RSPD services.
   2. If the provider delays calling for an extension and the services are denied based on the lack of medical necessity, the patient will not be held liable.

B. For a Medicaid patient under age one (1), the days from the admission date through the day before the patient's first birthday are exempt from the MUMP procedures. MUMP procedures become effective on the one-year birthday; the patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day following the patient's first birthday, the RSPD medical staff must apply for MUMP certification to extend the RSPD admission.

C. Medicaid guidelines and the medical judgment of its professional staff are used to determine the number of days to extend the admission.

D. Additional extensions may be requested if more days are needed beyond the original extension.

E. If the extension request is denied by a physician advisor, the RSPD provider may request an expedited reconsideration review by sending the medical record for review and determination. The provider must specify that an expedited reconsideration is being requested. The RSPD provider will be notified of the decision by the next working day.

F. Providers may request administrative reconsideration of an adverse decision or they can appeal as provided in Section 190.003 of the Arkansas Medicaid provider manual.

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G. If the denial is because of incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the nurse may approve the extension of benefits without referral to a physician advisor.

H. If the denial is because there is no proof of medical necessity or the documentation does not allow for approval by the nurse, the original documentation, reason for denial and new information submitted will be referred to a different physician advisor for reconsideration.

I. All parties will be notified in writing of the outcome of the reconsideration.

J. Medicaid claims submitted without an approved extension will result in automatic denials of any days billed beyond the fourth day. The only exception is claims involving third party liability. (See Section 217.134.)

217.132 Transfer Admissions 8-1-21

If a patient is transferred from one RSPD facility to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours to certify the residential stay. **View or print the contact information to obtain the DHS or designated vendor step-by-step process for submitting the request.**

217.133 Retroactive Medicaid Eligibility 8-1-21

A. If retroactive Medicaid eligibility is determined prior to discharge of the patient, the RSPD provider may contact DHS or its designated vendor to request post-certification of the days beyond the first four (4) days (or all days if the admission was by transfer) and a concurrent extension for additional days, if needed.

B. If the retroactive Medicaid eligibility is determined after discharge, the RSPD provider may contact DHS or its designated vendor to request post-certification of the days beyond the first four (4) days (or all days if the admission was by transfer). If the certification is requested for a length-of-stay longer than thirty (30) days, the provider must submit the entire medical record for review. (Refer to Section 217.200 for the annual benefit limit on the length-of-stays.) **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request**

217.134 Third Party and Medicare Claims 8-1-21

If a provider has not requested MUMP certification of an extension of days because there is apparent coverage by private insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification of days beyond the first four (4) days may be obtained.) **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request**

262.300 Billing Instructions—Paper Only 8-1-21

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements, and regulations for claim form CMS-1450.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) **View or print NUBC contact information.**

PROPOSED

The committee develops, maintains, and distributes to its subscribers the UB-04 Data Element Specifications Manual and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Data Element Specifications Manual (UB-04 Manual), a CMS-1450 (UB-04) claim form.

Forward the original of the completed form to the Fiscal Agent's Claims Department. **View or print DHS or its designated Fiscal Agent's contact information.** One (1) copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

PROPOSED

TOC not required

218.310 Benefit Extension Requests

~~2-1-05~~8-1-21

A. Requests to extend the RHC core service encounter benefit must be submitted to DHS or its designated vendor. **View or print contact information to obtain instructions for submitting the request.** Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.~~mailed to Arkansas Foundation for Medical Care, Inc. (AFMC). **View or print Arkansas Foundation for Medical Care, Inc. (AFMC) contact information.**~~

~~1. AFMC will not accept benefit extension requests transmitted via electronic facsimile (FAX).~~

~~2. Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.~~

B. Submit ~~with the request~~ a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.

C. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.~~AFMC reserves the right to request additional information as needed to process a benefit extension request. Failures to timely provide requested additional information will result in technical denials, reconsiderations of which are not available.~~

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available.~~AFMC must receive a benefit extension request within 90 calendar days of the date of the benefits-exhausted denial.~~

~~1. AFMC will consider extending benefits only when extended benefits are medically necessary and all required documentation is received timely.~~

~~2. Requests received after the 90-day deadline will not be considered.~~

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

MARKUP

TOC not required

218.310 Benefit Extension Requests 8-1-21

A. Requests to extend the RHC core service encounter benefit must be submitted to DHS or its designated vendor. **View or print contact information to obtain instructions for submitting the request.** Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

B. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.

C. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

PROPOSED

TOC not required

242.000 Prior Authorization and Documentation Requirements for Medicaid Eligible Beneficiaries Under Age 21

~~7-1-11~~8-1-21

~~The Arkansas Foundation for Medical Care (AFMC)~~DHS or its designated vendor must approve all requests for prior authorization for targeted case management services for Medicaid eligible beneficiaries under age twenty-one (21). View or print contact information to obtain instructions for submitting the request.

The following information must be submitted ~~to AFMC~~ for Child Health Services (EPSDT) beneficiaries and for DDS eligible beneficiaries under the age of twenty-one (21):

A. Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21 Form (DMS-601). **View or print form DMS-601.**

B. Prescription or Arkansas Medicaid Primary Care Physician Managed Care Program Referral Form (DMS-2610) signed by the beneficiary's PCP and written within the last sixty (60) days. **View or print form DMS-2610**.

C. Service Plan

D. For DDS eligible beneficiaries under age twenty-one (21), forms DDS/FS #0001a and DDS/FS #0009 completed by the DDS service coordinator or an authorized Licensed Community Program staff person.

E. For Child Health Services (EPSDT) beneficiaries under age twenty-one (21), medical documentation substantiating the diagnosis, must accompany the DMS-601, the prescription and the service plan. **View or print form DMS-601**.

F. Applications completed by a targeted case manager for all siblings under age twenty-one (21) in a family group must be submitted ~~to AFMC~~ on the same date.

NOTE: A family group should be managed by only one case manager for any targeted case management service.

~~**The PA request and documentation must be submitted by mail or fax to the Arkansas Foundation for Medical Care (AFMC).** View or print AFMC contact information.~~

242.100 Prior Authorization Request for Targeted Case Management for Medicaid Eligible Beneficiaries Under Age 21

~~7-1-11~~8-1-21

Requests for prior authorization must be submitted ~~to the Arkansas Foundation for Medical Care (AFMC)~~ using the Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21 Form (DMS-601). **View or print form DMS-601.** ~~Requests may be submitted to AFMC via mail, facsimile, UPS or FedEx.~~ The documentation submitted with the prior authorization request must support the medical necessity of the requested services.

A medical necessity determination will be made within fifteen (15) working days of receipt of a completed prior authorization request. For prior authorization requests meeting the medical necessity requirements, ~~AFMC will issue~~ an authorization number designation, the length of services, procedure codes and units approved for the requesting provider will be issued. For denied requests, a letter containing case-specific rationale that explains why the request was not approved will be sent~~mailed~~ to the requesting provider and to the Medicaid beneficiary.

MARKUP

TOC not required

242.000 Prior Authorization and Documentation Requirements for Medicaid Eligible Beneficiaries Under Age 21 8-1-21

DHS or its designated vendor must approve all requests for prior authorization for targeted case management services for Medicaid eligible beneficiaries under age twenty-one (21). View or print contact information to obtain instructions for submitting the request.

The following information must be submitted for Child Health Services (EPSDT) beneficiaries and for DDS eligible beneficiaries under the age of twenty-one (21):

A. Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21 Form (DMS-601). **View or print form DMS-601.**

B. Prescription or Arkansas Medicaid Primary Care Physician Managed Care Program Referral Form (DMS-2610) signed by the beneficiary's PCP and written within the last sixty (60) days. **View or print form DMS-2610**.

C. Service Plan

D. For DDS eligible beneficiaries under age twenty-one (21), forms DDS/FS #0001a and DDS/FS #0009 completed by the DDS service coordinator or an authorized Licensed Community Program staff person.

E. For Child Health Services (EPSDT) beneficiaries under age twenty-one (21), medical documentation substantiating the diagnosis, must accompany the DMS-601, the prescription and the service plan. **View or print form DMS-601**.

F. Applications completed by a targeted case manager for all siblings under age twenty-one (21) in a family group must be submitted on the same date.

NOTE: A family group should be managed by only one case manager for any targeted case management service.

242.100 Prior Authorization Request for Targeted Case Management for Medicaid Eligible Beneficiaries Under Age 21 8-1-21

Requests for prior authorization must be submitted using the Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21 Form (DMS-601). **View or print form DMS-601.** The documentation submitted with the prior authorization request must support the medical necessity of the requested services.

A medical necessity determination will be made within fifteen (15) working days of receipt of a completed prior authorization request. For prior authorization requests meeting the medical necessity requirements, an authorization number designation, the length of services, procedure codes and units approved for the requesting provider will be issued. For denied requests, a letter containing case-specific rationale that explains why the request was not approved will be sent to the requesting provider and to the Medicaid beneficiary.

PROPOSED

TOC not required

281.100 EIDT/ADDT Transportation Survey

~~7-1-18~~8-1-21

EIDT and ADDT transportation providers are required to prepare and submit an annual EIDT/ADDT Survey **(View or print EIDT/ADDT Transportation Survey DMS-632)** and other applicable information concerning the survey to the Arkansas Department of Human Services Division of Medical Services, Provider Reimbursement Unit. **View or print the Arkansas Department of Human Services Division of Medical Services, Provider Reimbursement Unit contact information.**

The survey information will be reported for the provider's fiscal period. The survey must be submitted within five (5) months after the close of the provider's fiscal year end. Providers with financial reporting periods of less than six (6) months are not required to submit a survey. However, if no survey is required, the provider must notify the Division of Medical Services (DMS) in writing why the survey is not being submitted. Failure to submit the completed survey or failure to submit a written explanation of a reporting period of less than six (6) months within the prescribed period, except as expressly extended by the State Medicaid agency, may result in the suspension of reimbursement until DMS receives this information.

Survey information requested includes direct and indirect/overhead costs, revenues and client mileage information associated with and applicable to the EIDT or ADDT Transportation Program. No other program costs, revenues or mileage information is to be included on the survey. If the provider provides transportation services for programs other than EIDT or ADDT programs, please remove the other program costs, revenues and mileage information before completing the survey and submit a narrative describing how these other transportation program amounts were calculated and removed. All cost and revenue amounts are to be reported using the accrual method of accounting and will be reported in whole dollar amounts, no cents.

Providers must also submit with the survey a written general description of what costs are included with indirect/overhead costs and how these costs were identified, calculated and allocated to the EIDT or ADDT transportation program.

Providers are required to maintain adequate financial records, mileage data and rider data for proper documentation and support of the cost and statistical information reported on the annual survey. These records must be retained for a period of five (5) years after submission of the survey. The surveys, supporting documentation and provider narratives are subject to on-site review and inspection by DHS/DMS personnel.

EIDT and ADDT providers may order copies of Form DMS-632 on the Medicaid Form Request. Requests may be forwarded to the DHS or designated Fiscal Agent's ~~Hewlett Packard Enterprise~~ Provider Assistance Center. **View or print the DHS or designated Fiscal Agent's contact information.** ~~**View or print the DXC Provider Assistance Center contact information.**~~

WA DRAFT

TOC not required

281.100 EIDT/ADDT Transportation Survey 8-1-21

EIDT and ADDT transportation providers are required to prepare and submit an annual EIDT/ADDT Survey **(View or print EIDT/ADDT Transportation Survey DMS-632)** and other applicable information concerning the survey to the Arkansas Department of Human Services Division of Medical Services, Provider Reimbursement Unit. **View or print the Arkansas Department of Human Services Division of Medical Services, Provider Reimbursement Unit contact information.**

The survey information will be reported for the provider's fiscal period. The survey must be submitted within five (5) months after the close of the provider's fiscal year end. Providers with financial reporting periods of less than six (6) months are not required to submit a survey. However, if no survey is required, the provider must notify the Division of Medical Services (DMS) in writing why the survey is not being submitted. Failure to submit the completed survey or failure to submit a written explanation of a reporting period of less than six (6) months within the prescribed period, except as expressly extended by the State Medicaid agency, may result in the suspension of reimbursement until DMS receives this information.

Survey information requested includes direct and indirect/overhead costs, revenues and client mileage information associated with and applicable to the EIDT or ADDT Transportation Program. No other program costs, revenues or mileage information is to be included on the survey. If the provider provides transportation services for programs other than EIDT or ADDT programs, please remove the other program costs, revenues and mileage information before completing the survey and submit a narrative describing how these other transportation program amounts were calculated and removed. All cost and revenue amounts are to be reported using the accrual method of accounting and will be reported in whole dollar amounts, no cents.

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EIDT and ADDT providers may order copies of Form DMS-632 on the Medicaid Form Request. Requests may be forwarded to the DHS or designated Fiscal Agent's Provider Assistance Center. **View or print the DHS or designated Fiscal Agent's contact information.**

PROPOSED

TOC not required

221.000 Prior Authorization (PA)

~~8-1-09~~8-1-21

Reimbursement for ventilator equipment must have prior approval by DHS or its designated vendor. **View or print contact information to obtain instructions for submitting the request.**~~the Arkansas Foundation for Medical Care Inc. (AFMC).~~

222.000 Request for Prior Authorization

~~8-1-09~~8-1-21

A request for prior authorization must originate with the provider of ventilator equipment. The provider is responsible for obtaining the required medical information and necessary prescription information needed for completion of form **DMS-679**. This form must be signed and dated by the physician. **View or print form DMS-679 and instructions for completion.**

Providers must specify the brand name/model of the ventilator on the prior authorization request.

~~The request for prior authorization will be reviewed by AFMC. All requests must be submitted by mail.~~ ~~**AFMC will not accept prior authorization requests via telephone, email or facsimile (FAX).**~~ The documentation submitted with the prior authorization request must support the medical necessity of the requested ventilator. If necessary~~, AFMC may request~~ additional information (i.e., original prescription, records from the hospitalization initiating the need for ventilator, etc.) shall be requested from the provider. ~~**View or print AFMC contact information.**~~

A prior authorization of ventilator equipment services does not guarantee payment.

Providers must note the date the ventilator is no longer in daily use.

222.100 Approvals of Prior Authorization

~~8-1-09~~8-1-21

When a prior authorization (PA) request is approved, a prior authorization control number will be assigned ~~by AFMC~~ and returned ~~by mail~~ to the requesting provider.

Prior authorization approvals are authorized for a maximum of six (6) months (180 days) or for the life of the prescription, whichever is shorter. A new request must be made for services needed for a longer period of time.

The effective date of the ~~prior authorization~~pa will be the date the beneficiary begins using the equipment or the day following the last day of the previous prior authorization approval.

Within thirty (30) working days before the end of an authorization for ventilator equipment, the provider must obtain a new prescription and submit a new Medical Equipment Request for Prior Authorization and Prescription (form DMS-679) signed by the prescribing physician.

~~Prior authorization~~PA for ventilator equipment does not guarantee payment. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits. The provider must follow all applicable billing procedures.

MARKUP

TOC not required

221.000 Prior Authorization (PA) 8-1-21

Reimbursement for ventilator equipment must have prior approval by DHS or its designated vendor. **View or print contact information to obtain instructions for submitting the request.**

222.000 Request for Prior Authorization 8-1-21

A request for prior authorization must originate with the provider of ventilator equipment. The provider is responsible for obtaining the required medical information and necessary prescription information needed for completion of form **DMS-679**. This form must be signed and dated by the physician. **View or print form DMS-679 and instructions for completion.**

Providers must specify the brand name/model of the ventilator on the prior authorization request.

The documentation submitted with the prior authorization request must support the medical necessity of the requested ventilator. If necessary additional information (i.e., original prescription, records from the hospitalization initiating the need for ventilator, etc.) shall be requested from the provider.

A prior authorization of ventilator equipment services does not guarantee payment.

Providers must note the date the ventilator is no longer in daily use.

222.100 Approvals of Prior Authorization 8-1-21

When a prior authorization (PA) request is approved, a prior authorization control number will be assigned and returned to the requesting provider.

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Within thirty (30) working days before the end of an authorization for ventilator equipment, the provider must obtain a new prescription and submit a new Medical Equipment Request for Prior Authorization and Prescription (form DMS-679) signed by the prescribing physician.

PA for ventilator equipment does not guarantee payment. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits. The provider must follow all applicable billing procedures.

PROPOSED

For questions regarding the Evidence-Based Prescription Drug Program or to request an override for non-preferred drugs, prescribers may contact the DHS Contracted Pharmacy Vendor Help Desk.

221.100 Extension of Benefits Review Process 8-1-21

Extension of Benefits must be submitted to DHS or its designated vendor for review. **View or print contact information to obtain a step-by-step outline for the extension process.**

242.430 Special Processing Procedures 8-1-21

The CMS-1500 claim form must be used by the ophthalmologists or optometrists when billing the Medicaid Program for non-prescription services. Submit the completed claim form to the Arkansas Medicaid fiscal agent.

If prescription services are required and are within the allowable limits outlined in Section 213.200, the provider must complete the prescription form provided by the optical contractor. Visual Care providers who submit claims electronically must submit a copy of the eligibility verification for the date on which the service is being provided along with the prescription form to the optical contractor for processing. The printout will provide verification of the beneficiary's eligibility, last visual exam date and last optical prescription date. (A photocopy of the beneficiary's plastic identification card will not be accepted by the optical contractor.) The prescription form and the eligibility verification can be sent to the optical contractor. **View or print the DHS Designated Optical Contractor contact information.**

If the copy of the eligibility on the date of service is not verified, and/or the benefit has been exhausted, the optical contractor will not fill the prescription and will return the claim to the physician.

PROPOSED

TOC required

216.200 Procedure for Obtaining Extension of Benefits for Medical Services Provided by an Optometrist

~~2-1-05~~8-1-21

A. Requests for extension of benefits for medical services provided by an optometrist must be ~~mailed to Arkansas Foundation for Medical Care, Inc. (AFMC), Attention EOB Review.~~ **~~View or print the Arkansas Foundation for Medical Care, Inc. contact information.~~**submitted to DHS or its designated vendor. **View or print contact information to obtain instructions for submitting the request.** Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.

Submit ~~with the request~~ a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. *Do not* send a claim.

B. A request for extension of benefits must be received ~~by AFMC~~ within ninety (90) calendar days of the date of benefits-exhausted denial. Requests received after the 90-day deadline will not be considered.

~~C. AFMC will consider extending benefits in cases of medical necessity if all required documentation is received timely.~~

216.210 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services"

~~7-1-07~~8-1-21

Requests for extension of benefits for Clinical Services (Physician's Visits) Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring-EEG, EKG, etc.) must be submitted to ~~AFMC~~ DHS or its designated vendor for consideration. **View or print contact information to obtain instructions for submitting the request.** ~~Consideration of r~~Requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print DMS-671 form.**

~~Complete i~~Instructions for accurate competition of form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each provider manual.

216.300 Prescription Drugs

~~3-14-15~~8-1-21

PRESCRIPTION DRUG INFORMATION

Act 186 of 1997 authorizes optometrists to prescribe and administer both oral and topical drugs for the diagnosis and treatment only of conditions of the eye, lids, adnexa or visual system, except for those drugs listed in Schedules I and II of the Uniform Controlled Substance Act. They can also prescribe and administer epinephrine, Benadryl® or other comparable medication for the emergency treatment of anaphylaxis or anaphylactic reactions.

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective vendors is located on the DHS or designated Pharmacy vendor website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded

MARKUP

from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

For prescription drug prior authorization concerns or the latest information regarding prescription drug coverage, providers may ~~call~~ visit the Prescription Drug PA Help Desk. ~~View or print Prescription Drug PA contact information.~~

For questions regarding the Evidence-Based Prescription Drug Program or to request an override for non-preferred drugs, ~~P~~prescribers may contact the ~~request an override for non-preferred drugs by calling~~ DHS Contracted Pharmacy Vendor Help Desk. ~~View or print UAMS College of Pharmacy Evidence-Based Prescription Drug Program Help Desk contact information.~~

~~Prescribers may also refer to the website at~~ **~~https://arkansas.magellanrx.com/provider/documents/~~** ~~to obtain the latest information regarding prescription drug coverage.~~

221.100 ~~AFMC~~ Extension of Benefits Review Process ~~3-1-06~~8-1-21

Extension of Benefits must be submitted to DHS or its designated vendor for review. **View or print contact information to obtain a step-by-step outline for the extension process.** ~~The following is a step-by-step outline of AFMC's extension of benefits review process:~~

~~A. Requests received via mail are screened for completeness and researched to verify the beneficiary's eligibility for Medicaid when the service was provided and to determine whether the claim has already been paid.~~

~~B. The documentation submitted is reviewed by a nurse. If, in the judgment of the nurse the documentation supports medical necessity, he or she may approve the request. An approval letter is computer-generated and mailed to the provider the following day.~~

~~C. If the nurse reviewer determines the documentation does not justify the service or it appears that the service is not medically necessary, he or she will refer the case to the appropriate physician advisor for a decision.~~

~~D. The physician reviewer's rationale for approval or denial is entered into the computer review system and the appropriate notification is created. If services are denied for medical necessity, the physician reviewer's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.~~

~~E. Providers may request administrative reconsideration of an adverse decision or they can appeal as provided in Section 190.003 of this manual.~~

~~F. If the denial is because of incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the nurse may approve the extension of benefits without referral to a physician advisor.~~

~~G. If the denial is because there is no proof of medical necessity or the documentation does not allow for approval by the nurse, the original documentation, reason for denial and new information submitted will be referred to a different physician advisor for reconsideration.~~

~~H. All parties will be notified in writing of the outcome of the reconsideration.~~

242.430 Special Processing Procedures ~~10-1-07~~8-1-21

The CMS-1500 claim form must be used by the ophthalmologists or optometrists when billing the Medicaid Program for non-prescription services. Submit the completed claim form to the Arkansas Medicaid fiscal agent.

MARKUP

If prescription services are required and are within the allowable limits outlined in Section 213.200, the provider must complete the prescription form provided by the optical contractor. Visual Care providers who submit claims electronically must submit a copy of the eligibility verification for the date on which the service is being provided along with the prescription form to the optical contractor for processing. The printout will provide verification of the beneficiary's eligibility, last visual exam date and last optical prescription date. (A photocopy of the beneficiary's plastic identification card will not be accepted by the optical contractor.) The prescription form and the eligibility verification can be ~~faxed or mailed~~sent to the optical contractor~~, Select Optical~~. **View or print the DHS Designated Optical Contractor contact information.~~Select Optical's contact information~~.**

If the copy of the eligibility on the date of service is not verified, and/or the benefit has been exhausted, the optical contractor will not fill the prescription and will return the claim to the physician.

MARKUP

TOC required

216.200 Procedure for Obtaining Extension of Benefits for Medical Services Provided by an Optometrist 8-1-21

A. Requests for extension of benefits for medical services provided by an optometrist must be submitted to DHS or its designated vendor. **View or print contact information to obtain instructions for submitting the request.** Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.

Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. *Do not* send a claim.

B. A request for extension of benefits must be received within ninety (90) calendar days of the date of benefits-exhausted denial. Requests received after the 90-day deadline will not be considered.

216.210 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services" 8-1-21

Requests for extension of benefits for Clinical Services (Physician's Visits) Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring-EEG, EKG, etc.) must be submitted to DHS or its designated vendor for consideration. **View or print contact information to obtain instructions for submitting the request.** Requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print DMS-671 form.**

Instructions for accurate competition of form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each provider manual.

216.300 Prescription Drugs 8-1-21

PRESCRIPTION DRUG INFORMATION

Act 186 of 1997 authorizes optometrists to prescribe and administer both oral and topical drugs for the diagnosis and treatment only of conditions of the eye, lids, adnexa or visual system, except for those drugs listed in Schedules I and II of the Uniform Controlled Substance Act. They can also prescribe and administer epinephrine, Benadryl® or other comparable medication for the emergency treatment of anaphylaxis or anaphylactic reactions.

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective vendors is located on the DHS or designated Pharmacy vendor website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

For prescription drug prior authorization concerns or the latest information regarding prescription drug coverage, providers may visit the Prescription Drug PA Help Desk.

PROPOSED

For questions regarding the Evidence-Based Prescription Drug Program or to request an override for non-preferred drugs, prescribers may contact the DHS Contracted Pharmacy Vendor Help Desk.

221.100 Extension of Benefits Review Process 8-1-21

Extension of Benefits must be submitted to DHS or its designated vendor for review. **View or print contact information to obtain a step-by-step outline for the extension process.**

242.430 Special Processing Procedures 8-1-21

The CMS-1500 claim form must be used by the ophthalmologists or optometrists when billing the Medicaid Program for non-prescription services. Submit the completed claim form to the Arkansas Medicaid fiscal agent.

If prescription services are required and are within the allowable limits outlined in Section 213.200, the provider must complete the prescription form provided by the optical contractor. Visual Care providers who submit claims electronically must submit a copy of the eligibility verification for the date on which the service is being provided along with the prescription form to the optical contractor for processing. The printout will provide verification of the beneficiary's eligibility, last visual exam date and last optical prescription date. (A photocopy of the beneficiary's plastic identification card will not be accepted by the optical contractor.) The prescription form and the eligibility verification can be sent to the optical contractor. **View or print the DHS Designated Optical Contractor contact information.**

If the copy of the eligibility on the date of service is not verified, and/or the benefit has been exhausted, the optical contractor will not fill the prescription and will return the claim to the physician.

PROPOSED

TOC not required.

101.300 Obtaining Provider Manuals

~~8-1-12~~8-1-21

All provider manuals, manual updates, notices of rule making, official notices and RAs are available for downloading, without charge, from the Arkansas Medicaid website[dKS(H1] (**https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx**).

Enrolled providers may purchase extra paper copies of a manual through the fiscal agent. See information below regarding purchasing copies. Persons, entities and organizations that are not enrolled providers may purchase a paper copy of a provider manual through the fiscal agent.

The cost for a printed copy of an Arkansas Medicaid provider manual is $125.00.

Send orders for printed manuals to the Arkansas Medicaid F~~f~~iscal A~~a~~gent, Information Library Unit. Include with your order a check made to ~~DXC Technology~~the Fiscal Agent for the appropriate amount. **View or print the manual order contact information.**

110.200 Provider Relations and Claims Processing Contractor

~~8-1-12~~8-1-21

Provider assistance and education and the processing of claims for the Medicaid program are performed by an independent contractor.

The Arkansas Medicaid ~~fiscal~~ Fiscal ~~agent~~ Agent has a staff of **claims representatives** available to assist with any needs concerning claims. ~~**View or print Claims Department contact information**~~.

The Arkansas Medicaid ~~fiscal~~ Fiscal ~~agent~~ Agent maintains a **Provider Assistance Center (PAC)** to assist Arkansas Medicaid providers. ~~**View or print PAC contact information**~~.

The Arkansas Medicaid fiscal agent has a full-time staff of Provider Representatives available for consultation regarding billing problems and technical assistance that cannot be resolved through the Provider Assistance Center. Provider Representatives are available to visit providers' offices to provide training on billing and on-site technical assistance. To find your Provider Representative to schedule a visit, view the ~~AFMC~~ DHS or designated vendor's **Outreach Specialists** page. ~~under the Provider section of the Arkansas Medicaid website (**https://medicaid.mmis.arkansas.gov/**)~~.

MARKUP

TOC not required.

101.300 Obtaining Provider Manuals 8-1-21

All provider manuals, manual updates, notices of rule making, official notices and RAs are available for downloading, without charge, from the Arkansas Medicaid website (**https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx**).

Enrolled providers may purchase extra paper copies of a manual through the fiscal agent. See information below regarding purchasing copies. Persons, entities and organizations that are not enrolled providers may purchase a paper copy of a provider manual through the fiscal agent.

The cost for a printed copy of an Arkansas Medicaid provider manual is $125.00.

Send orders for printed manuals to the Arkansas Medicaid Fiscal Agent, Information Library Unit. Include with your order a check made to the Fiscal Agent for the appropriate amount. **View or print the manual order contact information.**

110.200 Provider Relations and Claims Processing Contractor 8-1-21

Provider assistance and education and the processing of claims for the Medicaid program are performed by an independent contractor.

The Arkansas Medicaid Fiscal Agent has a staff of **claims representatives** available to assist with any needs concerning claims.

The Arkansas Medicaid Fiscal Agent maintains a **Provider Assistance Center (PAC)** to assist Arkansas Medicaid providers.

The Arkansas Medicaid fiscal agent has a full-time staff of Provider Representatives available for consultation regarding billing problems and technical assistance that cannot be resolved through the Provider Assistance Center. Provider Representatives are available to visit providers' offices to provide training on billing and on-site technical assistance. To find your Provider Representative to schedule a visit, view the DHS or designated vendor's **Outreach Specialists** page.

PROPOSED

TOC not required

301.240 Prior Authorization Request

~~11-1-17~~8-1-21

Providers can review instructions for Prior Authorization Requests in the Section II of their program's provider manual.

Some prior authorizations are processed by other Medicaid contractors:

A. ~~Arkansas Foundation for Medical Care (AFMC)~~ DHS or its designated vendor can assist with the Medicaid Utilization Management Process, surgical procedures, assistant surgeons, transplants, anesthesia, orthotics and prosthetics, inpatient services, lab and radiology, lab-molecular pathology, rehabilitation hospitals, personal care for beneficiaries under age 21, Child Health Management Services, and Professional Services including extension of benefits for Podiatry and Professional level visits. **View or print contact information for the designated vendor for these types of PAs~~Arkansas Foundation for Medical Care, Retrospective Review for Therapy and Prior Authorization for Personal Care for Under Age 21~~.**

B. DHS or its designated behavioral health vendor~~Beacon Health Options~~ can assist with PAs for Inpatient Psychiatric Services, Outpatient Behavioral Health Services and Substance Abuse Services. **View or print contact information for the designated behavioral health vendor~~Beacon Health Options~~**.

314.131 The Adjustment Transaction

~~11-1-17~~8-1-21

The *Claim Adjustments* report has two parts. The first includes the adjustment transaction header elements. In this section, the Arkansas Medicaid fiscal agent identifies the adjustment transaction with an internal control number (ICN). Adjustment ICNs are formatted in the same way as claim numbers; the first two digits of an adjusted claim ICN indicate the type of adjustment:

50	Adjustments – Non-Check Related
51	Adjustments – Check Related
52	Mass Adjustments – Non-Check Related
53	Mass Adjustments – Check Related
54	Mass Adjustments – Void Transaction
55	Mass Adjustments – Provider Retro Rates
56	Adjustments – Void Non-Check Related
57	Adjustments – Void Check Related
58	Adjustment – Processed by ~~DXC~~ Fiscal Agent's System Engineer
59	Adjustments/Voids Web – 837
60	Adjustments by State – Non-Check Related
61	Adjustments by State – Check Related
63	Adjustments Non Check History Only Adjustment

MARKUP

64	Void by State – Non-Check Related
65	Void by State – Check Related
66	History Only Non-Check Related Adjustment
67	History Only Check Related Adjustment
68	Adjustments Check Related History Only Adjustment
72	Encounter Adjustments
73	Encounter Mass Adjustments
74	Adjustments – Encounter
75	Adjustments – Encounter Void

Displayed to the right of the ICN are the provider's patient control number or medical record number from the original claim, the claim beginning and ending dates of service and the original billed amount. Keep in mind that the Arkansas Medicaid fiscal agent adjusts the entire claim, even if only one detail paid in error, so the total billed amount shown here is the total billed amount of the entire claim being adjusted. Other withheld or credited amounts that impact the paid amount are listed and can include insurance, spenddown, copay (coinsurance) and deductible amounts. The Adjustment EOB code entered when the claim was adjusted indicates the reason for initiating the claim adjustment.

The second part of the adjustment transaction displays the claim details and the adjudication of the reprocessed claim. Detail EOBs for each procedure code are shown.

Additional payment, overpayment to be withheld, refund amount applied as well as total claim adjustments are shown at the bottom of the *Claim Adjustments* report. The actual withholding of the original paid amount does not occur in the *Claim Adjustments* report; it occurs in the *Financial Transactions* report of the RA. Adjustments are listed in the *Accounts Receivable* section, with the appropriate amounts displayed under the field headings "A / R (Action/Reason) Number," "Setup Date,": "Original Amount," "Recoupment Amount to Date," "Balance," "Reason Code," "Adjustment ICN," "Previous ICN," and "Amount Recouped in Current Cycle." (See the discussion of *Financial Transactions* in Section 314.170.)

Finally, the total of all adjusted amounts paid or withheld from the remittance are displayed in the *Summary* report of the RA under the field header *Claims Data* "Claim Adjustments" and *Earnings Data* "Payments: Claim Specific: Current Cycle."

332.100 Medicare-Medicaid Crossover Claim Filing Procedures

~~11-1-17~~8-1-21

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

When the original Medicare plan intermediary completes the processing of the claim, the payment information is automatically crossed to Medicare's Coordination of Benefits Agreement (COBA) process and from there crossed to Arkansas Medicaid and the claim is processed in the

MARKUP

next weekend cycle for Medicaid payment of applicable coinsurance and deductible. The transaction will usually appear on the provider's Medicaid RA within four (4) to six (6) weeks of payment by Medicare. If it does not appear within that time, payment should be requested according to the instructions below.

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

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

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

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

Providers without electronic billing capability must mail the appropriate National Standard Claim Form (**CMS-1500** or **CMS-1450**) to ~~DXC Technology~~the **Fiscal Agent**.~~, PO Box 34440, Little Rock, AR 72203. (See Section V of this manual for examples of CMS-1500 and CMS-1450).).~~ Along with the National Standard Claim Form, providers must submit attachment DMS-600. (**View or print attachment DMS-600.**) Providers must also submit the Medicare Explanation of Benefits (EOMB). Claims must be submitted in the following order:

A. National Standard Claim Form

B. DMS-600

C. Medicare Explanation of Benefits (EOMB)

D. Other supporting or applicable documentation

Paper claims will be returned to the provider if not submitted in the above order.

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TOC not required

301.240 Prior Authorization Request 8-1-21

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B. DHS or its designated behavioral health vendor can assist with PAs for Inpatient Psychiatric Services, Outpatient Behavioral Health Services and Substance Abuse Services. **View or print contact information for the designated behavioral health vendor**.

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PROPOSED

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D. Other supporting or applicable documentation

Paper claims will be returned to the provider if not submitted in the above order.

PROPOSED

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers, according to established program guidelines.

Monitoring visits may be as frequent as necessary, within established Medicaid maximum allowable limitations.

Monitoring is allowed through regular contacts with service providers at least every other month to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least ~~monthly~~**every other month**, that the beneficiary continues to participate in the service plan and is satisfied with services.

Face to face monitoring contacts must be completed as often as deemed necessary, based on the professional judgment of the TCM, but no less frequent than established in Medicaid TCM program policy.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Case management providers must be certified by the Division of **Provider Services and Quality Assurance** on an annual basis, unless approved otherwise by the Division of Medical Services, based on performance evaluations or other approved data.

MARK-UP

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

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(42 CFR 440.169(e))

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Case management providers must be certified by the Division of **Provider Services and Quality Assurance** on an annual basis, unless approved otherwise by the Division of Medical Services, based on performance evaluations or other approved data.

MARK-UP

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE 501-320-6540 **FAX** 501-682-8155 **EMAIL:** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Technical Corrections – Vendor Name Removal from Medicaid Provider Manuals

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;
   N/A

   (b) The reason for adoption of the more costly rule;
   N/A

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;
   N/A

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.
   N/A

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	0	Total	0

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	0	Total	0

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0	$ 0

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0	$ 0

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute**;**

(3) a description of the factual evidence that:
   (a) justifies the agency's need for the proposed rule; and
   (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Statement of Necessity and Rule Summary
Technical Corrections – Vendor Name Removal from Medicaid Provider Manuals

Statement of Necessity

The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) issues technical corrections and updates. DMS replaces vendor names and associated business processes in provider manuals with hyperlinks to specific information that can be updated in a timely manner as needed. Also, DMS issues technical corrections to certain rules and the State Plan.

Rule Summary

DMS issues the following technical corrections to provider manuals and the State Plan. Vendor names and associated processes have been removed from the following Medicaid Provider manuals:

- Ambulatory Surgical Center
- Chiropractic
- Dental
- Federally Qualified Health Center
- Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)
- Hyperalimentation
- Nurse Practitioner
- Patient-Centered Medical Home
- Pharmacy
- Physician/Independent Lab/CRNA/Radiation Therapy Center
- Podiatrist
- Portable X-Ray
- Prosthetics
- Rehabilitative Hospital
- Rehabilitative Services for Persons with Physical Disabilities
- Rural Health Clinic
- Targeted Case Management
- Transportation
- Ventilator Equipment
- Visual Care

Also, DMS updates the electronic billing requirements in the Dental Provider Manual and removes prior authorization from National Procedure Code E0705-Transfer device, any type, in the Prosthetics Manual. Finally, DMS issues a technical correction to the State Plan Amendment (Supplement 1 to Attachment 3.1-A, Page 5) to match recent updates to the Targeted Case Management Manual.

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

Effective August 1, 2021:

The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) intends to remove the names of contracted vendors and the vendor's associated business practices from provider manuals. DMS replaces the vendor names with hyperlinks to specific information that can be updated in a timely manner as needed. DMS removes vendor names from the following Medicaid provider manuals: Ambulatory Surgical Center; Chiropractic; Dental; Federally Qualified Health Center; Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD); Hyperalimentation; Nurse Practitioner; Patient-Centered Medical Home; Pharmacy; Physician/Independent Lab/CRNA/Radiation Therapy Center; Podiatrist; Portable X-Ray; Prosthetics; Rehabilitative Hospital; Rehabilitative Services for Persons with Physical Disabilities; Rural Health Clinic; Targeted Case Management; Transportation; Ventilator Equipment; and Visual Care. Also, DMS updates electronic billing requirements in the Dental Provider Manual, removes prior authorization from National Procedure Code E0705-Transfer device, any type in the Prosthetics Manual, and issues a technical correction to the State Plan Amendment (Supplement 1 to Attachment 3.1-A, Page 5) to match recent updates to the Targeted Case Management Manual.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation (ORP), 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule on the Medicaid website at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments may be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than June 12, 2021. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on May 26, 2021, at 10:00 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/81862039587. The webinar ID is 818 6203 9587. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6266.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed, and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528

S. Elizabeth Pitman

Elizabeth Pitman, Director
Division of Medical Services