ARKANSAS REGISTER

Transmittal Sheet

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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

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Statutory Authority for Promulgating Rules Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

Rule Title: Medicaid Administrative Reconsiderations and Appeals

Intended Effective Date (Check One)

- ☐ Emergency (ACA 25-15-204)
- ☐ 10 Days After Filing (ACA 25-15-204)
- ☑ Other 06/01/2025 (Must be more than 10 days after filing date.)

	Date
Legal Notice Published	01/19/2025
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Reviewed by Legislative Council	05/22/2025
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Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Contact Person	E-mail Address	Date
Jack Tiner	Jack.Tiner@dhs.arkansas.gov	05/22/2025

CERTIFICATION OF AUTHORIZED OFFICER

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

S. Elizabeth Pitman
Signature

501-244-3944 elizabeth.pitman@dhs.arkansas.gov
Phone Number E-mail Address

Director, Division of Medical Services
Title

05/22/2025
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

TOC not required

161.200 Administrative Reconsideration 6-1-25

A. Within thirty (30) calendar days after notice of an adverse decision/action, the provider may request administrative reconsideration. Requests must be in writing and include:

1. A copy of the letter or notice of adverse decision/action
2. Additional documentation that supports medical necessity

Administrative reconsideration does not postpone any adverse action that may be imposed pending appeal.

B. Requests for reconsideration must be submitted as follows:

1. In situations where the adverse decision/action has been taken by a reviewing agent, the request must be directed to that reviewing agent. Contact information for the department's reviewing agents can be found in Section V of this manual.
2. When an adverse decision/action has been taken by the Office of Medicaid Inspector General on behalf of Division of Medical Services (DMS), the request for reconsideration must be directed to Office of Medicaid Inspector General (OMIG). **View or print the Office of Medicaid Inspector General contact information.** Within twenty (20) calendar days of receiving a timely and complete request for administrative reconsideration, OMIG will designate a reviewer and proceed according to its own procedures. When an adverse decision/action has been taken by Utilization Review (UR) Section of DMS, the request for reconsideration must be directed to UR. **View or print the Utilization Review contact information**.

The 30-day time period to request a reconsideration begins to run five (5) days after the date of the written notice.

No administrative reconsideration is allowed if the adverse decision/action is due to loss of licensure, accreditation or certification.

161.300 Administrative Appeals of Adverse Actions that are not Sanctions 6-1-25

In addition to sanction reconsiderations and appeal procedures set forth in Sections 160.000-169.000, providers may appeal any other decision of the Department of Human Services, its reviewers or contractors if that decision adversely affects a Medicaid provider or beneficiary with regard to receipt or payment of Medicaid-covered services. Such decisions and consequent actions are "non-sanction adverse actions."

Within thirty (30) calendar days of receiving notice of non-sanction adverse action, or ten (10) calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision/action, whichever is later, the provider may appeal. The time period for filing an appeal shall begin to run five (5) days after the date of the written notice of non-sanction adverse action or administrative reconsideration decision. An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions/actions that the provider alleges are not supported by applicable laws, including state and federal laws and rules, applicable professional standards, or both. Providers shall mail or deliver the appeal to the **Arkansas Department of Health, Office of Medicaid Provider Appeals**..

161.400 Sanction Appeals 6-1-25

Within thirty (30) calendar days of receiving notice of adverse decision/action, the provider may appeal. The thirty (30) days begins to run five (5) days after the date of the written notice.

An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions/actions that the provider alleges are not supported by applicable laws; including state and federal laws and rules, applicable professional standards or both. Providers shall mail or deliver the appeal to the **Arkansas Department of Health, Office of Medicaid Provider Appeals**. No appeal is allowed if the adverse decision/action is due to loss of licensure, accreditation or certification.

161.500 Continued Services During the Appeal Process 6-1-25

To receive continued services during the appeal process, the beneficiary must file an appeal within thirty (30) days from the date of the written notice of action. The thirty (30) day time period begins to run five (5) days after the date of the written notice. The beneficiary's benefits will be continued with no change until the administrative appeal has concluded and a hearing decision has been entered. The notice of action must be sent to the Medicaid beneficiary in accordance with 42 CFR §431.230.

The beneficiary may affirmatively opt out of receiving benefits during the appeal period.

191.004 Administrative Appeals 6-1-25

When notice of an adverse decision is received from the Division of Medical Services, the beneficiary may appeal. The appeal request must be in writing and submitted to the Department of Human Services, Appeals and Hearings Section. **View or print the Department of Human Services, Appeals and Hearings Section contact information.** The appeal request must be received by the Appeals and Hearings Section no later than thirty (30) days from the date of written notice. The thirty (30) days begins to run five (5) days after the date of written notice.

All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

TOC required

241.000 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

TOC required

215.124 Administrative Reconsiderations and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

215.200 Reserved 6-1-25

TOC required

214.200 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

214.210 Reserved 6-1-25

TOC required

214.130 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

214.140 Reserved 6-1-25

272.533 Injections, Therapeutic and/or Diagnostic Agents 6-1-25

A. 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 in the Healthcare Common Procedural Coding System Level II (HCPCS) coding books.

Injection administration code is payable for beneficiaries of all ages. 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.

Cannot be billed separately for Influenza Virus vaccines or Vaccines for Children (VFC) vaccines.

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.

Cannot be billed when the drug administered is not FDA approved.

Covered drugs can be billed electronically or on paper. 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.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See Section 272.531 for further information.

Administration of therapeutic agents is payable only if provided in a physician’s office, place of service code “11.” These procedures are not payable to the certified nurse-midwife if performed in any other setting. Therapeutic injections should only be provided by certified nurse-midwives 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.

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 for therapeutic and chemotherapy administration procedure codes.

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

1. The provider must submit an electronic or 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.

C. **Immunizations**

Physicians 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 the **Procedure Code Tables – Arkansas Department of Human Services**.

Influenza virus vaccine through the Vaccines for Children (VFC) program is determined by the age of the beneficiary and which vaccine is used.

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

D. **Vaccines for Children (VFC)**

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 Division 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.** ARKids First-B beneficiaries are not eligible for the 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 First-B SCHIP vaccines. **View or print the Department of Health contact information.**

When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **SL** must be used for billing. Any additional billing and coverage protocols are listed under the specific procedure code in the tables in this section of this manual. See Part F of this section.

E. **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.

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. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.

    b. **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.

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.

See Section 272.531 for additional information regarding National Drug Code (NDC) billing.

F. **Process for Obtaining a Prior Authorization (PA) Number from the DHS contracted Prior Authorization vendor.**

Covered 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.

A PA 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.

The PA requests should be completed using the approved contracted vendor PA request form **(View or print PA form.)**

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

If approved, the Prior Authorization 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.

G. **Contact Information for Obtaining Prior Authorization**

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

H. All family planning procedures require an FP modifier and a primary family planning diagnosis on the claim.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)

See Section 240.000-240.200 for prior authorization procedures.

List 603 diagnosis codes include: (**View ICD Codes**.) Diagnosis List 603 restrictions apply to ages twenty-one (21) years and above unless otherwise indicated in the age restriction column.

TOC required

229.000 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse action, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000,190.000, and 191.000 of Section I of this Manual.

TOC required

220.205 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

220.210 Reserved 6-1-25

220.220 Reserved 6-1-25

TOC required

213.512 Benefit Extension Denials and Reconsideration Requests 6-1-25

When an extension is denied or only partially approved, the provider and the beneficiary receive notification letters.

213.513 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

213.514 Continuation of Services Pending the Outcome of an Appeal 6-1-25

Refer to Section 161.500 of Section I of this Manual regarding the continuation of services pending the outcome of an appeal.

213.515 Reserved 6-1-25

215.000 Reserved 6-1-25

223.000 Reserved 6-1-25

TOC required

212.502 Administrative Reconsiderations 6-1-25

Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

212.503 Paper Review After Administrative Reconsiderations: Special Cases 6-1-25

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, 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.

212.504 Appeals 6-1-25

When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal the decision and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

212.505 Continuation of Services Pending the Outcome of an Appeal 6-1-25

Refer to Section 161.500 of Section I of this Manual regarding the continuation of services pending the outcome of an appeal.

212.506 Reserved 6-1-25

215.104 Reserved 6-1-25

215.110 Reserved 6-1-25

218.280 Reserved 6-1-25

218.303 Reconsideration Review 6-1-25

A. When the reviewing QIO denies all or part of a previously paid claim on retrospective review, the therapy provider may request reconsideration of that decision by submitting additional information.

B. Additional information submitted for reconsideration must reach the QIO thirty (30) days following the postmark date on the envelope bearing the denial notification.

1. A therapist whose professional discipline is that of the denied service reviews the additional information.
2. The therapist reviewing a case being reconsidered will not be the same therapist who reviewed the case initially.

C. If the additional documentation enables the therapist to approve the services, he or she will reverse the previous denial.

D. If the case documentation still appears insufficient to allow the therapist to approve the services, he or she must refer the case to a physician advisor for final determination.

1. The physician advisor will not be an AMD who denied the services during the first review.
2. The therapist provides a written recommendation to the physician advisor.

E. The physician advisor reconsidering the case may uphold or reverse all or part of the previous decision.

1. A written notification of the outcome of each reconsideration review is mailed to all parties.
2. Notification includes the physician advisor's case-specific rationale for upholding or overturning the QIO's initial determination.

245.100 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of a denied prior approval request. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a prior approval request, the beneficiary may appeal the denial and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000 and 190.000 of Section I of this Manual.

245.200 Reserved 6-1-25

TOC required

222.200 Denial of Prior Authorization Requests 6-1-25

For a denied request, a letter containing case specific rationale that explains why the request was not approved will be mailed to the requesting provider and to the Medicaid beneficiary.

222.300 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

222.400 Reserved 6-1-25

TOC required

250.200 Reserved 6-1-25

250.300 Administrative Reconsideration and Appeals 6-1-25

If the Department issues any adverse action, the participant may request an Administrative Reconsideration according to Section 160.000 of Section I of the Medicaid Provider Manual. If the Department denies the request for administrative reconsideration or issues any adverse action, the participant may appeal and request a fair hearing in accordance with Sections 160.000, 190.000, and 191.000 of Section I of the Medicaid Provider Manual.

A request for a fair hearing may be filed by a participant or Representative based on actions or circumstances listed below:

A. Dissatisfaction with action taken by an IndependentChoices Counselor or Fiscal Agent

B. Involuntary case terminations including but not limited to:

1. Loss of Medicaid eligibility
2. Institutionalization
3. Dissatisfaction with number of personal care hours
4. Health, safety or well being of participant is compromised
5. Duplication of services
6. IndependentChoices case closure based on noncompliance with program requirements

C. Loss of Medicaid eligibility and closure of the case.

250.400 Continuation of Benefits During an Appeal 6-1-25

When a participant is involuntarily disenrolled from the IndependentChoices program, the participant may be returned to the traditional personal care program. If the participant appeals this decision, the participant will continue to receive Medicaid personal care services through a personal care agency during the time of the appeal.

TOC required

216.000 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

216.100 Reserved 6-1-25

216.200 Reserved 6-1-25

230.210 Reserved 6-1-25

230.220 Reserved 6-1-25

242.310 Reconsideration 6-1-25

If the audit report is unfavorable, the provider has the right to request reconsideration by the contractor within thirty (30) calendar days from the date on the report. The thirty (30) days begins to run five (5) days after the date on the report.

The provider may furnish the contractor additional documents from the medical record (if additional information is available) or may present a written explanation of why the facility believes any particular audit finding is in error. Following the receipt of the written request for reconsideration, the contractor will review the findings in question. The reconsideration review is completed by a psychiatrist who was not involved in the original decision.

A written response to the request for reconsideration will be forwarded to the facility and to the Division of Medical Services. The decision of the contractor, upon reconsideration, is final.

TOC required

214.940 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

214.950 Reserved 6-1-25

214.951 Reserved 6-1-25

214.952 Reserved 6-1-25

222.000 Reserved 6-1-25

TOC not required

215.300 PACE Participant Appeal Process 6-1-25

When an adverse decision is received, the PACE participant may appeal. The appeal request must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

TOC required

247.000 PASSE Grievance System 6-1-25

The PASSE must have an internal grievance process to address member concerns and complaints. The grievance process must:

A. Allow the member forty-five (45) days from the date of the action to file the grievance;

B. Be completed and resolved within thirty (30) days of the filing date; and

C. Result in written notice of the resolution being sent to the member. This notice must include:

1. A statement of the relief requested by the member;
2. A clear explanation of the decision, including the rationale and the applicable law or policy; and
3. The member's right to request a state fair hearing.

D. The PASSE grievance system must be approved by DHS. This requires that:

1. Any proposed changes to the grievance system must be approved by DHS prior to implementation; and
2. The PASSE must send written notice to members of significant changes to the grievance system at least thirty (30) days prior to implementation.

The PASSE must submit a grievance log with their quarterly report.

247.100 Appeal of Adverse Action of DHS 6-1-25

When the Division of Medical Services (DMS) takes an adverse action against a PASSE or member, the PASSE or member may request a fair hearing to appeal the adverse action.

To do so, the member or PASSE must follow the procedures in Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

247.200 Appeal of Adverse Decision/Adverse Action of a PASSE 6-1-25

When an adverse decision/adverse action has been taken by a PASSE, the following appeals are available in response to that adverse decision/adverse action:

A. A member, or his or her guardian or legal representative may appeal on his or her own behalf.

B. A direct service provider of medical assistance that is the subject of the adverse action may appeal on the member's behalf.

C. If the adverse decision/adverse action denies a claim for covered medical assistance that was previously provided to a Medicaid-eligible member, the direct service provider of such medical assistance may appeal on the direct service provider's behalf. The direct service provider does not have standing to appeal a non-payment decision if the direct service provider has not furnished any service for which payment has been denied.

D. When the adverse action denies a claim for previously authorized, covered medical assistance, the PASSE must send the notice of the adverse action no less than ten (10) days before the action will be taken in accordance with 42 CFR 431.211. In all other cases, notice must be sent immediately after the adverse decision is made. If the member

requests a hearing before the date of action, the PASSE may not terminate or reduce services until a decision is rendered after the hearing unless:

1. It is determined at the hearing that the sole issue is one of Federal or State law or policy; and
2. The PASSE promptly informs the member in writing that services are to be terminated or reduced pending the hearing decision.

E. If the PASSE's action is sustained by the hearing decision, and the member does not then seek an appeal to DHS, the PASSE may institute recovery procedures against the member to recoup the cost of any services furnished the member, to the extent they were furnished solely by reason of this section.

F. The appeal process must result in written notice of the resolution being sent to the member. This notice must include the member's right to appeal to the State.

The PASSE must adhere to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 *et seq*. in the conduct of appeals and hearings.

The PASSE appeal process must be approved by DHS. This requires that:

A. Any proposed changes to the appeals process must be approved by DHS prior to implementation; and

The PASSE must send written notice to members of significant changes to the appeals process at least thirty (30) days prior to implementation.

TOC required

244.100 Administrative Reconsideration and Appeals 6-1-25

A. A provider that disagrees with a DMS decision regarding program participation, payment, or other adverse action may request an administrative reconsideration. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual. DMS will not pay practice support payments after the notice of adverse action. If the practice prevails during the appeal, or reconsideration, the practice support payments will resume retroactively from the date of the adverse action notice.

B. If DMS upholds the decision upon administrative reconsideration, the provider may request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

TOC required

226.000 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid only allows one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

TOC required

245.000 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

246.000 Reserved 6-1-25

TOC required

214.000 Administrative Reconsiderations and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

TOC required

229.130 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000,190.000, and 191.000 of Section I of this Manual.

229.140 Reserved 6-1-25

229.240 Reserved 6-1-25

261.230 Reserved 6-1-25

261.231 Reserved 6-1-25

264.000 Reserved 6-1-25

TOC required

215.120 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

215.130 Reserved 6-1-25

TOC required

214.200 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

214.210 Reserved 6-1-25

TOC required

221.400 Denial of Prior Authorization Request 6-1-25

For denied cases, both Utilization Review and AFMC will mail a letter containing case specific rationale that explains why the request was not approved to the requesting provider and to the Medicaid beneficiary within thirty (30) working days of receipt of the prior authorization request.

221.500 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

221.600 Reserved 6-1-25

TOC required

213.170 Reserved 6-1-25

215.124 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests for denied benefit extensions or denied services must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

215.130 Reserved 6-1-25

216.115 Reserved 6-1-25

216.116 Reserved 6-1-25

TOC required

217.136 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

217.137 Reserved 6-1-25

219.000 Reserved 6-1-25

TOC required

218.314 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

218.320 Reserved 6-1-25

TOC required

218.000 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests of denied benefit extensions or prior authorizations must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

231.100 Reserved 6-1-25

TOC required

222.200 Denial of Prior Authorization Requests 6-1-25

For a denied request, a letter containing case specific rationale that explains why the request was not approved will be mailed to both the requesting provider and to the Medicaid beneficiary.

222.300 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

222.400 Reserved 6-1-25

TOC required

216.230 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

216.240 Reserved 6-1-25

A-200 Health Care Coverage Periods

MS Manual 06/01/25

The coverage period is the period of time the individual has coverage for Health Care. Once eligibility has been determined, the Health Care coverage period begins from the point of application and generally is open-ended. Pregnant Woman and Newborn categories have a fixed eligibility period as do the Spend-Down categories. In addition, fixed eligibility may be authorized in any category. (See MS A-220.)

The effective first (1st) and last date of coverage is dependent on the eligibility group in which the individual is placed as identified below:

1. Families and Individuals Eligibility Groups (ARKids First, Parents/Caretaker Relatives, Former Foster Care Adults, Pregnant Woman and Adult Expansion Group)

   The effective first (1st) day of coverage is the first (1st) day of the month of application unless retroactive coverage is approved. Coverage will end on the last day of the month eligibility ceases.

   EXCEPTION: For individuals in the Adult Expansion Group, coverage will end the last day of the month before their sixty-fifth (65th) birthday.

   NOTE: When an ARKids A recipient is an inpatient on their nineteenth (19th) birthday, eligibility will continue until the end of the inpatient stay, provided the recipient remains income eligible. Recipients with severe disabilities will be referred to Social Security for SSI determination. This special continuation of coverage only applies to ARKids A. ARKids B recipients cannot receive coverage past their nineteenth (19th) birthday.

2. AABD Eligibility Groups (Nursing Facility, Home and Community Based Waivers, TEFRA, Medicare Savings Program: ARSeniors and SSI Related Groups)

   An individual's coverage period may begin or end on any day of the month. When eligibility is established, the effective first (1st) day of coverage is the date of application, unless retroactive coverage is approved or one (1) of the exceptions listed below applies. For most categories, coverage may be terminated at any time within the month eligibility ceases. The end date of eligibility will be the last day of the notice period, unless the recipient requests a hearing within the advance notice period.

3. Medicare Savings Program exceptions:

    a. QMB-The effective date of coverage is the first (1st) day of the month following the month of approval.

    b. SMB-The effective first (1st) date of coverage is the first (1st) day of the month of application. Coverage must always begin on the first (1st) day of the month.

    c. QI-1- The effective day of coverage is the first (1st) day of the month of application. Coverage must always begin on the first (1st) day of the month.

    d. QDWI-The effective day of coverage will be the first (1st) day of the month based on the date of the application and the date on which all eligibility factors are met, including the effective month of Medicare Part A.

4. Medically Needy Groups (Exceptional and Spend Down)

    With date specific eligibility, an individual's or family's eligibility for exceptional Medically Needy may begin or end on any day of a month. When found eligible, the certification period will begin on the day application was made, unless retroactive coverage is needed. If retroactive coverage is needed and if eligibility is established, the certification period may begin up to three (3) months prior to the date of application (but not on the first(1st) day of a retroactive month, unless application was made on the first (1st) day of a month).

    Termination may occur at the time of reevaluation or by reported changes that affect client eligibility.

    The spend down period is the three (3) calendar months used in determining eligibility. The spend down quarter can be any continuous three (3) calendar month period between the first (1st) day of the three (3) month retroactive period (three (3) calendar months prior to the application month) and the last day of the three (3) month period beginning after the application month. The three (3) months chosen for the spend down period should be the three (3) months in which the applicant has the greatest medical expenses, or the three (3) months in which they would receive the greatest benefit. See MS E-300 - 340. Refer to MS A-210 through MS A-215 for retroactive eligibility for each category listed above.

E-410 Income Evaluation

MS Manual 06/01/25

Determination of income eligibility will be based on an applicant/recipient's monthly income. The recipient's gross monthly income will be compared to the monthly income eligibility standard to make this determination. Exclude VA Aid and Attendance and Continuing or Unusual Medical Expense reimbursements (CME/UME) in this computation.

Income which is received on a basis other than monthly (annually, semiannually, etc.) will be considered as income for the month of receipt only. (Do not count dividends received from insurance policies as income in eligibility determinations). Amounts carried over into the following month will be considered as resources.

Non-monthly income receipts will be treated as follows:

1. Regularly Received Non-Monthly Income - When income that will affect eligibility is regularly received by the individual in an established amount and at a set time, the case will be adjusted in the month prior to the receipt of the income after an advance notice. If the increased income will result in only one (1) month of ineligibility, the case may be reinstated effective the first (1st) day of the month following the month of ineligibility without taking a new application.

   If the anticipated income is in an amount great enough that is likely to result in two (2) or more months of ineligibility, the client will be informed in the advance notice that the case will be closed and that a new application will be required to reopen the case.

   If the anticipated income change will not result in case closure, the recipient or representative will be notified of the increased vendor payment at least ten (10) days prior to the change.

2. Irregularly Received Non-Monthly Income - When the recipient receives income on an unpredictable basis and in unpredictable amounts, income adjustments and ineligibility resulting from its inclusion in the budget will not be processed until after its receipt. The advance notice of intended action will be given before any case closures or income adjustments resulting in changes in vendor payment are completed. Every effort should be made to anticipate non-monthly income receipts so that advance action can be taken.

   As with regularly received non-monthly income, if benefits will be terminated for only one (1) month for receipt of irregular non-monthly income, a new application will not be required. Closures of two (2) or more months will require a new application.

3. SSI/SSA Lump Sum Benefits - SSI lump sum payments will not be counted as income in the month of receipt and will be given a resource exclusion according to the schedule at MS E-523 #6. SSA lump sum payments will be counted as income in the month of receipt, but will be given the appropriate resource exclusion. Interest earned on these excluded funds will be counted as income in the month accrued and as a resource, if retained, in the month(s) following.

   When SSA lump sum benefits result in income ineligibility, the case will be suspended in the month of receipt of the lump sum. A new application will not be required to reopen the case in the following month.

4. Interest and Dividend Income - Interest and dividends on checking and savings accounts, certificates of deposit, etc. represent a return on an investment or a loan of money, and are considered unearned income when credited to an account. Interest and dividends are considered credited to an account when a financial institution normally reports the income to the customer. The frequency with which interest is computed is immaterial in determining when the income is received (For example: a bank may compute interest daily, but credit an account only monthly or quarterly).

   Interest and dividends will be considered in both eligibility and net income determinations. An individual will not be allowed to retain interest and dividends for personal needs in addition to the monthly personal needs allowance.

   In determining initial eligibility and at subsequent reevaluations, the latest interest/dividend statement (two (2) if paid quarterly, at least three (3) if paid monthly) will be used to determine the countable monthly amount. Small interest/dividend amounts paid monthly or quarterly which fluctuate slightly may be averaged until the next scheduled reevaluation, unless an adjustment is necessary sooner due to a reported change. Interest/dividends credited or paid annually will be counted as income in the month of credit or receipt.

   NOTE: Interest income of State Human Development Centers and Arkansas Health Center residents will be used in determining initial eligibility but will not be considered in determining net income. Interest income of residents in ten (10) bed ICF/IID (Intermediate Care Facilities/Individuals with Intellectual Disabilities) facilities is counted in BOTH initial and post-eligibility determinations, as semi-annual cost reporting is not done for these facilities.

   Gross earned income is counted in determining initial eligibility for ICF/IID residents including residents of State Human Development Centers. In post eligibility determinations, earnings less mandated deductions up to an amount equal to the current SSI Standard Payment Amount are disregarded.

F-121 Social Security Administration

MS Manual 06/01/25

Because SSA decisions are controlling, any new evidence or allegations relating to previous SSA determinations must be presented to SSA for reconsideration or requests for reopening of the decisions.

Therefore, the agency must refer to SSA all applicants who allege new information or evidence which affects previous SSA determinations of "not disabled" for reconsideration or reopening of a determination, except in cases specified in MS F-122. When the conditions in MS F-122 are met, counties will be required to make an eligibility determination for Health Care.

Counties may also refer to SSA, for SSI application, those individuals whose income and resources are below SSI limits, because it would be to their advantage to receive both cash assistance and Health Care.

F-123 Dual Applications

MS Manual 06/01/25

When an individual applies for both Health Care and Social Security Disability or SSI, and the application with SSA is still pending, if the individual appears to meet all other eligibility requirements a MRT determination of disability will be initiated. The agency will have ninety (90) days from the date of the Health Care application to make this determination.

If application for Social Security Disability is approved first, the Health Care application may be approved (if all other requirements have been met.) If application for SSI is approved first (1st), the Health Care application will be denied except for ARChoices, Living Choices, Autism, DDS, Nursing Facility (NF) and PACE which may be approved. If SSA determines the applicant is NOT disabled, the Health Care application will be denied.

If the Health Care application is approved based on a Medical Review Team (MRT) disability decision and later the individual is denied by SSA, the Health Care case will be closed after appropriate notice, unless the recipient appeals the closure. If the appeal is made timely, the Health Care case will remain open pending the outcome of the DHS appeals process. In no case will the Health Care case remain open pending the outcome of the SSA appeals process if the recipient has appealed the SSA decision.

If the Health Care application is denied based on a MRT decision and later SSA approves the disability, when the applicant notifies DCO, the original application will be reinstated regardless of the time frame. If the provider files claims timely, Health Care claims will be paid. Refer to MS A-190. The application will be processed with the original application date provided all other eligibility criteria were met for this time period.

F-125 MRT Decision

MS Manual 06/01/25

If an adverse action is taken on an individual's case, a notice will be sent to the individual listing the specific medical records that were used in making the determination and the criteria that was not met.

H-650 Appeal Rights

MS Manual 06/01/25

The waiver applicant may appeal the DHS decision regarding the hardship waiver by writing to the Office of Appeals and Hearings and requesting an administrative review of the decision. The request must be received no later than thirty-five (35) days from the date of the notice on the Notice of Action.

H-710 Hardship Waiver for Home Equity

Refer to Health Care Procedure Manual for more Information.

MS Manual 06/01/25

An individual who is denied eligibility due to excess home equity may request an Undue Hardship Waiver. (Refer to MS E-517.) An example of a situation in which an undue hardship may exist is if the individual makes an allegation that the home equity should not be counted because of a legal impediment to selling or transferring the home.

A decision on the hardship waiver will be made by the Hardship Waiver Committee. If the person who applied for the waiver disagrees with the DHS decision, they may appeal the decision within thirty-five (35) days of the date of notice about the DHS decision (MS J-100).

H-720 Hardship Waiver for Transfer of Resources/Income

Refer to Health Care Procedure Manual for more Information.

MS Manual 06/01/25

Once it has determined that this transfer does not meet an exception found at MS H-309 and it has been determined that the resource or income was not transferred exclusively for some other purpose through a rebuttal found at MS H-312-313, a hardship waiver may be pursued.

An individual who is denied Waiver services or nursing facility vendor payment due to a transfer of resources or income for less than fair market value may request an Undue Hardship Waiver. No penalty period for uncompensated transfer will be imposed upon an institutionalized or Waiver individual to the extent that it is determined that denial of eligibility would work an undue hardship. Undue hardship exists if each condition below is met:

1. Counting uncompensated value would make an individual ineligible;
2. Lack of assistance would deprive the individual of food, shelter, and care determined to be medically necessary;
3. The individual's total resources are not great enough to pay for facility care for one (1) month; and
4. The resource(s) cannot be recovered from the individual(s) to whom the resource(s) was transferred without compensation due to loss, destruction, theft, or other extraordinary circumstance.

Undue hardship does not exist when applying the transfer provisions merely would cause the individual inconvenience or would restrict his lifestyle without putting him at risk of serious deprivation.

The individual or the individual's authorized representative may apply for an undue hardship waiver. In addition, a representative from the facility in which an individual is residing may apply for an undue hardship waiver on behalf of the client with either the consent of the client or their personal representative.

A decision on the hardship waiver will be made by the DCO Hardship Waiver Committee. If the person who applied for the waiver disagrees with the committee's decision, they may appeal the decision within thirty-five (35) days of the date of notice about the decision (MS J-100).

H-730 Hardship Waiver for Estate Recovery

MS Manual 06/01/25

The personal representative or distributee of an estate may apply for a hardship waiver at the time notice of the estate is given to DHS, or within thirty-five (35) days after receiving notice from DHS of intent to recover Health Care payments and the procedures for requesting a hardship waiver.

To apply for a waiver, the representative or distributee must mail a statement setting forth the facts which constitute the undue hardship to:

Third Party Liability Unit
Attention: Decedents' Estates
P. O. Box 1437, Slot S296
Little Rock, AR 72203-1437

The statement must set forth the facts that constitute the undue hardship. Tax returns, income statements or other documents which support the position that estate recovery would work an undue hardship on the survivors must be submitted. The Third Party Liability Unit will send the hardship request and supporting documents to the DCO Hardship Waiver Committee. In determining the existence of an undue hardship, the DCO Hardship Waiver Committee will consider factors including, but not limited to the following:

1. The estate asset subject to recovery is the sole-income producing asset of beneficiary of the estate;
2. Without receipt of the proceeds of the estate, a beneficiary would become eligible for federal or state benefits;
3. Allowing a beneficiary to receive the inheritance from the estate would enable a beneficiary to discontinue eligibility for federal or state benefits;
4. The estate asset subject to recovery is a home with a value of fifty percent (50%) or less of the average price of homes in the county where the homestead is located, as of the date of the decedent's death; and
5. Other compelling circumstances.

A determination that hardship does not exist will be made if the individual created the hardship through estate planning in which assets were divested in order to avoid estate recovery.

A decision on the hardship waiver will be made by the DCO Hardship Waiver Committee. The committee's decision and information about the right to appeal the decision will be sent by certified mail, return receipt requested, to the person who applied for the waiver. If the person who applied for the waiver disagrees with the DHS decision, they may appeal the decision within thirty-five (35) days of receipt of the notice about the decision (MS J-100).

If recovery is not made due to the determination of hardship, DHS may decide to recover at a later time if the conditions which caused the original hardship cease to exist.

I-630 ARChoices Waiver

MS Manual 06/01/25

Recipients will be advised to report any changes in the amount of household income or resources.

If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) or Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC) determines that cost effectiveness is not met, that the client no longer meets the requirements for Intermediate Level of Care, or that the client is no longer receiving Waiver services, the Waiver case will be closed. If the Waiver case is closed for any reason, the system will determine if the client is eligible for any other Health Care category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ARChoices Waiver client loses eligibility for one (1) month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the County has advance knowledge of ineligibility in a future month (For example: land rent paid annually), procedures at MS E-410 will be followed, advance notice given, and the case adjusted.

If the Waiver client will be ineligible for more than one (1) month, the case will be closed and a new application will be required.

A Waiver client may appeal an adverse decision made on their case as outlined in MS L 100-173. If a timely appeal is received on or before the date listed on the Notice of the Action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out.

I-640 Living Choices (Assisted Living Facility)

MS Manual 06/01/25

Living Choices Waiver (Assisted Living Facility) recipients will be advised to report any changes in income or resources. If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) or the Office of Long Term Care determines that cost effectiveness is not met or that the client no longer meets the requirements for an Intermediate Level of Care, the Living Choices case will be closed. If the case is closed for any reason, the system will determine if the client is eligible in any other Health Care category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the Living Choices Waiver client loses eligibility for one (1) month only, the case may remain open with an overpayment submitted for the month of ineligibility. When DHS has advance knowledge of ineligibility in a future month, procedures at MS E-410 will be followed, advance notice given, and the case adjusted at the appropriate time.

If the Living Choices recipient will be ineligible for more than one (1) month, the case will be closed and a new application will be required to reopen.

A Living Choices Waiver recipient may appeal an adverse decision made on their case as outlined in MS Section L. If a timely appeal is received on or before the date listed on the Notice of the Action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out.

I-650 DDS Waiver

MS Manual 06/01/25

Recipients will be required to report changes to DDS within ten (10) days. Eligibility will be redetermined when information is received about changes in a recipient's circumstances. When a change occurs that results in ineligibility, an advance notice will be given unless advance notice is not required. Refer to MS J-130.

Eligibility will end at the end of the advance notice period, unless the recipient or their legal representative requests a hearing, or unless whatever was causing the intent to close is resolved prior to the end of the notice period.

I-660 TEFRA

MS Manual 06/01/25

When a change occurs that affects eligibility, the applicant will be sent an advance notice, unless advance notice is not required. (Refer to MS J-130.)

J-100 Notice of Action Requirements

MS Manual 06/01/25

A Notice of Action is sent to an individual whenever an application has been approved or denied, a hardship request has been denied or assistance has been reduced or terminated. All notices must include:

- A statement of action the Agency intends to take,
- The effective date of the action,
- The reason(s) for the action,
- The manual policy reference(s) supporting the action,
- An explanation of the individual's right to request a hearing, and
- An explanation of the circumstances under which assistance is continued if a hearing is requested.

Federal regulations require an advance notice be given for termination of assistance or reduction of assistance. The following sections define these notice requirements and list when advance notice is not required.

J-110 Advance Notice for Termination of Assistance

MS Manual 06/01/25

When the Division of County Operations (DCO) proposes to terminate assistance for a recipient, advance notice will be sent to the recipient using a form called a "Notice of Action." The effective date of any reductions or terminations of service, as well as time for appeals, is counted from the date listed on the Notice of Action.

Advance Notice must contain all information listed in MS J-100. To provide the recipient with time to appeal the adverse decision, the effective date of the action will be no earlier than thirty-five (35) days from the date listed on the Advanced Notice. If a hearing is not requested within thirty-five (35) days of the date listed on the Advance Notice, the adverse action indicated on the notice will be taken.

J-120 Advance Notice for Reduction of Assistance

MS Manual 06/01/25

Reduction of assistance means a change in vendor payment or a categorical change resulting in a reduction in benefits in the service package (For example: changing from ARKids A to ARKids B). When the recipient's income increases, an advance notice will be given. If the income change results in a change in vendor payment to the nursing facility, an information copy of the Decision for Nursing Home/Waiver Placement, will be provided to the nursing facility.

L-120 Continuation of Assistance or Services during Appeal Process

MS Manual 06/01/25

If the beneficiary, or provider on behalf of a beneficiary, files an appeal within thirty-five (35) days from the date on the Notice of Adverse Action, the beneficiary's benefits will be continued with no change until the administrative appeal has concluded and a hearing decision has been entered. The beneficiary may affirmatively opt out of receiving benefits during the appeal period.

DCO will not terminate or reduce services until a decision is rendered after the hearing, unless the hearing official determines at the hearing that the sole issue is one of Federal or State law or policy or the client withdraws. DCO needs to promptly inform the recipient in writing that services are to be terminated or reduced pending the hearing decision.

L-100 Administrative Hearings

MS Manual 06/01/25

The purpose of the administrative hearing process is to provide a procedure for DHS clients to appeal:

1. The denial of Medical Assistance,
2. The failure of the Division of County Operations (DCO) to process the application within specified timeframes,
3. When a petitioner disagrees with any DCO action resulting in suspension, reduction or discontinuance of assistance, or
4. When an Institutionalized Spouse (IS) or Community Souse (CS) is dissatisfied with the determination of:
    a. The CS's monthly income allowance,
    b. The amount of monthly income otherwise available to the CS,
    c. The computation of the spousal share of resources, or
    d. The attribution of resources or the CS's resource allowance.

A hearing will not be granted when either state or federal law requires a reduction in medical assistance. A request for a hearing must be received in the Office of Appeals and Hearings (OAH) within 35 days of the Notice of Action date.

O-731 Establish Duration of Eligibility - Exceptional Medically Needy Cases

MS Manual 06/01/25

With date specific eligibility, eligibility for Exceptional Medically Needy cases begins on the day of application (current) and/or as far back as three (3) months prior to the date of application (retroactive), provided eligibility requirements are met and there are incurred medical expenses for each month of the retroactive period of certification.

EXAMPLE: If application is made on May 3rd, eligibility may be given retroactively to February 3rd, if there are incurred medical expenses in each of the three (3) months and if income/resources requirements are met in each of the months. A shorter retroactive period could be given if the only medical bill in the retroactive period was incurred on April 16th. In that case, eligibility would begin on April 16th.

Eligibility for the Exceptional Medically Needy continues until terminated by the system. Termination may occur at the time of reevaluation or at any other time that changes affect eligibility.

The recipient is required to report all changes within ten (10) days. The end date of eligibility will be the last day of the advance notice period, unless a recipient requests a hearing.

O-810 County Office Certification Responsibility

MS Manual 06/01/25

Refer to Health Care Procedures Manual for more Information.

O-940 Medically Needy Case Closures

MS Manual 06/01/25

The system will automatically affect closure of current open Spend Down cases and all cases which are converted to SSI eligibility. With the exception of closed past Spend Down and Fixed Eligibility Certifications, the advance notice applies to all categories.

Eligibility for Health Care ceases at the end of the advance notice period. Under date specific eligibility, eligibility may be terminated on any day of a month for Exceptional Medically Needy cases and for Spend Down cases.

Medical Services – Glossary

MS Manual 06/01/25

Absent Parent –

A child's parent who does not live in the same home as the child.

Activities of Daily Living (ADL) –

Personal tasks that are ordinarily performed on a daily basis and include eating, mobility/transfer, dressing, bathing, toileting, and grooming.

Adequate Notice –

A notice mailed to the applicant/recipient no later than the date action is taken upon the case.

Advance Notice –

A notice of adverse action mailed to the recipient 35 days prior to taking the action and giving the applicant/recipient an opportunity to rebut the decision or to appeal the proposed action.

Adverse Action –

An agency action which results in a denial, reduction or termination of benefits.

Affidavit for Collection of Small Estates –

Allow the distributees of an estate that does not exceed $100,000 to receive the estate without the appointment of a personal representative or administration of the estate.

Alien –

An individual who is not a U.S. citizen or U.S. national.

Alien Sponsor –

An individual or organization that agreed to provide certain support to an alien as a condition of the alien's entry into the United States as a permanent resident.

Appeal –

A request for a fair hearing concerning a proposed agency action, a completed agency action or failure of the agency to make a timely determination.

A legal proceeding in which the applicant/recipient and the agency representative present the case being appealed before a hearing officer.