ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable N/A

Previous Agency Name, If Applicable N/A

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TOC not required

161.200 Administrative Reconsideration

~~1-1-16~~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. ~~General rules regarding due process are contained in Section I of each provider manual; but some administrative reconsideration and appeal processes are program-specific and are set forth in Section II of the applicable program 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, ~~the Director of the Division of Medical Services~~ 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**~~who did not participate in the initial determination leading to the adverse decision/action, who is knowledgeable in the subject matter of the administrative reconsideration, to review the reconsideration request and associated documents. The reviewer shall recommend to the Director that the adverse decision/action be sustained, reversed or modified. The Director may adopt or reject the recommendation in whole or in part~~.

~~A reconsideration request received within 35 calendar days of the written notice will be deemed timely. The request must be mailed or delivered by hand. Faxed or E-mailed requests will not be accepted~~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

~~9-15-09~~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**.~~Mail or deliver the appeal to the Office of Appeals and Hearings, Arkansas Department of Human Services, P.O. Box 1437, Slot N401, 7th and Main Streets, Little Rock, AR 72203-1437~~.

161.400 Sanction Appeals

~~9-15-09~~6-1-25

Within thirty (30) calendar days of receiving notice of adverse decision/action, the provider may appeal.~~, or 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 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**. ~~Mail or deliver the appeal to the Director, Division of Medical Services, P.O. Box 1437, Slot S401, 7th and Main Streets, Little Rock, AR 72203-1437.~~ 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

~~9-15-09~~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 ~~adverse action~~ notice of action must be sent to the Medicaid beneficiary ~~must comply within accordance with~~ 42 CFR §431.230~~. entitled "Maintaining Services," which states in part:~~

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

~~(a) When the department mails the 10-day or 5-day notice, as required, and the beneficiary requests a hearing before the date of action, the department 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 department promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.~~

191.004 Administrative Appeals

~~9-15-09~~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 next business day following the date of the postmark on the envelope containing the written notice of an adverse decision~~ 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~~Beneficiary or Provider Appeal Process~~ ~~4-1-09~~6-1-25

~~When an adverse extended services or prior authorization request decision is made, the provider may request an administrative reconsideration and/or the provider and/or the beneficiary may file for a fair hearing or appeal of the denial of services decision as provided is Section 190.003 of this manual. The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter explaining the denial. Appeal requests must be submitted to the Department of Human Services Appeals and Hearings Section. Further details, guidelines and procedures are outlined and provided within the respective discipline's Medicaid Provider Manual. Refer to your individual specialty provider manual for further assistance.~~ **~~View or print the Department of Human Services Appeals and Hearings Section address.~~**

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~~Reconsideration of Benefit Extension Denials~~ ~~2-1-05~~6-1-25

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

B. ~~Reconsideration requests that do not include all required documentation will be automatically denied.~~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.

~~C. Requests to reconsider benefit extension denials must be received by AFMC within 30 calendar days of the date of the denial notice. When requesting reconsideration:~~

~~1. Return all previously submitted documentation and pertinent additional information to justify the medical necessity of additional services.~~

~~2. Include a copy of the NOTICE OF ACTION denial letter with the resubmission.~~

215.200 ~~Appealing an Adverse Action~~Reserved ~~2-1-05~~6-1-25

~~A. When the state Medicaid agency or its designee denies a benefit extension request, the beneficiary may appeal the denial and request a fair hearing.~~

~~B. An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the provider notification denial letter from AFMC.~~ **~~View or print the Department of Human Services, Appeals and Hearings Section contact information~~**~~.~~

TOC required

214.200 Administrative Reconsideration ~~of Extensions of Benefits Denial~~and Appeals

~~8-1-21~~6-1-25

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.~~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. ~~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~~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 ~~Appealing an Adverse Action~~Reserved

~~11-1-06~~6-1-25

~~Please see Section 190.000 *et al* for information regarding administrative appeals.~~

TOC required

214.130 Administrative Reconsideration ~~of Extension of Benefits Denial~~and Appeals ~~7-1-06~~6-1-25

~~A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation as detailed in Section 214.120. The deadline request will be enforced as indicated in Sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days gives rise to a rebuttable presumption that it is not timely.~~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 ~~Appealing an Adverse Action~~Reserved ~~7-1-06~~6-1-25

~~Please see Section 190.000 for information regarding administrative appeals.~~

272.533 Injections, Therapeutic and/or Diagnostic Agents ~~1-1-23~~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.

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

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

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 ~~Medicaid Client Appeal Process~~Administrative Reconsideration and Appeals ~~1-1-23~~6-1-25

~~When an adverse decision is received, the client may request a fair hearing of the denial decision.~~

~~The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty (30) days of the date on the letter explaining the denial of services.~~

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 ~~of Benefit Extension Denials~~and Appeals

~~2-1-05~~6-1-25

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

B. ~~Reconsideration requests that do not include all required documentation will be automatically denied.~~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.

~~C. Requests to reconsider benefit extension denials must be received by AFMC within 30 calendar days of the date of the denial notice. When requesting reconsideration:~~

~~1. Return all previously submitted documentation and pertinent additional information to justify the medical necessity of additional services.~~

~~2. Include a copy of the **NOTICE OF ACTION** denial letter with the resubmission.~~

220.210 ~~Appealing an Adverse Action~~Reserved

~~2-1-05~~6-1-25

~~A. When the state Medicaid agency or its designee denies a benefit extension request, the beneficiary may appeal the denial and request a fair hearing.~~

~~B. An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the letter from AFMC explaining the denial.~~ **~~View or print the Department of Human Services, Appeals and Hearings Section contact information.~~**

220.220 ~~Beneficiary Appeal Process for Denial of Service Coverage or Benefit Extension~~Reserved

~~10-13-03~~6-1-25

~~When DMS denies coverage of FQHC services or denies a benefit extension request for FQHC services, the beneficiary may request a fair hearing to appeal the denial.~~

~~The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter from DMS explaining the denial. Appeal requests must be submitted to Department of Human Services, Appeals and Hearings Section.~~ **~~View or print DHS Appeals and Hearings Section contact information.~~**

TOC required

213.512 Benefit Extension Denials and Reconsideration Requests ~~11-1-05~~6-1-25

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

~~A. The provider may request reconsideration of the extension request.~~

~~B. Reconsideration may be given only once per date of service for home health visits and once per month for medical supplies and diapers and underpads.~~

~~C. Reconsideration requests must contain all documentation originally submitted and the additional documentation that the provider believes justifies the request.~~

~~D. Reconsideration of benefit extension requests is contingent upon the provider's submitting additional documentation to support the request.~~

213.513 Administrative Reconsideration and Appeals ~~10-15-09~~6-1-25

A. ~~A beneficiary may appeal a denied benefit extension by requesting a fair hearing.~~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. ~~A provider may appeal on behalf of a beneficiary for whom an extension has been denied.~~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.

~~C. An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the first business day following the date of the postmarks on the envelopes in which the beneficiary and provider received their denial confirmations.~~ **View or print the Department of Human Services, Appeals and Hearings Section contact information.**

213.514 ~~Requesting~~ Continuation of Services Pending the Outcome of an Appeal ~~10-15-09~~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.

~~A. A beneficiary may request that services be continued pending the outcome of an appeal.~~

~~B. A provider may not, on behalf of a beneficiary, request continuation of services pending the outcome of an appeal.~~

~~1. An appeal that includes a request to continue services must be received by the DHS Appeals and Hearings Section within 10 days of the first business day following the date of the postmark on the envelope in which the beneficiary received the denial confirmation letter.~~

~~2. When such requests are made and timely received by the Appeals and Hearings Section, DMS authorizes the services and notifies the provider and beneficiary.~~

3. The provider will be reimbursed for services furnished under these circumstances and for which the provider correctly bills Medicaid.

C. If the beneficiary loses the appeal, DMS will take action to recover from the beneficiary Medicaid's payments for the services that were provided pending the outcome of the appeal.

213.515 Unfavorable Administrative Decisions – Judicial ReliefReserved 11-1-056-1-25

Providers and Medicaid beneficiaries have standing to appeal to circuit court unfavorable administrative decisions under the Arkansas Administrative Procedures Act, § 25-15-201 *et. seq*.

215.000 Appeal Process for Medicaid ClientsReserved 10-13-036-1-25

When home health services are denied and the client wishes to appeal the denial, the client may request a fair hearing from the Department of Human Services. The appeal request must be in writing and received by the Appeals and Hearing Section of the Department of Human Services within thirty days of the date on the letter from Utilization Review explaining the denial. Appeal requests must be 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.**

223.000 Reconsideration of DenialsReserved 10-15-096-1-25

If the denial decision is reversed during the reconsideration review, an approval is forwarded to the providers specifying the approved units and services. If the denial decision is upheld, the provider and the Medicaid beneficiary will be notified in writing of the review determination.

Reconsideration is available only once per prior authorization request. However, if the denial is upheld during the reconsideration process, the provider may submit a new prior authorization request, for different dates of services, providing new supporting documentation is available. **A subsequent prior authorization request will not be reviewed if it contains the same documentation submitted with the previous authorization and reconsideration requests.**

TOC required

212.502 Administrative Reconsiderations 8-1-216-1-25

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

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 Administrative Reconsiderations: Special Cases 8-1-216-1-25

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 6-1-066-1-25

A. A beneficiary may appeal a denied extension of inpatient days by requesting a fair hearing.

B. A hospital provider may appeal on behalf of a beneficiary for whom an extension has been denied.

C. An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Health and Human Services (DHHS) within 30 days of the first business day following the date of the postmarks on the envelopes in which the beneficiary and provider received their denial confirmations. **View or print the Department of Health and Human Services, Appeals and Hearings Section contact information.**

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 Requesting Continuation of Services Pending the Outcome of an Appeal

6-1-06 6-1-25

A. A beneficiary may request that services be continued pending the outcome of an appeal.

1. A provider may not, on behalf of a beneficiary, request continuation of services pending the outcome of an appeal.

2. An appeal that includes a request to continue services must be received by the DHHS Appeals and Hearing Section within 10 days of the first business day following the date of the postmark on the envelope in which the beneficiary received the denial confirmation letter.

B. When such requests are made and timely received by the Appeals and Hearings Section, DMS will authorize the services and notify the provider and beneficiary.

1. The provider will be reimbursed for services furnished under these circumstances and for which the provider correctly bills Medicaid.

2. If the beneficiary loses the appeal, DMS will take action to recover from the beneficiary Medicaid's payments for the services that were provided pending the outcome of the appeal.

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

212.506 Unfavorable Administrative Decisions – Judicial Relief Reserved

6-1-06 6-1-25

Providers, as well as Medicaid beneficiaries, have standing to appeal to circuit court unfavorable administrative decisions under the Arkansas Administrative Procedures Act, § 25-15-201 *et. Seq.*

215.104 Reconsideration of Benefit Extension Denials Reserved

2-1-05 6-1-25

A. Medicaid allows only one reconsideration of a denied benefit extension request.

B. Reconsideration requests that do not include all required documentation will be automatically denied.

C. Requests to reconsider benefit extension denials must be received by AFMC within 30 calendar days of the date of the denial notice. When requesting reconsideration:

1. Return all previously submitted documentation and pertinent additional information to justify the medical necessity of additional services.

2. Include a copy of the **NOTICE OF ACTION** denial letter with the resubmission.

215.110 ~~Appealing an Adverse Action~~Reserved

~~2-1-05~~6-1-25

~~A. When the state Medicaid agency or its designee denies a benefit extension request, the beneficiary may appeal the denial and request a fair hearing.~~

~~B. An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the provider notification denial letter from AFMC.~~ **~~View or print the Department of Human Services, Appeals and Hearings Section contact information.~~**

218.280 ~~Administrative Reconsideration~~Reserved

~~8-1-21~~6-1-25

~~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.~~

218.303 Reconsideration Review

~~10-1-08~~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 ~~by the 30th~~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 ~~Requests to Reconsider Denied Prior Approvals~~Administrative Reconsideration and Appeals

~~3-15-05~~6-1-25

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

B. ~~Reconsideration requests that do not include required documentation will be denied automatically~~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.

~~C. Requests to reconsider transplant prior approval denials must be received by UR within 30 calendar days of the date of the **NOTICE OF ACTION** denial letter. When requesting reconsideration:~~

~~1. Return all previously submitted documentation and pertinent additional information to justify the medical necessity of the denied transplant.~~

~~2. Include a copy of the **NOTICE OF ACTION** denial letter with the resubmission.~~

245.200 ~~Beneficiary Appeal Process for Denied Prior Approvals~~Reserved ~~3-15-05~~6-1-25

~~When DMS or its designee (AFMC in this case) denies a request for prior approval of a transplant or transplant evaluation, the beneficiary may appeal the denial and request a fair hearing.~~

~~A. An appeal request must be in writing.~~

~~B. The appeal request must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the **NOTICE OF ACTION** denial letter. **View or print the Department of Human Services, Appeals and Hearings Section contact information.**~~

TOC required

222.200 Denial of Prior Authorization Requests

~~10-1-06~~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.

~~The provider may request reconsideration of the denial within thirty-five calendar days of the denial date. Requests must be made in writing and include additional documentation to substantiate the medical necessity or program criteria of the requested services.~~

222.300 ~~Reconsideration Requests~~Administrative Reconsideration and Appeals

~~10-1-06~~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.

~~If the decision is reversed during the reconsideration review, an approval is forwarded to all relevant parties specifying the approved units and services. If the denial is upheld, the provider and the Medicaid beneficiary are notified in writing of the review determination.~~

~~Reconsideration is available only once per prior authorization request.~~ ~~**A subsequent prior authorization request will not be reviewed if it contains the same documentation submitted with the previous authorization and reconsideration requests.**~~

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

222.400 ~~Fair Hearing Requests~~Reserved

~~10-1-06~~6-1-25

~~The Medicaid beneficiary may request a fair hearing of an adverse review determination from the Department of Health and Human Services (DHHS). The appeal request must be in writing and sent to the Appeals and Hearings Section of DHHS within thirty-five calendar days of the date on the denial letter. Providers may refer to Section 190.000 for information regarding provider appeals through the Medicaid Fairness Act.~~

TOC required

250.200 ~~Appeal Rights~~Reserved ~~1-1-19~~6-1-25

~~IndependentChoices participants have the right to appeal certain decisions or actions with which they disagree. The method used to make the appeal and the time frames within which an appeal is made depends on the basis of the appeal. The Division within the Department of Human Services that will hear the appeal is also based on the reason for the appeal.~~

~~Appeals for hearings will also be handled in several ways based on the reason the appeal was made.~~

250.300 ~~Reason for Appeal~~Administrative Reconsideration and Appeals ~~1-1-19~~6-1-25

If ~~the participant loses eligibility for personal assistance services, he or she may ask for~~ the Department issues any adverse action, the participant may request an Administrative Reconsideration according to Section 160~~1~~.2000 of Section I of the Medicaid Provider Manual. ~~or may appeal the decision according to Medicaid Provider Manual policy 161.300 through 169.000~~ 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~~n~~ request ~~appeal may be filed by a participant or Representative based on actions or circumstances listed below:~~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 ~~will result in the~~and closure of the case. ~~Any appeal made by the participant must be filed with the Office of Appeals and Hearings according to Medicaid Provider Manual Policy 161.300 through 169.000.~~

250.400 ~~Administrative Review and Appeal of Involuntary Disenrollment~~Continuation of Benefits During an Appeal ~~1-1-19~~6-1-25

~~A participant may request administrative review of the involuntary closure of his/her case by writing to the Division of Provider Services and Quality Assurance, P.O. Box 1437, Slot S530, Little Rock, AR 72203-1437 or may be sent by fax (1-501-683-4180).~~

~~The participant has thirty (30) days from the date of notification of disenrollment to file an administrative review of this decision. Administrative Review requests may be mailed or faxed to DPSQA and must be post marked or received within 30 days of the disenrollment decision. All notifications of Involuntary Disenrollment must be made in writing and sent by Certified Mail with~~

~~a receipt to assure that the date the notification was received is documented. Requests received after the 30-day limit will not be reviewed. Reviews will be completed and decisions will be available within 45 days of the request.~~

~~The Administrative Review decision, if unfavorable, may be appealed through the established DHS Hearings and Appeals policy according to Medicaid Provider Manual Policy 161.300 through 169.000.~~

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 ~~Process~~ ~~10-13-03~~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.

~~If the decision by the independent CON Team is to authorize fewer days than requested or to deny the request for admission, the provider may request a reconsideration of the decision. If the decision is a denial of services, the beneficiary may file an appeal with the Department of Human Services after the reconsideration period expires or a decision is made via reconsideration.~~

216.100 ~~Provider Reconsideration Process~~Reserved ~~10-14-16~~6-1-25

~~If the admitting facility is not satisfied with the CON decision, it may request reconsideration from the independent CON Team. Any request for reconsideration, as well as any documentation substantiating the reconsideration request, must be received within thirty (30) days of the date on the notice of decision.~~

~~Submit reconsideration requests to the current contractor.~~ **~~View or print current contractor contact information.~~**

216.200 ~~Beneficiary Appeal Process~~Reserved ~~10-13-03~~6-1-25

~~If the stay is denied by the independent CON Team following the provider reconsideration process, the beneficiary may file a request for a fair hearing.~~

~~The appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within thirty (30) days of the date on the denial notice from the independent CON Team.~~ **~~View or print Department of Human Services, Appeals and Hearings Section contact information.~~**

230.210 ~~Provider Reconsideration Process~~Reserved ~~10-13-03~~6-1-25

~~If the admitting facility is not satisfied with the PA denial decision, it may request a reconsideration by the contractor. Any request for a reconsideration, as well as any documentation refuting the reason for denial, must be received by the contractor within thirty (30) calendar days of the date of the denial notice of action. The admitting facility and the beneficiary will be notified in writing of the decision after reconsideration.~~

~~If a reconsideration after denial is not requested by the provider, a final denial notice will be sent to the facility and the beneficiary when the 30 calendar days have expired.~~

230.220 ~~Beneficiary Appeal Process~~Reserved ~~10-13-03~~6-1-25

~~After the reconsideration process is completed, the beneficiary may request a hearing if he or she is not satisfied with the decision. Instructions for the filing process for an appeal are included on the denial notice.~~ **~~View or print an Approval/Denial Codes for Inpatient Psychiatric Services form, DMS-2687.~~**

242.310 Reconsideration

~~7-1-04~~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 Division of Medical Services accepts reconsideration requests based on the postmark on the envelope from the contractor. The provider is responsible for retaining the envelope containing the postmark.~~ 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 ~~of Extensions of Benefits Denial~~and Appeals ~~8-1-21~~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.~~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.~~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.

~~C. Further clinical documentation shall be requested when deemed necessary to complete the medical review.~~

214.950 Reserved ~~1-15-16~~6-1-25

214.951 ~~Appealing an Adverse Decision~~Reserved ~~3-1-05~~6-1-25

~~When the Division of Medical Services (DMS) denies a benefit extension request for laboratory and x-ray services, and the beneficiary wishes to appeal the denial, the beneficiary may request a fair hearing.~~

~~An appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within 30 days of the date on the letter from DMS explaining the denial. Appeal requests must be 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.~~

214.952 ~~Requesting Initiation or Continuation of Services Pending the Outcome of an Appeal~~Reserved ~~3-1-05~~6-1-25

~~A. A beneficiary may request that services be continued (or that services begin, in cases where coverage has been denied), pending the outcome of an appeal.~~

~~1. Appeals that include a request to begin or continue services must be received by the DHS Appeals and Hearing Section within 10 days of the date on the DMS denial letter.~~

~~2. When such requests are made and timely received by the Appeals and Hearings Section, DMS will authorize the services and notify the provider and beneficiary.~~

~~3. The provider will be reimbursed for services furnished under these circumstances and for which the provider correctly bills Medicaid.~~

~~B. If the beneficiary loses the appeal, DMS will take action to recover from the beneficiary Medicaid's payments for the services that were provided pending the outcome of the appeal.~~

222.000 ~~Appeal Process for Medicaid Beneficiaries~~Reserved ~~1-15-16~~6-1-25

~~When the Division of Medical Services denies coverage of services the beneficiary may request a fair hearing of the reconsideration decision of the denial of services from the Department of Human Services.~~

~~The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty (30) days of the date on the letter explaining the denial. Appeal requests must be 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~~**~~.~~

TOC not required

215.300 PACE Participant Appeal Process

~~1-1-13~~6-1-25

When an adverse decision is received, the PACE participant may appeal. The appeal request must be ~~in writing and received by the Appeals and Hearing Section of the Department of Human Services within thirty (30) days of the date on the letter explaining the decision. **View or print Appeals and Hearings Section contact information.**~~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 ~~3-1-19~~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~~s~~ to ~~appeal to the state~~ 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 ~~DHS Appeal Rights~~Appeal of Adverse Action of DHS ~~3-1-19~~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 ~~the Medicaid Provider Manual,~~ Sections 160.000, ~~&~~ 190.000, and 191.000 of Section I of this Manual.

247.200 ~~PASSE Appeal Rights~~Appeal of Adverse Decision/Adverse Action of a PASSE ~~3-1-19~~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 ~~Appealing An Adverse Action~~Administrative Reconsideration and Appeals ~~7-1-06~~6-1-25

~~Please see Section 190.000 et al for information regarding administrative appeals.~~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 ~~Provider Process for Reconsideration of PA Determination~~Administrative Reconsideration and Appeals ~~1-1-19~~6-1-25

~~Reconsideration of a denial may be requested within thirty calendar days of the denial date. Reconsideration requests must be made in writing to DHS professional staff or the contractor(s) designated by DHS and must include additional documentation to substantiate the medical necessity of the requested services.~~

~~If the decision is reversed during the reconsideration review, an approval is forwarded to all relevant parties specifying the approved units and services. If the denial is upheld, the DHS professional staff or the contractor(s) designated by DHS issues a written notification of the decision to the beneficiary and provider.~~ **~~View or print AFMC contact information.~~**

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 ~~Beneficiary Process for Appeal of PA Determination~~Reserved ~~10-1-08~~6-1-25

~~When the beneficiary receives an adverse decision concerning a request for PA determination, the beneficiary may request a fair hearing of the reconsideration decision of the denial of services from the Department of Human Services.~~

~~The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter from the DHS professional staff or contractor(s) designated by DHS explaining the denial. Appeal requests must be 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~~**~~.~~

TOC required

214.000 ~~Appealing An Adverse Action~~Administrative Reconsiderations and Appeals

~~10-1-06~~6-1-25

~~Please see Section 190.000 et al for information regarding administrative appeals.~~

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 ~~of Extensions of Benefits Denial~~and Appeals ~~8-1-21~~6-1-25

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.~~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. ~~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.~~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 ~~Appealing an Adverse Action~~Reserved ~~6-1-25~~~~2-1-06~~

~~Please see Section 190.000 *et al.* for information regarding administrative appeals.~~

229.240 ~~Administrative Reconsideration~~ Reserved ~~6-1-25~~~~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.~~

261.230 ~~Reconsideration for Denied Prior Approvals~~Reserved ~~6-1-25~~~~10-1-06~~

~~A request for administrative reconsideration of a denied prior approval must be in writing and sent to AFMC within 35 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 manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis. Reconsideration requests must be mailed or delivered by hand. Faxed or emailed requests will not be accepted.~~

261.231 ~~Beneficiary Appeal Process for Denied Prior Approvals~~Reserved ~~6-1-25~~~~10-1-06~~

~~When DMS or its designee (AFMC in this case) denies a request for prior approval of a transplant or transplant evaluation, the beneficiary may appeal the denial and request a fair hearing.~~

~~A. An appeal request must be in writing.~~

~~B. The appeal request must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the provider notification denial letter from the Utilization Review Section or AFMC.~~ **~~View or print the Department of Human Services, Appeals and Hearings Section contact information.~~**

264.000 ~~Appeal Process for Medicaid Beneficiaries~~Reserved

~~6-1-25~~~~10-13-03~~

~~When health services are denied, the beneficiary may request a fair hearing of the reconsideration decision of the denial of services from the Department of Human Services.~~

~~The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty (30) days of the date of the denial notification.~~

~~Submit appeals requests to the Department of Human Services Appeals and Hearings Section.~~ **~~View or print the Department of Human Services Appeals and Hearings Section address.~~**

TOC required

215.120 Administrative Reconsideration ~~of Extension of Benefits Denial~~and Appeals

~~5-1-06~~6-1-25

~~A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 35 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 manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis. Reconsideration requests must be mailed and will not be accepted via facsimile or email.~~

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 ~~Appealing an Adverse Action~~Reserved

~~5-1-06~~6-1-25

~~Please see Section 190.003 for information regarding administrative appeals.~~

TOC required

214.200 Administrative Reconsideration ~~of Extensions of Benefits Denial~~and Appeals

~~11-1-06~~6-1-25

A. ~~A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation pursuant to Section 212.130 of this manual.~~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. ~~The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis. Reconsideration requests must be mailed and will not be accepted via facsimile or email.~~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 ~~Appealing an Adverse Action~~Reserved

~~11-1-06~~6-1-25

~~Please see Section 190.000 *et al.* of this manual for information regarding administrative appeals.~~

TOC required

221.400 Denial of Prior Authorization Request

~~12-1-06~~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.

~~The provider may request reconsideration of the denial within thirty-five calendar days of the denial date. Requests must be made in writing and include additional documentation to substantiate the medical necessity of the requested services. Requests received after thirty-five calendar days of the denial date will not be accepted for reconsideration.~~

221.500 Administrative Reconsideration ~~of Denials~~and Appeals

~~12-1-06~~6-1-25

~~If the denial decision is reversed during the reconsideration review, an approval is forwarded to the provider specifying the approved units and services. If the denial decision is upheld, the provider and the Medicaid beneficiary will be notified in writing of the review determination.~~

~~Reconsideration is available only once per prior authorization request. However, if the denial is upheld during the reconsideration process, the provider may submit a new prior authorization request, for different dates of service, providing new supporting documentation is available. **A subsequent prior authorization request will not be reviewed if it contains the same documentation submitted with the previous authorization and reconsideration requests.**~~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 ~~Fair Hearing Request~~Reserved

~~12-1-06~~6-1-25

~~The Medicaid beneficiary may request a fair hearing of a denied review determination made by either Utilization Review, Department of Health and Human Services (DHHS) or the Arkansas Foundation for Medical Care (AFMC). The fair hearing request must be in writing and sent to the Appeals and Hearings Section of DHHS within thirty-five calendar days of the date on the denial letter. **View or print the Department of Health and Human Services Appeals and Hearings Section contact information.** Providers may refer to Section 190.000 for information regarding provider appeals through the Medicaid Fairness Act.~~

TOC required

213.170 ~~Requests for Reconsideration~~Reserved ~~8-1-21~~6-1-25

~~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.~~**

215.124 Administrative Reconsideration ~~of Benefit Extension Denials~~and Appeals ~~2-1-05~~6-1-25

A. Medicaid allows only one (1) reconsideration of an ~~denied benefit extension request~~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. ~~Reconsideration requests that do not include all required documentation will be automatically denied.~~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.

~~C. Requests to reconsider benefit extension denials must be received by AFMC within 30 calendar days of the date of the denial notice. When requesting reconsideration:~~

~~1. Return all previously submitted documentation and pertinent additional information to justify the medical necessity of additional services.~~

~~2. Include a copy of the **NOTICE OF ACTION** denial letter with the resubmission.~~

215.130 ~~Appealing an Adverse Action~~Reserved ~~2-1-05~~6-1-25

~~A. When the state Medicaid agency or its designee denies a benefit extension request, the beneficiary may appeal the denial and request a fair hearing.~~

~~B. An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the letter from DMS explaining the denial.~~ **~~View or print the Department of Human Services, Appeals and Hearings Section contact information.~~**

216.115 ~~Administrative Reconsideration~~Reserved ~~1-1-09~~6-1-25

~~A request for administrative reconsideration of the denial of services must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter, all previously submitted documentation and pertinent additional supporting documentation to justify the medical necessity of additional services.~~

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

216.116 ~~Appealing an Adverse Action~~Reserved

~~1-1-09~~6-1-25

~~When the state Medicaid agency or its designee denies an extended therapy request, the beneficiary or the provider may appeal the decision and request a fair hearing.~~

~~An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the letter from DMS explaining the denial.~~ **~~View or print the Department of Human Services, Appeals and Hearings Section contact information.~~**

TOC required

217.136 Administrative Reconsideration ~~of Extension of Benefits Denial~~and Appeals

~~3-1-06~~6-1-25

~~A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 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 manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis.~~

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 ~~Appealing an Adverse Action~~Reserved

~~3-1-06~~6-1-25

~~Please see Section 190.003 for information regarding administrative appeals.~~

219.000 ~~Appeal Process An Adverse Action~~Reserved

~~7-1-07~~6-1-25

~~The Medicaid beneficiary or provider may request a fair hearing from the Department of Health and Human Services for a reconsideration of denied services.~~

~~The appeal request must be in writing and received by the Appeals and Hearings Section of the Arkansas Department of Health and Human Services within thirty (30) days of the date of the denial or adverse action notice.~~ **~~View or print DHS Appeals and Hearings Section contact information.~~**

~~See Section 190.000, et al, for information regarding administrative appeals.~~

TOC required

218.314 Administrative Reconsideration ~~of Benefit Extension Denials~~and Appeals

~~2-1-05~~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.~~denied benefit extension request.~~

B. ~~Reconsideration requests that do not include all required documentation will be automatically denied.~~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.

~~C. Requests to reconsider benefit extension denials must be received by AFMC within 30 calendar days of the date of the denial notice. When requesting reconsideration:~~

~~1. Return all previously submitted documentation and pertinent additional information to justify the medical necessity of additional services.~~

~~2. Include a copy of the **NOTICE OF ACTION** denial letter with the resubmission.~~

218.320 ~~Appealing an Adverse Action~~Reserved

~~2-1-05~~6-1-25

~~A. When the state Medicaid agency or its designee denies a benefit extension request, the beneficiary may appeal the denial and request a fair hearing.~~

~~B. An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the provider notification denial letter from AFMC. **View or print the Department of Human Services, Appeals and Hearings Section contact information.**~~

TOC required

218.000 Administrative Reconsideration and Appeals

~~1-1-22~~6-1-25

A. ~~A provider may submit additional information for administrative reconsideration of a denial of a request for extension of benefits pursuant to Section 216.000, or a denial of billed services on retrospective review pursuant to Section 217.000, within thirty-five (35) calendar days of the date shown on the denial letter. **View or print the QIO administrative reconsideration submission instructions.**~~**View or print the QIO administrative reconsideration submission instructions**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.

1. ~~Each request for administrative reconsideration must include a copy of the denial letter and additional information substantially different from the service record and information initially submitted. Re-submitting the exact same information that was included with initial submission that was denied will result in the denial being upheld.~~

2. ~~Only one (1) reconsideration is allowed per denial.~~

B. ~~All documentation submitted with the request for administrative reconsideration is reviewed by an appropriately licensed clinician~~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.

1. ~~If the reviewing clinician determines the denial is inappropriate, then an approval letter granting the reconsideration is mailed to the requesting provider.~~

2. ~~If the reviewing clinician determines they cannot grant the reconsideration request for any reason, the request for administrative reconsideration is forwarded to a physician reviewer. The physician reviewer on administrative reconsideration must be different from the physician reviewer that issued that original denial.~~

~~C. The physician reviewer will make a final decision to grant the reconsideration request or uphold the denial. A written notification of the outcome of the reconsideration request is mailed to the service provider and will include a case specific rationale for granting the reconsideration request or upholding the denial.~~

~~D. Any denial that is upheld on administrative reconsideration remains eligible for appeal as provided in Section 190.003.~~

231.100 ~~Administrative Reconsideration of Prior Authorization Denial~~Reserved

~~1-1-22~~6-1-25

~~Administrative reconsideration of a denial of a prior authorization request in Section 231.000 may be requested within thirty (30) calendar days of the denial date. Requests must be made in writing and must include additional documentation to substantiate the medical necessity of the SGD evaluation. **View or print administrative reconsideration submission instructions**. Any denial that is upheld on administrative reconsideration remains eligible for appeal as provided in Section 190.003.~~

TOC required

222.200 Denial of Prior Authorization Requests

~~8-1-09~~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.

~~The requesting provider may request reconsideration through AFMC or may request a Fair Hearing through the Office of Appeals and Hearings, or both, if the reconsideration through AFMC is upheld as a denial.~~

~~The provider may request reconsideration of the denial within thirty-five (35) calendar days of the denial date. Requests must be made in writing and include additional documentation to substantiate the medical necessity or program criteria of the requested services. Requests received after 35 calendar days of the denial date will not be accepted for reconsideration. Reconsideration is available only once per prior authorization request. If the reconsideration denial is upheld by AFMC secondary review, both the provider and/or the beneficiary may file for a Fair Hearing through the Office of Appeals and Hearings.~~

222.300 ~~Request for~~ Administrative Reconsideration and Appeals

~~8-1-09~~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.~~The provider may request reconsideration of the AFMC determination within thirty-five (35) calendar days of the denial date. Requests must be made in writing and include additional documentation to substantiate the medical necessity or program criteria of the requested services. The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of this provider manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. Reconsideration requests must be mailed and will not be accepted via telephone, facsimile or email. Reconsideration is available only once per prior authorization request.~~

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.

~~If the decision is reversed during the reconsideration review, an approval is forwarded to all relevant parties specifying the approved units and services. If the denial is upheld, both the provider and the Medicaid beneficiary are notified in writing of the review determination. Upheld denials remain eligible for appeal by way of a Fair Hearing request.~~

~~**A subsequent prior authorization request will not be reviewed if it contains the same documentation submitted with the previous authorization and reconsideration requests.**~~

222.400 ~~Administrative Appeal~~Reserved

~~8-1-09~~6-1-25

~~The Medicaid provider or beneficiary may request a fair hearing of a denied review determination made by Utilization Review, the Department of Human Services or the Arkansas Foundation for Medical Care (AFMC). The fair hearing request must be in writing and sent to the Appeals and Hearings Section of DHS within 30 days of the date of the denial letter. **View or print the Department of Human Services Appeals and Hearings Section contact information**. The deadline for receipt of the Fair Hearing Request will be enforced pursuant to Sections 190.012 and 190.013 of this program manual. Requests must be mailed and will not be accepted via~~

~~telephone, facsimile or email. Providers may refer to Section 190.000 for information regarding provider appeals through the Medicaid Fairness Act.~~

TOC required

216.230 Administrative Reconsideration ~~of Extensions of Benefits Denial~~and Appeals

~~3-1-06~~6-1-25

~~A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation pursuant to Section 221.100.~~

~~The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days gives rise to a rebuttable presumption that it is not timely.~~

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 ~~Appealing an Adverse Action~~Reserved

~~3-1-06~~6-1-25

~~Please see Section 190.000 et al for information regarding administrative appeals.~~

A-200 ~~Medicaid~~ Health Care Coverage Periods

MS Manual ~~01/01/17~~06/01/25

The coverage period is the period of time the individual has coverage for ~~Medicaid~~Health Care. Once eligibility has been determined, the ~~Medicaid~~ 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 ~~a caseworker is informed that~~ an ARKids A recipient is an inpatient on ~~his/her~~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 ~~10-day~~ 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). ~~Exceptional Medically Needy eligibility continues until terminated by the County Office.~~ 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 ~~he or she~~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~~07/01/20~~

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 ~~10-day~~ 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 (~~e.g.,~~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 ~~01/01/22~~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 ~~within sixty (60) days of the SSA denial notice. If the decision has not been appealed within sixty (60) days, the individual may still request a~~ or requests for reopening of the decision~~s within one (1) year~~.

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 ~~01/01/22~~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~~within the ten~~

~~(10) day time frame~~, 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 ~~01/01/22~~06/01/25

~~The Medical Review Team (MRT) will report the decision regarding physical or mental incapacity to the eligibility worker on a DCO-0109.~~

If an adverse action is taken on an individual's case, ~~MRT will send~~ 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 ~~01/01/14~~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)~~0~~ days from the date of the notice on the Notice of Action~~of negative action~~.

H-710 Hardship Waiver for Home Equity

Refer to Health Care Procedure Manual for more Information.

MS Manual ~~08/29/22~~06/01/25

An individual who is denied eligibility due to excess home equity may request an Undue Hardship Waiver. (~~Re~~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.

~~The eligibility worker will submit all Home Equity Undue Hardship Waiver requests and supporting documentation to the Division of County Operations (DCO) Hardship Waiver Committee.~~ A decision on the hardship waiver will be made by the Hardship Waiver Committee. ~~The eligibility worker will send the committee decision and information about the right to appeal the decision 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 (3~~0~~5) days of ~~receipt 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 ~~08/29/22~~06/01/25

Once ~~the eligibility worker~~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. ~~To ensure consistency with decisions regarding what constitutes a hardship, the eligibility worker will route all applications for an undue hardship waiver to the Division of County Operations LTSS Unit~~.

A decision on the hardship waiver will be made by the DCO Hardship Waiver Committee. ~~The eligibility worker will send the committee's decision and information about the right to appeal the decision to the person who applied for the waiver.~~ If the person who applied for the waiver disagrees with the committee's decision, they may appeal the decision within thirty-five (3~~5~~0) days ~~receipt~~ of the date of notice about the decision (MS J-100).

H-730 Hardship Waiver for Estate Recovery

MS Manual ~~08/29/22~~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 (3~~5~~0) days after receiving notice from DHS of intent to recover Health Care payments and the procedures for requesting a hardship waiver. ~~(DHS-20).~~

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, ~~he/she~~they may appeal the decision within thirty-five (3~~0~~5) 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 ~~01/01/21~~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 County Office will be notified, and~~ the Waiver case will be closed. If the Waiver case is closed for any reason, the ~~eligibility worker~~ system will determine if the client is eligible for any other ~~Medicaid~~ 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 (~~e.g~~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 ~~his/her~~their case as outlined in MS L 100-173~~ of the Medical Services Policy manual~~. If a timely appeal is received on or before the ~~effective~~ date listed on the Notice of the ~~a~~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 ~~Assisted Living Facility~~Living Choices (Assisted Living Facility)

MS Manual ~~01/01/21~~06/01/25

~~ALF~~ Living Choices Waiver (Assisted Living Facility) recipients will be advised to report any changes in income or resources ~~to the DHS County Office~~. 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 County Office will be notified and~~ the ~~ALF~~ Living Choices case will be closed. If the case is closed for any reason, the ~~eligibility worker~~system will determine if the client is eligible in any other ~~Medicaid~~ Health Care category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ~~ALF~~ 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 ~~the County~~ 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 ~~ALF~~ 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 ~~n ALF~~ Living Choices Waiver recipient may appeal an adverse decision made on their~~his/her~~ case as outlined in MS Section L-100. If a timely appeal is received on or before the ~~effective~~ date Listed on the Notice of the ~~a~~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-600 Changes~~

I-600~~50~~ Changes~~DDS Waiver~~

I-650 DDS Waiver

MS Manual ~~07/01/20~~06/01/25

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

Eligibility will end at the end of the ~~10-day~~ advance notice period, unless the recipient or ~~his/her~~their legal representative requests a hearing, or unless whatever was causing the intent to close is resolved prior to the end of the ~~10-days~~notice period.

I-660 TEFRA

MS Manual ~~07/01/20~~06/01/25

When a change occurs that affects eligibility, the applicant will be sent an ~~10-day~~ advance notice, unless advance notice is not required. (Refer to MS J-130.)

J-100 Notice of Action Requirements

MS Manual ~~01/01/14~~06/01/25

A N~~n~~otice of A~~a~~ction 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 ~~and~~or reduction of assistance. The following sections define these notice requirements and ~~also~~ list when advance notice is not required. ~~For purposes of the notices described below, day one of the 10 day advance notice period is the day after the date of the notice.~~

J-110 Advance Notice for Termination of Assistance

MS Manual 06/01/25~~01/01/14~~

When the Division of County Operations (DCO) proposes to terminate assistance for a recipient, advance notice will be ~~either be system generated or mailed~~sent to the recipient using ~~Form DCO-700,~~a formed called a "Notice of Action." ~~Form DCO-700 includes a field labeled "Date of Notice." 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.~~
~~"Date of Notice."~~

Advance N~~n~~otice must contain all information listed in MS J-100. ~~The advance notice given on the DCO-700 must be mailed to the recipient at least ten (10) days prior to the effective date of action unless probable fraud is indicated. Where probable fraud exists, five (5) days prior notice is required.~~To provide the recipient with time to appeal the adverse decision ~~described in the advance notice~~, the effective date of the action will be no earlier than thirty-five (35) days ~~after~~from the ~~Date~~date listed on ~~of~~ the Advanced Notice.

~~If a hearing is requested within the advance notice period~~thirty-five (35) days of the Date of ~~Notice, the caseworker will forward a copy of the DCO-700 with the DCO-1200, Appeal for Hearing, and the Hearing File to Central~~DHS Office Appeals and Hearings. ~~and delay~~ The action ~~will be delayed pending outcome of the appeal and the recipient's benefits will not be terminated or reduced.~~ If a hearing is not requested within ~~the advance notice period~~thirty-five (35) days of

~~J-100 Notice of Action Requirements~~

J-1020 ~~Advance~~ Notice ~~of~~or Action~~Reduction of Assistance~~

the ~~Date~~date listed on the ~~of~~ Advance Notice, ~~t~~the adverse action indicated on the notice will be ~~taken by the caseworker on the date indicated~~taken ~~on the DCO-700~~.

J-120 Advance Notice for Reduction of Assistance

MS Manual ~~01/01/14~~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: ~~such as a~~ changinge from ARKids A to ARKids B). ~~-~~ When the recipient's income increases, an ~~10 day~~ 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 ~~DCO-704,~~ Decision for Nursing Home/Waiver Placement, will be provided to the nursing facility.

~~L-100 Administrative Hearings~~

L-10~~2~~0 Administrative Hearings~~Continuation of Assistance or Services during Appeal Process~~

L-120 Continuation of Assistance or Services during Appeal Process

MS Manual ~~01/01/2021~~06/01/25

If the beneficiary, or provider on behalf of a beneficiary, files an appeal within thirty-five (35) days from the ~~Date~~date ~~of Notice~~ 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.~~In cases where an adverse action is taken against a beneficiary who qualifies for an institutional level of care (e.g. ARChoices, Living Choices, TEFRA, Autism, PACE, CES/DD, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and LTC/nursing home), if a timely appeal is received on or before the effective date 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 pending the hearing decision, they must opt out.~~

~~In all other cases, if a petitioner files an appeal for a hearing within the ten (10) day notice period, or five (5) days in the case of probable fraud, the case will remain open at the petitioner's request until the hearing decision. Otherwise, benefits will NOT continue.~~

DCO ~~may~~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. ~~, and~~ DCO ~~promptly~~ needs to promptly informs~~s~~ the ~~beneficiary~~recipient in writing that services are to be terminated or reduced pending the hearing decision.~~At the conclusion of the hearing, the hearing official will decide whether the case should be closed or services reduced prior to the rendering of the hearing decision. The criteria for determining whether adverse action is taken prior to the rendering of the hearing decision will be based on whether or not a fact or judgment situation exists. If it is determined that the sole issue is one of state or federal law or policy, the proposed action will be taken.~~

~~Examples of issues of fact:~~

- ~~Verified earned or unearned income which caused net income to be in excess of the maximum income limitations.~~
- ~~Protest of Agency Policy The recipient agrees that his income or resources exceed the limitation but feels that the policy imposing these limitations is unreasonable.~~

~~If the sole issue is one of judgment relating to a state or federal law or policy, no adverse action is taken prior to the hearing decision.~~
~~At the conclusion of the hearing, the hearing official will decide whether the case should be closed or services reduced prior to the rendering of the hearing decision. The criteria for determining whether adverse action is taken prior to the rendering of the hearing decision will be based on whether or not~~

~~a fact or judgment situation exists. If it is determined that the sole issue is one of state or federal law or policy, the proposed action will be taken.~~

~~Examples of issues of fact:~~

- ~~Verified earned or unearned income which caused net income to be in excess of the maximum income limitations.~~
- ~~Protest of Agency Policy The recipient agrees that his income or resources exceed the limitation but feels that the policy imposing these limitations is unreasonable.~~

~~If the sole issue is one of judgment relating to a state or federal law or policy, no adverse action is taken prior to the hearing decision.~~

~~Examples of judgment are:~~

- ~~Disability in MRT cases.~~
- ~~Value of real or personal property.~~

~~The petitioner will be advised at the beginning of the hearing that a decision will be made at the conclusion of the hearing regarding whether the benefits will be reduced or terminated prior to the rendering of the hearing decision. If the decision by the hearing official is to reduce or terminate benefits, a Notice of Action will be prepared by DCO and mailed for immediate action. This Notice is not an additional appealable adverse action as it is simply an affirmation of the agency's original action.~~

~~If a subsequent change in the petitioner's open case occurs that results in adverse action while the hearing decision is pending and the petitioner does not timely appeal that new adverse action, the change will occur on the date specified in the notice.~~

L-100 Administrative Hearings

MS Manual 06/01/2501/01/14

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) no later than 30 days from the dateDate of Notice printed on the Notice of Adverse Action. The thirty-day time period begins to run on the fifth day after the Date of Notice.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-700 Income Determination for Medically Needy Program~~

O-700~~31~~ Income Determination for Medically Needy

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

MS Manual ~~01/01/14~~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 ~~County Office~~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 ~~10 day~~ advance notice period, unless a recipient requests a hearing. ~~within the advance notice period.~~

~~The recipient is required to report all changes within 10 days so that the County Office can initiate necessary case actions.~~

O-810 County Office Certification Responsibility

Refer to Health Care Procedures Manual for more Information.

MS Manual ~~01/01/14~~06/01/25

~~When all factors of Medically Needy eligibility have been established, the case will be certified in ANSWER.~~

~~With date specific eligibility, the beginning date of medical eligibility for~~ Exceptional Medically Needy cases ~~(EC) will be the day of application unless retroactive eligibility is authorized. Retroactive eligibility may be authorized as far back as three months prior to the date of application, provided the individual or family meets the eligibility requirements for the retroactive period, and medical expenses were incurred during the period. Eligibility may be authorized for any one or all of the months during the retroactive period. Each period of retroactive eligibility must be keyed in ANSWER. Refer to ANSWER Desk Guide.~~

~~No termination date will be entered for Exceptional Medically Needy cases. Eligibility will continue until closure is authorized by the caseworker. With date specific eligibility, an end date can be entered to terminate coverage on any day of a month, after appropriate 10 day advance notice. For example, if a county is informed of an income increase on 10/13/2012 which makes an individual ineligible, the case may be closed effective 10/23/2012 after advance notice.~~

~~Both the beginning and end dates of eligibility are shown for~~ Medically Needy Spend Down ~~cases. The beginning date listed in ANSWER will always be the day of Spend Down. The ending date for Spend Down cases listed in ANSWER is the last day of the third month of the Spend Down quarter used. Once the entitlement period has been established and the certifying document has been submitted, no additional medical expenses can be considered for the entitlement period. The "unmet liability" amount will be rounded to the next lower dollar and entered in ANSWER.~~ Date Specific Eligibility ~~will not change the consideration of the Begin and End dates for the Spend Down certification period.~~

~~The begin and end dates will also be shown for fixed eligibility cases. If certifying for fixed eligibility, the begin and end dates may be any day of a month. For example, an individual who applies 5/15/2012 needs coverage for April and May, and is income/resource eligible for those months. Bills were incurred April 18th, and May 5th through 10th. The fixed eligibility period for this individual will begin April 18th and end May 10th.~~

~~O-800 County Office Certification~~

0-8010 County Office Certification ~~Responsibility~~

~~In AFDC-MN and U-18 households that require separation of the eligible members into different cases (Re. MS O-710) each eligible member will be entered in open status in his/her case, and the other eligible members of the unit will be entered in closed status.~~

~~When an eligible member is entered in closed status in another eligible's case, the member's status will be "active" in the budget of the eligible's case to show that the income of the closed member is included in the budget.~~

~~**EXAMPLE:** In a stepparent household where a man, his wife, and her child live, if there are separate cases for the child and his/her natural/adoptive parent, with an open and closed member in each case, "active" will be entered for the natural/adoptive parent that is in closed status to show that the income of the closed member (the natural/adoptive parent) in this case is included in the budget.~~

~~In UP-MN cases, the principal wage earner will be added to the child's parent tab with the deprivation reason "unemployed".~~

~~When only one member of an AABD couple has expenses on the date of Spend Down, enter the unmet liability amount in ANSWER of that member. Where both members of an AABD couple had expenses on the date of Spend Down, prorate the unmet liability amount to each member on the basis of their percent of expenses on the date of Spend Down. For example, an AABD couple has $200 in unmet liability and $250 in expenses (i.e. $150 - Member A and $100 - Member B) on the date of Spend Down. The amount of unmet liability to be entered in ANSWER of each member is determined as follows:~~

1. ~~Divide the expenses of each member by total expenses.~~
   ~~Member A - $150 divided by 250 = 60%~~
   ~~Member B - $100 divided by 250 = 40%~~
2. ~~Multiply the unmet liability amount by each member's percent of expenses.~~
   ~~Member A - $200 x 60% = $120~~
   ~~Member B - $200 x 40% = $80~~

~~In AFDC or U-18 related cases when more than one member had medical expenses on the date of Spend Down, the total unmet liability will be prorated for each member and each individual's prorated unmet liability will be shown in the member segment in ANSWER.~~

~~**EXAMPLE A:** In an AFDC-SD case containing 3 members, medical expenses were incurred on the date of Spend Down by only one member and totaled $300.00. The unmet~~

~~liability on the date of Spend Down was $100.00 The total unmet liability should be entered in ANSWER for the member who had medical expenses on the date of Spend Down.~~

~~**EXAMPLE B:** In a U-18-SD case, three members had medical bills on the date of Spend Down. Child 201 incurred $150.00 on the date of Spend Down, child 202 incurred $75.00, and child 203 incurred $275.00. The total unmet liability was $100.00 on the date of Spend Down. To determine each member's unmet liability:~~

~~For each case:~~

~~1. Divide the expenses of each member by the total expenses.~~

~~Member 201-$150 divided by $500 = 30%~~

~~Member 202-$75 divided by $500 = 15%~~

~~Member 203-$275 divided by $500 = 55%~~

~~2. Multiply the total unmet liability by each member's percent of the expenses.~~

~~Member 201-$100 x 30% = $30.00~~

~~Member 202-$100 x 15% = 15.00~~

~~Member 203-$100 x 55% = 55.00~~

O-940 Medically Needy Case Closures

MS Manual ~~01/01/14~~06/01/25

The system will automatically affect closure of current open Spend Down cases and all cases which are converted to SSI eligibility. ~~The County Office will affect all other closures by input into ANSWER.~~

With the exception of closed past Spend Down and Fixed Eligibility Certifications, the ~~ten day~~ advance notice applies to all categories. ~~Recipient notifications will be made on form DCO-700 or system generated notice.~~

~~The reason for closure will be made in the narrative of each closed case and a copy of the Notice of Action will be filed electronically in the case file.~~

Eligibility for ~~Medicaid~~ Health Care ceases at the end of the ~~10 day~~ 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 ~~08/24/15~~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 ~~10~~ 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.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Medicaid Administrative Reconsiderations and Appeals

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 no, please explain:

   (a) how the additional benefits of the more costly rule justify its additional cost;

   (b) the reason for adoption of the more costly rule;

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

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		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$537,212	General Revenue	$6,346,541
Federal Funds	$2,890,105	Federal Funds	$34,381,262
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 3,427,317.00	Total	$ 40,727,803.00

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$	$

6. What is the total estimated cost by fiscal year to a state, county, or 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**
$ 537,212.00	$ 6,346,541.00

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
Medicaid Administrative Reconsiderations and Appeals

Statement of Necessity

This rule change was developed to comply with a settlement agreement in Elder v. Gillespie¸ Case No. 3:19-cv-155-KGB. This rule amendment will provide consistency across all programs administered by DHS. DHS beneficiaries will receive thirty (30) days' notice, which begins five (5) days after the date of the written notice, effectively allowing thirty-five (35) days, before any final adverse action is taken regarding their eligibility for assistance or availability of benefits. Beneficiaries may file an administrative appeal of the final action within this notice period. If a request for an appeal is timely filed, eligibility or benefits will remain unchanged until a final decision is issued regarding the appeal.

Rule Summary

Medicaid Provider Manuals

Sections 161.200, 161.300, 161.400, 161.500, and 191.004 are amended to:

- Allow 30 days to request a reconsideration or appeal which begins 5 days after the date of the written notice, effectively allowing 35 days.
- Update the address of where to send an appeal.
- Clarify that beneficiaries will continue receiving benefits during the appeal process unless the beneficiary opts out of the continuation of benefits.

Section II of the following Medicaid Provider Manuals have been amended to reflect and reference the changes listed in Section I above; and some sections are being deleted if no longer applicable: ARKids First-B; Ambulatory Surgical Center; Chiropractic; Certified Nurse-Midwife; Counseling Services; Federally Qualified Health Center; Home Health; Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD); Hyperalimentation; IndependentChoices; Inpatient Psychiatric Services for Under Age 21; Nurse Practitioner; Program of All-Inclusive Care for the Elderly (PACE); Provider-Led Arkansas Shared Savings Entity (PASSE) Program; Patient-Centered Medical Home; Private Duty Nursing Services; Personal Care; 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; Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services; Ventilator Equipment; and Visual Care.

Medical Services Policy Manual

Sections A-200; E-410; F-121, 123, and 125; H-650, 710, 720, and 730; I-630, 640, 650, and 660; J-100, 110, and 120; L-100; O-731, 810, and 940; and the Glossary are being amended to:

- Remove references to 10-day advanced notices and the client appealing within 10 days.
- Allow 30 days to request an appeal which begins 5 days after the date of the written notice, effectively allowing 35 days.
- Clarify that some determinations are done by the "system" instead of the eligibility worker.
- Remove procedures that will be moved to the Health Care Procedure Manual.
- Provide general formatting and clean-up.

A-200 is also amended to clarify when eligibility ends for an individual turning 65 in the Adult Expansion Group.

NOTICE OF RULEMAKING

The Department of Human Services (DHS) 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. The proposed effective date is June 1, 2025.

The Division of Medical Services (DMS) amends numerous sections of the Arkansas Medicaid Provider Manuals and Medical Services Policy (MSP) Manual to ensure all DHS beneficiaries in DHS programs receive thirty (30) days' notice, which begins five (5) days after the date of the written notice, effectively allowing thirty-five (35) days, before any final adverse action is taken regarding their eligibility for assistance or availability of benefits. If a beneficiary files an administrative appeal of the final action within the notice period, eligibility or benefits will remain unchanged until a final appeal decision is issued. Updates to the MSP manual include clarification that some determinations are automated by system processes and details on when eligibility ends for an individual turning 65 in the Adult Expansion Group. DHS projects an annual fiscal impact of $40,727,803.00 (federal share $34,381,262; state share $6,346,541).

The full list of manuals or sections of manuals affected are found in the full proposed rule available for review at ar.gov/dhs-proposed-rules or at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. This notice also shall be posted at the local office of the Division of County Operations (DCO) of DHS in every county in the state.

Public comments can 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 February 17, 2025. 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 will be held by remote access through Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at ar.gov/dhszoom.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at (501) 320-6428. 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. 4502201653

Elizabeth Pitman, Director
Division of Medical Services