



Arkansas Department of Human Services

Division of Medical Services

Donaghey Plaza South

PO Box 1437

Little Rock, Arkansas 72203-1437

Internet Website: www.medicaid.state.ar.us

Telephone: (501) 682-8292 TDD: (501) 682-6789 or 1-877-708-8191 FAX: (501) 682-1197

OFFICIAL NOTICE

DMS-2003-A-2 DMS-2003-II-6 DMS-2003-SS-2 DMS-2003-R-12
DMS-2003-O-7 DMS-2003-L-8 DMS-2003-KK-9 DMS-2003-OO-7

TO: **Health Care Provider – Ambulatory Surgical Center; Certified Nurse-Midwife; Federally Qualified Health Center (FQHC); Hospital; Independent Lab; Nurse Practitioner; Physician and Rural Health Clinic (RHC)**

DATE:

SUBJECT: **Requirements for Requests for Extension of Benefits for Clinical, Outpatient, Laboratory and X-ray Services**

Effective for dates of service on and after January 1, 2004, new and revised procedures for requesting extension of benefits are implemented. A new form, DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-ray Services, has been developed effective January 1, 2004. The purpose of new and revised procedures and the new form is to reduce delays in processing requests for extension of benefits and to avoid returning requests due to incomplete information and/or lack of supportive documentation.

I. Procedural Policy

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

A copy of the Medical Assistance Remittance and Status Report reflecting the claim benefit limit denial must be submitted with the request. *Do not* send the CMS-1500 (formerly HCFA-1500) or the CMS-1450 (formerly UB-92).

- B. A request for extension of benefits must be received within 90 calendar days of the date of benefit limit denial. Any requests received beyond the 90-day deadline will not be considered.

- C. Benefit extension requests for dates of service that have already been denied for untimely filing will neither be considered nor returned.

I. Procedural Policy (Continued)

- D. DMS Utilization Review will consider extending benefit limits in cases of medical necessity if *all* required documentation is received.

II. Completion of Request Form DMS-671

- A. Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-ray Services (form DMS-671). A copy of the new form is attached to this notice.
- B. If the provider of service is a member of a provider group, the performing provider's number and the group provider number must be entered in the Medicaid provider ID number fields.
- C. The provider's signature with credentials and date of request is required on the form. Stamped or electronic signatures are accepted.
- D. Claims for reimbursement should be filed in chronological order. Dates of service *must* be listed in chronological order on form DMS-671. If request includes more than four procedures, a separate form must be used for additional procedures.
- E. Enter a valid type of service code using the applicable type of service code for paper claim(s). Some procedure codes require modifiers on paper claims
- F. Enter a valid diagnosis code and brief narrative description of the diagnosis.
- G. Enter a valid procedure code and, if applicable, modifier(s) along with a brief narrative description of the procedure.
- H. Enter the number of units requested under the extension.

III. Documentation Requirements

- A. To request extension of benefits for *any* benefit limited service, all applicable records that support the medical necessity of extended benefits are required.

III. Documentation Requirements (Continued)

- B. The following documentation requirements are included in this notice as clarification for applicable services.
1. Clinical records *must*:
 - a. Be legible and include records supporting the specific request
 - b. Be signed by the performing provider
 - c. Include clinical, outpatient and/or emergency room records for dates of service in chronological order
 - d. Include related diabetic and blood pressure flow sheets
 - e. Include current medication list for date of service
 - f. Include obstetrical record related to current pregnancy
 - g. Include clinical indication for laboratory and x-ray services ordered with a copy of orders for laboratory and x-ray services signed by the physician
 2. Laboratory and radiology reports *must* include:
 - a. Clinical indication for laboratory and x-ray services ordered
 - b. Signed orders for laboratory and radiology services
 - c. Results signed by performing provider
 - d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests

IV. Diagnoses Exempt from Extension of Benefits Requirements

The Arkansas Medicaid Program automatically extends the benefit limits when one of following diagnosis exists and is entered as the primary diagnosis in both header and detail fields of the claim:

- A. Malignant neoplasm (ICD-9-CM code range 140.0 – 208.91)
- B. HIV disease (ICD-9-CM code 042)
- C. Renal failure (ICD-9-CM code range 584 – 586)

V. Reconsideration of Extension of Benefits Denial

- A. Any reconsideration request for denial of extension of benefits must be received within 30 days of the date of denial notice. When requesting reconsideration of denial, the following information is required:
1. Return a copy of current NOTICE OF ACTION denial letter with re-submissions.
 2. Return all previously submitted documentation with additional information for reconsideration.
- B. Only one reconsideration is allowed. Any reconsideration request that does not include required documentation will be automatically denied.
- C. DMS Utilization Review reserves the right to request further clinical documentation as deemed necessary to complete medical review.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and Out-of-State at (501) 376-2211.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

REQUEST FOR EXTENSION OF BENEFITS FOR CLINICAL, OUTPATIENT, LABORATORY AND X-RAY SERVICES

Arkansas Department of Human Services
Division of Medical Services
P O Box 1437, Slot S413
Little Rock, AR 72203-1437

DATE: ___/___/___

Important: If all required information is not completed, the form will be returned to provider.

(1) PERFORMING PROVIDER	(2) PROVIDER ID# _____
(3) MAILING ADDRESS	(4) GROUP PROVIDER ID # _____
CITY _____	STATE _____
ZIP CODE _____	
(5) PERFORMING PROVIDER SIGNATURE & CREDENTIALS 	

(6) RECIPIENT NAME [LAST] _____	[FIRST] _____	[M.I.] _____
(7) ADDRESS _____	CITY _____	STATE _____
(8) MEDICAID RECIPIENT ID (10 digits) _____		(9) DOB MM/DD/YY _____ _____
		SEX _____

To file a Request for Extension of Benefits, the following information is required:

								Request Disposition		
								Completed By Utilization Review		
(10) SERVICE FROM DATE	(11) SERVICE TO DATE	(12) TYPE OF SERVICE	(13) DIAGNOSIS CODE	(14) DIAGNOSIS CODE DESCRIPTION	(15) PROCEDURE CODE	(16) PROCEDURE CODE DESCRIPTION	(17) UNITS	DECISION		DATE OF REVIEW
								APPROVED	DENIED	

Benefit Extension Control # _____ **Reviewer** _____
Completed by Utilization Review Completed by Utilization Review

When filing claim use the control number above to indicate the benefit extension is authorized.

Note: Attach copies of Medical Records/Supporting Documentation substantiating **medical necessity** of requested services/procedures.
 [Instructions for requesting extension of benefits and completion of this form are included on the reverse side of this form.]

Comments:

Requirements for Requests for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services

Procedural Policy

To reduce delays in processing requests and to avoid returning requests due to incomplete and/or lack of documentation, the following procedures must be followed.

- I. Requests for extension of benefits will be considered after a claim has been denied for exceeding the benefit limit.
- II. The Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services (Form DMS-671) must be filed within 90 calendar days of the date of denial. Any request filed beyond the 90 calendar day deadline will be denied.
- III. Extension of benefits will be denied if the original claim was denied for untimely filing (12 months beyond the date of service).
- IV. DMS Utilization Review will consider extending benefits if ***all*** of the following documentation is received with request.
 - A. All fields of form DMS-671 must be correctly completed by entering the following information:**
 - (1) Enter performing provider's name.
 - (2) Enter the Medicaid provider # of performing provider.
 - (3) Enter the address provider will use to receive correspondence regarding this extension.
 - (4) If the provider is a member of a group, enter the group provider ID #.
 - (5) Performing provider's signature and credentials must be entered in this field.
 - (6) Enter the recipient's full name.
 - (7) Enter the recipient's complete address.
 - (8) Enter the recipient's Medicaid ID #.
 - (9) Enter the recipient's date of birth and sex.
 - (10) Enter the service from date.
 - (11) Enter the service to date.
 - (12) Enter the type of service code (if claim was filed on paper).
 - (13) Enter the diagnosis code.
 - (14) Enter the diagnosis code description.
 - (15) Enter the procedure code and applicable modifier(s). (If there are more than 4 procedures, additional procedures must be added to a separate completed form.)
 - (16) Enter the procedure code description.
 - (17) Enter the number of units.
 - B. Copy of the Medical Assistance Remittance and Status Report stating benefits are exhausted for date of service. Do not send the CMS-1500 (HCFA-1500) form or the CMS-1450 (HCFA-UB-92).**
 - C. Clinical records must:**
 1. Be legible and include records supporting the specific request
 2. Be signed by the performing provider
 3. Include clinical, outpatient and/or emergency room records for dates of service in chronological order
 4. Include related diabetic and blood pressure flow sheets
 5. Include current medication list for date of service
 6. Include obstetrical record related to current pregnancy
 - D. Laboratory and radiology reports must include:**
 1. Clinical indication for lab and x-ray ordered
 2. Signed orders for laboratory and radiology
 3. Results signed by performing provider
 4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests
 - E. The Arkansas Medicaid Program automatically extends benefits when one of the following diagnoses exists and is entered as the primary diagnosis in both header and detail fields:**
 1. Malignant neoplasm (code range 140.0 – 208.91)
 2. HIV, including AIDS (code 42)
 3. Renal failure (code range 584 – 586)
 - F. Requests for reconsideration must be received within 30 calendar days of UR denial. Only one reconsideration will be allowed.**
 - G. DMS Utilization Review reserves the right to request further clinical documentation as deemed necessary to complete medical review.**