



# Arkansas Department of Human Services

## Division of Medical Services

Donaghey Plaza South  
 P.O. Box 1437  
 Little Rock, Arkansas 72203-1437  
 Internet Website: [www.medicaid.state.ar.us](http://www.medicaid.state.ar.us)  
 Telephone (501) 682-8292 TDD (501) 682-6789 or 1-877-708-8191  
 FAX (501) 682-1197

**TO:** Arkansas Medicaid Health Care Providers

**DATE:** December 1, 2003

**SUBJECT:** Provider Manual Update Transmittal

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**REMOVE**

142.000      10-13-03  
142.100      10-13-03

**INSERT**

142.000 – 142.700      12-1-03

**Explanation of Updates**

Section 142.000 is divided into subsections for clarity of information regarding conditions of participation required of providers.

Section 142.100 clarifies the general conditions for participation.

Section 142.200 clarifies information regarding conditions related to billing for Medicaid services.

Section 142.300 clarifies the conditions related to record keeping.

Section 142.400 contains information regarding conditions related to disclosure of certain information from providers.

Section 142.410 contains information regarding disclosures of ownership and control by providers.

Section 142.420 contains information about disclosures of business transactions on the part of providers.

Section 142.430 contains information related to disclosure of information regarding personnel convicted of a crime.

Section 142.500 clarifies information regarding conditions related to fraud and abuse.

Section 142.600 clarifies conditions related to provider refunds to the Division of Medical Services (DMS).

Section 142.700 was previously numbered 142.100.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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 transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.**

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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](http://www.medicaid.state.ar.us).*

**142.000 Conditions of Participation**

12-01-03

Providers enrolled in the Arkansas Medicaid Program must agree to and meet the conditions of participation contained in Sections 142.000 through 142.600.

- A. Failure to comply with the requirements contained in Sections 142.000 through 142.600 may result in termination from the Medicaid Program and/or recovery of money paid for services by the Division of Medical Services.
- B. Nothing in the conditions of participation is a limitation on the ability of the Medicaid Program to take any action that is authorized by federal or state laws, regulations or rules or to refrain from taking any action that is not mandated by federal or state laws, regulations or rules.

**142.100 General Conditions**

12-01-03

- A. Each provider must be licensed, certified or both, as required by law, to furnish all goods or services that may be reimbursed by the Arkansas Medicaid Program.
- B. Providers must comply with applicable standards for professional and quality care.
- C. It is the responsibility of each provider to read the Arkansas Medicaid provider manual provided by the Division of Medical Services and to abide by the rules and regulations specified in the manual.
- D. All services provided must be medically necessary. The recipient is not liable for a claim or portion of a claim when the Medicaid Program, either directly or through a designee, determines that the services were not medically necessary.
- E. Services will be provided to qualified recipients without regard to race, color, national origin or disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.
- F. Each provider must notify the Division of Medical Services in writing immediately regarding any changes to its application or contract, such as:
  - 1. Change of address
  - 2. Change in members of group, professional association or affiliations
  - 3. Change in practice or specialty
  - 4. Change in Federal Employee Identification Number (FEIN)
  - 5. Retirement or death of provider
  - 6. Change of ownership
- G. The Medicaid Program has a compelling interest in preventing unnecessary provider costs and program utilization associated with provider efforts to encourage, solicit, induce or cause an individual to seek or obtain a Medicaid covered service. Therefore, except for Medicaid covered services and other professional services furnished in exchange for the provider's usual and customary charges, no Medicaid provider may knowingly give, offer, furnish, provide or transfer money, services or any thing of value to any Medicaid recipient, to anyone related to any Medicaid recipient within the third degree or any person residing in the household of a recipient for less than fair market value.

This rule does not apply to:

- 1. Pharmaceutical samples provided to a physician at no cost or to other comparable circumstances where the provider obtains the sample at no cost and distributes the samples without regard to Medicaid eligibility.

2. Provider actions taken under the express authority of state or federal Medicaid laws or rules or the provider's agreement to participate in the Medicaid Program.

**142.200 Conditions Related to Billing for Medicaid Services**

12-01-03

- A. Any covered service performed by a provider must be billed only after the service has been provided. No service or procedure may be pre-billed.
- B. Endorsement of the provider check issued by the Medicaid fiscal agent certifies that the services were rendered by or under the direct supervision of the provider as billed.
- C. It is the responsibility of each provider to be alert to the possibility of third party sources of payment and to report receipt of funds from these sources to the Division of Medical Services.
- D. Each provider must accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any Medicare deductible or coinsurance due and payable under Title XIX (Medicaid).
- E. Each provider must accept payment from Medicaid as payment in full for covered services, make no additional charges and accept no additional payment from the recipient for these services.
- F. Medicaid providers may not charge Medicaid recipients for the completion and submission of a Medicaid claim form. If the provider agrees to accept the patient as a Medicaid recipient and agrees to bill Medicaid for the services rendered, the recipient may not be charged for this billing procedure.
- G. Claims for services provided to eligible Medicaid recipients must be submitted to the Medicaid fiscal agent within twelve months from the date of service.

**142.300 Conditions Related to Record Keeping**

12-01-03

- A. Each provider must prepare and keep complete and accurate original records that fully disclose the nature and extent of goods, services or both provided to and for eligible recipients. The delivery of all goods and services billed to Medicaid must be documented in the recipient's medical record.
- B. If a provider maintains more than one office in the state, the provider must designate one such office as a home office. Original records must be maintained at the provider's home office. A copy of the records must be maintained at the provider's service delivery site. If the provider changes ownership or ceases doing business in the state, all required original records must be maintained at a site in the state that is readily accessible by the Arkansas Medicaid Program and its agents and designees.
- C. Each provider must retain all records for five (5) years from the date of service or until all audit questions or review issues, appeal hearings, investigations or administrative or judicial litigation to which the records may relate are finally concluded, whichever period is longer.
- D. Upon request, each provider must immediately furnish all original records in its possession regarding the furnishing or billing of Medicaid goods or services, upon request, to authorized representatives of the Division of Medical Services or their designated representatives, state Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services. The request may be made in writing or in person. No advance notice is required for an in-person request.

- E. Each provider must immediately furnish records, upon request, establishing the provider's charges to private patients for services that are the same as or substantially similar to services billed to Medicaid patients.

**142.400 Conditions Related to Disclosure 12-01-03**

**142.410 Disclosures of Ownership and Control 12-01-03**

- A. The Division of Medical Services (DMS) requires that providers disclose the following information regarding ownership and control.
1. The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent or more.
  2. In compliance with information shown above, the provider must also disclose if any person named above is related to another as a spouse, parent, child or sibling.
  3. The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:
    - a. Keep copies of all these requests and the responses to them;
    - b. Make them available to representatives of the Secretary of Health and Human Services or to the Division of Medical Services upon request, and
    - c. Advise DMS when there is no response to a request.
- B. Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified above to representatives of an Arkansas survey agency at the time of a survey. The survey agency must promptly furnish the information to the Secretary of Health and Human Services and to the Division of Medical Services.
- C. Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified above to the Secretary of Health and Human Services within the prior twelve month period, must submit the information to the Division of Medical Services before entering into a contract or agreement to participate in the program.

**142.420 Disclosures of Business Transactions 12-01-03**

A provider must submit, within 35 days of the date of a request by representatives of the Secretary of Health and Human Services or the Division of Medical Services, full and complete information about:

- A. The ownership of any subcontractor with whom the provider has business transactions totaling more than \$25,000 during the 12-month request, and
- B. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

**142.430 Disclosures of Information Regarding Personnel Convicted of Crime 12-01-03**

Before the Division of Medical Services enters into or renews a provider agreement, or at any time upon written request by DMS, the provider must disclose to DMS the identity of any person who:

