



Arkansas Department of Health and Human Services

Division of Medical Services



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TO: Arkansas Medicaid Health Care Providers – Podiatrist

DATE: May 1, 2006

SUBJECT: Provider Manual Update Transmittal #62

REMOVE

Section	Date
201.400	3-15-05
203.200	10-13-03
203.300	10-13-03
215.100	1-1-06
215.110	1-1-06
215.115	1-1-06
—	—
215.130	1-1-06
221.100	10-13-03

INSERT

Section	Date
201.400	5-1-06
203.200	5-1-06
203.300	5-1-06
215.100	5-1-06
215.110	5-1-06
215.115	5-1-06
215.120	5-1-06
215.130	5-1-06
221.100	5-1-06

Explanation of Updates

Section 201.400 pertaining to providers in non-bordering states has been rewritten.

Section 203.200: The information in this section has been updated.

Section 203.300: The information in this section has been updated.

Section 215.100: A minor correction has been made in the section.

Section 215.110: This is a new section number only.

Section 215.115 is a new section titled “AFMC Extension of Benefits Review Process” which explains the steps involved in AFMC making a decision on a provider’s extension request.

Section 215.120 is a new section number. Also, the number of days for a provider to request an administrative reconsideration of an extension of benefits denial has been corrected and other information has been reworded.

Section 215.130 contains a minor correction.

Section 221.100 has been updated with new information regarding prior authorization requests.

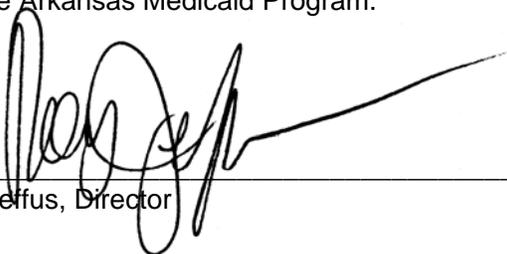
Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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.

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.

Thank you for your participation in the Arkansas Medicaid Program.



Roy Jeffus, Director

SECTION II - PODIATRIST CONTENTS

200.000	PODIATRIST GENERAL INFORMATION
201.000	Arkansas Medicaid Participation Requirements for Podiatrists
201.100	Participation Requirements for Individual Podiatrists
201.200	Group Providers of Podiatrists' Services
201.300	Podiatrists in Arkansas and Bordering States
201.400	Podiatrists in States Not Bordering Arkansas
202.000	Optional Enrollment in the Title XVIII (Medicare Program)
203.000	Documentation Requirements
203.100	General Records
203.200	Documentation in Beneficiary Files
203.300	Record Keeping Requirements
204.000	Role in the Child Health Services (EPSDT) Program
205.000	Clinical Laboratory Improvement Amendments (CLIA) Implementation
210.000	PROGRAM COVERAGE
211.000	Introduction
212.000	Scope
212.100	Assistant Surgeon
213.000	Bilaminar Graft or Skin Substitute
213.100	Bilaminar Graft or Skin Substitute Coverage Restriction
213.200	Bilaminar Graft or Skin Substitute Benefit Limits
214.000	Benefit Limits
214.100	New Patient Visit
214.200	Medical Visits and Surgical Services
214.300	Laboratory and X-Ray Services
215.000	Extension of Benefits
215.100	Procedure for Obtaining Extension of Benefits for Podiatry Services
215.110	Documentation Requirements
215.115	AFMC Extension of Benefits Review Process
215.120	Administrative Reconsideration of Extension of Benefits Denial
215.130	Appealing an Adverse Action
220.000	PRIOR AUTHORIZATION
221.000	Prior Authorization through the Arkansas Foundation for Medical Care, Inc. (AFMC)
221.100	Procedure for Requesting Prior Authorization
221.200	Approvals and Denials of Prior Authorization Requests
221.300	Post-Authorization
222.000	Prior Authorization of Bilaminar Graft or Skin Substitute
230.000	REIMBURSEMENT
231.000	Rate Appeal Process
240.000	BILLING PROCEDURES
241.000	Introduction to Billing
242.000	CMS-1500 (formerly HCFA-1500) Billing Procedures
242.100	Procedure Codes
242.110	Procedure Codes Payable in a Nursing Care Facility
242.120	Procedure Codes Requiring Prior Authorization
242.130	Procedure Codes Payable for Laboratory and X-Ray Services
242.200	Place of Service and Type of Service Codes
242.300	Billing Instructions—Paper Only
242.310	Completion of CMS-1500 Claim Form
242.400	Special Billing Procedures
242.410	Completion of Form—Medicare/Medicaid Deductible and Coinsurance

- 242.420 Services Prior to Medicare Entitlement
- 242.430 Services Not Medicare Approved
- 242.440 Bilaminate Graft or Skin Substitute Procedures

201.400

Podiatrists in States **Not Bordering Arkansas**

5-1-06

- A. Podiatrists in states not bordering Arkansas are called limited services providers because they may enroll in Arkansas Medicaid only after they have treated an Arkansas Medicaid beneficiary and have a claim to file, and because their enrollment automatically expires.
1. A non-bordering state provider may send a claim to Provider Enrollment and Provider Enrollment will forward by return mail a provider manual and a provider application and contract. [View or print Medicaid Provider Enrollment Unit contact information.](#)
 2. Alternatively, a non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, www.medicaid.state.ar.us, and then submit its application and claim to the Medicaid Provider Enrollment Unit.
- B. Limited services providers remain enrolled for one year.
1. If a limited services provider treats another Arkansas Medicaid beneficiary during its year of enrollment and bills Medicaid, its enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
 2. During its enrollment period the provider may file any subsequent claims directly to EDS.
 3. Limited services providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

203.200 Documentation in Beneficiary Files

5-1-06

The provider must contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with its delivery of medical assistance to any Medicaid beneficiary.

Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the aforementioned prescription, care plan or order within five (5) business days of the date it is written. Providers also must maintain a copy of each prescription, care plan or order in the beneficiary's medical record and follow all prescriptions, care plans, and orders as required by law, by Medicaid rule, or both.

The provider must adhere to all applicable professional standards of care and conduct.

Documentation should consist of, at a minimum, material that includes:

- A. History and physical examination.
- B. Chief complaint on each visit.
- C. Tests and results.
- D. Diagnosis.
- E. Treatment including prescriptions.
- F. Signature or initials of podiatrist after each visit.
- G. Copies of office, clinic, hospital and/or emergency room records that are available to disclose services.
- H. Each record must reflect date of visit when services were provided.

203.300 Record Keeping Requirements

5-1-06

All records must be completed promptly, filed and retained for a minimum of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer.

The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit, all records related to any Medicaid beneficiary. All documentation must be available at the provider's place of business during normal business hours. When records are stored off-premise or are in active use, the provider may certify, in writing, that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

At the time of an audit by the Division of Medical Services, Field Audit Unit, all documentation must be made available for review as outlined in the previous paragraph. In the case of recoupment, there will be no more than thirty days allowed after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the thirty-day period.

Failure to furnish records upon request may result in sanctions being imposed.

215.100 Procedure for Obtaining Extension of Benefits for Podiatry Services 5-1-06

- A. Requests for extension of benefits for podiatry services for beneficiaries under age 21 must be mailed to the Arkansas Foundation for Medical Care, Inc. (AFMC). [View or print the Arkansas Foundation for Medical Care, Inc., contact information.](#) A request for extension of benefits must meet the medical necessity requirement, and adequate documentation must be provided to support this request.
1. Requests for extension of benefits are considered only after a claim is denied because a benefit is exhausted.
 2. The request for extension of benefits must be received by AFMC within 90 calendar days of the date of the benefits-exhausted denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exhausted denial appears.
 3. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.
 4. AFMC will not accept extension of benefits requests sent via electronic facsimile (FAX).
- B. Use form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services, to request extension of benefits for podiatry services. [View or print form DMS-671.](#) Consideration of requests for extension of benefits requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider's signature (with his or her credentials) and the date of the request are required on the form. Stamped or electronic signatures are accepted. All applicable records that support the medical necessity of the extended benefits request should be attached.
- C. AFMC will approve or deny an extension of benefits request – or ask for additional information – within 30 calendar days of their receiving the request. AFMC reviewers will simultaneously advise the provider and the beneficiary when a request is denied.

215.110 Documentation Requirements 5-1-06

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

215.115 AFMC Extension of Benefits Review Process

5-1-06

The following is a step-by-step outline of AFMC's extension of benefits review process:

- A. Requests received via mail are screened for completeness and researched to verify the beneficiary's eligibility for Medicaid when the service was provided and to determine whether the claim has already been paid.
- B. The documentation submitted is reviewed by a nurse. If, in the judgment of the nurse the documentation supports medical necessity, he or she may approve the request. An approval letter is computer generated and mailed to the provider the following day.
- C. If the nurse reviewer determines the documentation does not justify the service or it appears that the service is not medically necessary, he or she will refer the case to the appropriate physician advisor for a decision.
- D. The physician reviewer's rationale for approval or denial is entered into the computer review system and the appropriate notification is created. If services are denied for medical necessity, the physician reviewer's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.
- E. Providers may request administrative reconsideration of an adverse decision or they can appeal as provided in section 190.003 of this manual.
- F. If the denial is because of incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the nurse may approve the extension of benefits without referral to a physician advisor.
- G. If the denial is because there is no proof of medical necessity or the documentation does not allow for approval by the nurse, the original documentation, reason for denial and new information submitted will be referred to a different physician advisor for reconsideration.
- H. All parties will be notified in writing of the outcome of the reconsideration.

215.120 Administrative Reconsideration of Extension of Benefits Denial

5-1-06

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.

215.130 Appealing an Adverse Action

5-1-06

Please see section 190.003 for information regarding administrative appeals.

221.100 Procedure for Requesting Prior Authorization

5-1-06

It is the responsibility of the podiatrist to initiate the prior authorization request. The podiatrist or his or her office nurse must contact AFMC to request prior authorization. [View or print AFMC contact information.](#) To request authorization, call AFMC at 1-800-426-2234, between the hours of 8:30 a.m.-12:00 noon and 1:00 p.m.-5:00 p.m., Monday through Friday, with the exception of holidays.

CPT codes that require prior authorization by AFMC are located in section 242.120 of this manual.

- A. When calling AFMC to perform a review for medical necessity of a prior authorization procedure, the following information will be required: (All calls will be tape-recorded for quality assurance purposes.)
1. Patient name and address (including ZIP code)
 2. Patient birth date
 3. Patient Medicaid identification number
 4. Podiatrist name and license number
 5. Podiatrist Medicaid provider number
 6. Hospital or ambulatory surgery center name
 7. Date of service for requested procedure
 8. Facility Medicaid provider number
 9. CPT code for procedure(s)
 10. Principal diagnosis and any other diagnoses
 11. Signs/symptoms of illness
 12. Medical indication for justification of procedure(s)
- B. All patient identification information and medical information related to the necessity of the procedure must be provided for services to be authorized.

