

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –  
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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QMBs:	Part A	<u>MR</u> Deductibles	<u>MR</u> Coinsurance	
	Part B	<u>MR</u> Deductibles	<u>MR</u> Coinsurance	
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Other Medicaid Recipients	Part A	<u>MR</u> Deductibles	<u>MR</u> Coinsurance	
	Part B	<u>MR</u> Deductibles	<u>MR</u> Coinsurance	
<hr/>				
Dual Eligible (QMB Plus)	Part A	<u>MR</u> Deductibles	<u>MR</u> Coinsurance	
	Part B	<u>MR</u> Deductibles	<u>MR</u> Coinsurance	
<hr/>				
QMBs:	*Part A	<u>SP</u> Deductibles	<u>SP</u> Coinsurance	Inpatient Hospital services only
<hr/>				
Other Medicaid Recipients	*Part A	<u>SP</u> Deductibles	<u>SP</u> Coinsurance	Inpatient Hospital services only
<hr/>				
Dual Eligible (QMB Plus)	*Part A	<u>SP</u> Deductibles	<u>SP</u> Coinsurance	Inpatient Hospital services only

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Payment of Medicare Part A and Part B Deductible/Coinsurance

\*The payment of the Medicare Part A deductible and coinsurance for inpatient hospital services is based on the following.

- (1) If the Medicare payment amount equals or exceeds the Medicaid payment rate, the state is not required to pay the Medicare Part A deductible/coinsurance on a crossover claim.
- (2) If the Medicare payment amount is less than the Medicaid payment rate, the state is required to pay the Medicare Part A deductible/coinsurance on a crossover claim, but the amount of payment is limited to the lesser of the deductible/coinsurance or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.

Coverage of a recipient's deductible and/or coinsurance liabilities as specified in this section satisfies the state's obligation to provide Medicaid coverage for services that would have been paid in the absence of Medicare coverage.

The payment of all other Part A deductible and coinsurance is based on the Medicare rate.

- (3) The Medicaid agency will use the Medicare all-inclusive payment rate for cost reimbursement of FQHC encounter coinsurance. The Medicaid agency will cost settle for the coinsurance percentage. The Medicaid agency will cost settle for the coinsurance percentage of the FQHC Medicare encounter cost after the final encounter cost has been determined by the Medicare intermediary.
- (4) Effective for dates of service on or after September 1, 1999, the State will make copayments for Medicare/Medicaid recipients who are enrolled in a Medicare HMO. The service categories and maximum copayment amount are:

<u>Service</u>	<u>Maximum Copayment</u>
Emergency Room	\$25.00 (payable to facility)
Physician/Chiropractor/Podiatrist (excluding Psychiatry/Psychology - see below)	\$ 5.00 (payable to physician/ chiropractor/podiatrist)
Occupational, Physical and Speech Therapy	\$ 5.00 (payable to facility)
Psychiatrist/Psychologist	50% (payable to provider) – Medi-Pak HMO
	\$20.00 (payable to provider) – Medicare Complete HMO



**Division of Medical Services**  
**Program Development & Quality Assurance**

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**TO:** Arkansas Medicaid Health Care Providers – Medicare/Medicaid Crossover Only

**EFFECTIVE DATE:** January 1, 2016

**SUBJECT:** Provider Manual Update Transmittal MEDX-1-15

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
230.000	—	230.000	—
—	—	230.010	1-1-16
—	—	230.100	1-1-16
—	—	241.300	1-1-16

**Explanation of Updates**

Section 230.000 is updated to remove policy for Medicaid reimbursement of Medicare Part A coinsurance and deductibles related to inpatient hospital services and move it to a new section.

Section 230.010 is added to include policy for Medicaid reimbursement of Medicare Part B coinsurance and deductibles.

Section 230.100 is added to include policy for Medicaid reimbursement of Medicare Part A coinsurance and deductibles related to inpatient hospital services.

Section 241.300 is added to include instructions for completing the CMS-1450 (UB-04) claim form.

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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).

Thank you for your participation in the Arkansas Medicaid Program.

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Dawn Stehle  
 Director

TOC required

**230.000 REIMBURSEMENT**

**230.010 Medicare Reimbursement 1-1-16**

Medicaid’s payment toward the Medicare Part B coinsurance and/or deductible is full payment of the amount submitted to Medicaid.

**230.100 Inpatient Hospital Services Reimbursement 1-1-16**

Effective for all claims and claim adjustments with dates of service on and after January 1, 2016, the Division of Medical Services will implement Medicaid reimbursement for Medicare Part A coinsurance and deductibles related to inpatient hospital services to the lesser of the Medicaid allowed amount minus the Medicare payment or the sum of the Medicare coinsurance and deductible. If the Medicaid allowed amount minus the Medicare paid amount is zero or a negative number, Medicaid’s reimbursement will be zero.

**241.300 Instructions for Completion of the Inpatient and Outpatient Services Medicare – Medicaid Crossover Invoice – CMS-1450 (UB-04) 1-1-16**

HP Enterprise Services offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those which require attachments or manual pricing.

To bill for Medicare – Medicaid crossover inpatient or outpatient services, use the claim form CMS-1450 (UB-04). [View a sample CMS-1450 \(UB-04\) claim form.](#) Arkansas Medicaid does not supply providers with Uniform Billing claim forms. Numerous vendors sell CMS-1450 (UB-04) forms.

Read and carefully adhere to the following instructions. The numbered items correspond to fields on the claim form. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Paper claims should be typed whenever possible.

Completed claim forms should be forwarded to the HP Enterprise Services Claims Department. [View or print the HP Enterprise Services Claims Department contact information.](#)

**NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.**

Field #	Field name	Description
1.	(blank)	<i>Inpatient and Outpatient Crossover:</i> Enter the provider’s name (physical address – service location) and billing address, including city, state, zip code, and telephone number.
2.	(blank)	<i>Inpatient and Outpatient Crossover:</i> The address that the provider submitting the bill intends payment to be sent if different from FL 01. (Use this address for provider’s return address for returned mail.)
3a.	PAT CNTL #	<i>Inpatient and Outpatient Crossover:</i> The provider may use this optional field for accounting purposes. It appears on the RA beside the letters “MRN.” Up to 16 alphanumeric characters are accepted.

Field #	Field name	Description
3b.	MED REC #	<i>Inpatient and Outpatient Crossover:</i> Required. Enter up to 15 alphanumeric characters.
4.	TYPE OF BILL	<i>Inpatient and Outpatient Crossover:</i> See the UB-04 manual. Four-digit code with a leading zero that indicates the type of bill.
5.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
6.	STATEMENT COVERS PERIOD	<p>Enter the covered beginning and ending service dates. Format: MMDDYY.</p> <p><i>Inpatient Crossover:</i> Enter the dates of the first and last covered days in the FROM and THROUGH fields.</p> <p>The FROM and THROUGH dates cannot span the State's fiscal year end (June 30) or the provider's fiscal year end.</p> <p>To file correctly for covered inpatient days that span a fiscal year end:</p> <ol style="list-style-type: none"> <li>1. Submit one interim claim (a first claim or a continuing claim, as applicable) on which the THROUGH date is the last day of the fiscal year that ended during the stay. <p>On a first claim or a continuing claim, the patient status code in field 17 must indicate that the beneficiary is still a patient on the indicated THROUGH date.</p> </li> <li>2. Submit a second interim claim (a continuing claim or a last claim, as applicable) on which the FROM date is the first day of the new fiscal year. <p>When the discharge date is the first day of the provider's fiscal year or the state's fiscal year, only one (bill type: admission through discharge) claim is necessary, because Medicaid does not reimburse a hospital for a discharge day unless the discharge day is also the first covered day of the inpatient stay.</p> <p>When an inpatient is discharged on the same date he or she is admitted, the day is covered when the TYPE OF BILL code indicates that the claim is for admission through discharge, the STAT (patient status) code indicates discharge or transfer, and the FROM and THROUGH dates are identical.</p> </li> </ol> <p><i>Outpatient Crossover:</i> To bill on a single claim for outpatient services occurring on multiple dates, enter the beginning and ending service dates in the FROM and THROUGH fields of this field.</p> <p>The dates in this locator must fall within the same fiscal year – the state's fiscal year and the hospital's fiscal year.</p>

Field #	Field name	Description
		When billing for multiple dates of service on a single claim, a date of service is required in field 45 for each HCPCS code in field 44 and/or each revenue code in field 42.
7.	Crossover Indicator	<i>Inpatient and Outpatient Crossover:</i> Required. Enter XOI for an Inpatient Crossover or XOO for an Outpatient Crossover.
8a.	PATIENT NAME	<i>Inpatient and Outpatient Crossover:</i> Enter the patient's last name and first name. Middle initial is optional.
8b.	(blank)	Not required.
9.	PATIENT ADDRESS	<i>Inpatient and Outpatient Crossover:</i> Enter the patient's full mailing address. Optional.
10.	BIRTH DATE	<i>Inpatient and Outpatient Crossover:</i> Enter the patient's date of birth. Format: MMDDYYYY.
11.	SEX	<i>Inpatient and Outpatient Crossover:</i> Enter M for male, F for female, or U for unknown.
12.	ADMISSION DATE	<i>Inpatient Crossover:</i> Enter the inpatient admission date. Format: MMDDYY. <i>Outpatient Crossover:</i> Not required.
13.	ADMISSION HR	<i>Inpatient and Outpatient Crossover:</i> Enter the national code that corresponds to the hour during which the patient was admitted for inpatient care.
14.	ADMISSION TYPE	<i>Inpatient Crossover:</i> Enter the code from the Uniform Billing Manual that indicates the priority of this inpatient admission. <i>Outpatient Crossover:</i> Not required.
15.	ADMISSION SRC	<i>Inpatient and Outpatient Crossover:</i> Admission source. Required. Code 1, 2, 3, or 4 is required when the code in field 14 is 4.
16.	DHR	<i>Inpatient Crossover:</i> See the UB-04 Manual. Required except for type of bill 021x. Enter the hour the patient was discharged from inpatient care.
17.	STAT	<i>Inpatient Crossover:</i> Enter the national code indicating the patient's status on the Statement Covers Period THROUGH date (field 6). <i>Outpatient Crossover:</i> Not applicable.
18.- 28.	CONDITION CODES	<i>Inpatient and Outpatient Crossover:</i> Required when applicable. See the UB-04 Manual for requirements and for the codes used to identify conditions or events relating to this bill.
29.	ACDT STATE	Not required.
30.	(blank)	Unassigned data field.
31.- 34.	OCCURRENCE CODES AND DATES	<i>Inpatient and Outpatient Crossover:</i> Required when applicable. See the UB-04 Manual.

Field #	Field name	Description
31a	(blank)	<i>Inpatient and Outpatient Crossover:</i> Required. Must have a value of 50 with the Medicare Paid Date. Format: MMDDYYYY.
35.- 36.	OCCURRENCE SPAN CODES AND DATES	<i>Inpatient Crossover:</i> Enter the dates of the first and last days approved, per the facility's PSRO/UR plan, in the FROM and THROUGH fields. See the UB-04 Manual. Format: MMDDYY.  <i>Outpatient Crossover:</i> See the UB-04 Manual.
37.	Not used	Reserved for assignment by the NUBC.
38.	Responsible Party Name and Address	See the UB-04 Manual.
39.	VALUE CODES	<i>Outpatient Crossover:</i> Not required.  <i>Inpatient Crossover:</i>
39a.	CODE  AMOUNT	Enter 80.  Enter number of covered days. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeros (00) to the right of the vertical dotted line.
39b.	CODE  AMOUNT	Enter 81.  Enter number of non-covered days. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeros (00) to the right of the vertical dotted line
40.	VALUE CODES	<i>Inpatient and Outpatient Crossover:</i> Required.
40a.	CODE  AMOUNT	Enter A1.  Regular deductible amount.
40b.	CODE  AMOUNT	Enter A2.  Co-insurance amount.
40c.	CODE  AMOUNT	Enter 06.  Blood deductible amount.
41.	VALUE CODES	Not required.
42.	REV CD	<i>Inpatient and Outpatient Crossover:</i> See the UB-04 Manual.
43.	DESCRIPTION	See the UB-04 Manual.
44.	HCPCS/RATE/HIPPS CODE	See the UB-04 Manual.
45.	SERV DATE	<i>Inpatient Crossover:</i> Not applicable.  <i>Outpatient Crossover:</i> Date format: MMDDYY.

Field #	Field name	Description
46.	SERV UNITS	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
47.	TOTAL CHARGES	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
48.	NON-COVERED CHARGES	See the UB-04 Manual, line item "Total" under "Reporting."
49.	Not used	Reserved for assignment by the NUBC.
50.	PAYER NAME	Line A is required and is for the Medicare payment. For lines B and C, see the UB-04 for additional regulations.
51.	HEALTH PLAN ID	Report the HIPAA National Plan Identifier; otherwise report the legacy/proprietary number.
52.	REL INFO	Required when applicable. See the UB-04 Manual.
53.	ASG BEN	Required. See "Notes" at field 53 in the UB-04 Manual.
54.	PRIOR PAYMENTS	<i>Inpatient and Outpatient Crossover:</i> Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. * Do <b>not</b> include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
55.	EST AMOUNT DUE	Situational. See the UB-04 Manual.
56.	NPI	Not required.
57.	OTHER PRV ID	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider in first line of field.
58. A, B, C	INSURED'S NAME	<i>Inpatient and Outpatient Crossover:</i> Comply with the UB-04 Manual's instructions when applicable to Medicaid.
59. A, B, C	P REL	<i>Inpatient and Outpatient Crossover:</i> Comply with the UB-04 Manual's instructions when applicable to Medicaid.
60. A, B, C	INSURED'S UNIQUE ID	<i>Inpatient and Outpatient Crossover:</i> Enter the patient's Medicaid identification number in first line of field.
61. A, B, C	GROUP NAME	<i>Inpatient and Outpatient Crossover:</i> Using the plan name if the patient is insured by another payer or other payers, follow instructions for field 60.
62. A, B, C	INSURANCE GROUP NO	<i>Inpatient and Outpatient Crossover:</i> When applicable, follow instructions for fields 60 and 61.
63. A, B, C	TREATMENT AUTHORIZATION CODES	<i>Inpatient Crossover:</i> Enter any applicable prior authorization, benefit extension, or MUMP certification control number on line 63A.  <i>Outpatient Crossover:</i> Enter any applicable prior authorization or benefit extension numbers on line 63A.
64. A, B, C	DOCUMENT CONTROL NUMBER	<i>Inpatient and Outpatient Crossover:</i> Required. Enter the Medicare ICN. Must be 14 characters or less.

Field #	Field name	Description
65. A, B, C	EMPLOYER NAME	<i>Inpatient and Outpatient Crossover:</i> When applicable, based upon fields 51 through 62, enter the name(s) of the individuals and entities that provide health care coverage for the patient (or may be liable).
66.	DX	Diagnosis Version Qualifier. See the UB-04 Manual. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM.  Comply with the UB-04 Manual's instructions on claims processing requirements.
67. A-H	(blank)	<i>Inpatient and Outpatient Crossover:</i> Enter the ICD CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Fields are available for up to 8 codes.
68.	Not used	Reserved for assignment by the NUBC.
69.	ADMIT DX	Required for inpatient. See the UB-04 Manual.
70.	PATIENT REASON DX	See the UB-04 Manual.
71.	PPS CODE	Not required.
72	ECI	See the UB-04 Manual. Required when applicable (for example, TPL and torts).
73.	Not used	Reserved for assignment by the NUBC.
74.	PRINCIPAL PROCEDURE	<i>Inpatient Crossover:</i> Required on inpatient claims when a procedure was performed. On all interim claims, enter the codes for all procedures during the hospital stay.  <i>Outpatient Crossover:</i> Not applicable.
	CODE	Principal procedure code.
	DATE	Format: MMDDYY.
74a-74e	OTHER PROCEDURE	<i>Inpatient Crossover:</i> Required on inpatient claims when a procedure was performed. On all interim claims, enter the codes for all procedures during the hospital stay.  <i>Outpatient Crossover:</i> Not applicable.
	CODE	Inpatient claims only. Other procedure code(s).
	DATE	Inpatient claims only. Format: MMDDYY.
75.	Not used	Reserved for assignment by the NUBC.
76.	ATTENDING NPI	NPI not required.
	QUAL	Enter 0B, indicating state license number. Enter the state license number in the second part of the field.
	LAST	Enter the last name of the primary attending physician.
	FIRST	Enter the first name of the primary attending physician.
77.	OPERATING NPI	NPI not required.

<b>Field #</b>	<b>Field name</b>	<b>Description</b>
	QUAL	Enter 0B, indicating state license number. Enter the operating physician's state license number in the second part of the field.
	LAST	Enter the last name of the operating physician.
	FIRST	Enter the first name of the operating physician.
78.	OTHER NPI	NPI not required.
	QUAL	Enter 0B, indicating state license number. Enter the state license number in the second part of the field.
	LAST	Enter the last name of the primary care physician.
	FIRST	Enter the first name of the primary care physician.
79.	OTHER NPI/QUAL/LAST/FIRS	Not used.
80.	REMARKS	For provider's use.
81.	Not used	Reserved for assignment by the NUBC.

## SECTION V – FORMS

## 500.000

## Claim Forms

## Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
<a href="#">Professional – CMS-1500</a>	Business Form Supplier
<a href="#">Institutional – CMS-1450*</a>	Business Form Supplier
<a href="#">Visual Care – DMS-26-V</a>	1-800-457-4454
<a href="#">Inpatient Crossover – HP-MC-001</a>	1-800-457-4454
<a href="#">Long Term Care Crossover – HP-MC-002</a>	1-800-457-4454
<a href="#">Outpatient Crossover – HP-MC-003</a>	1-800-457-4454
<a href="#">Professional Crossover – HP-MC-004</a>	1-800-457-4454

\* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

## Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
<a href="#">Alternatives Attendant Care Provider Claim Form - AAS-9559</a>	Client Employer
<a href="#">Dental – ADA-J430</a>	Business Form Supplier

## Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

## In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	<a href="#">DMS-2606</a>
Address Change Form	<a href="#">DMS-673</a>
Adjustment Request Form – Medicaid XIX	<a href="#">HP-AR-004</a>
Adverse Effects Form	<a href="#">DMS-2704</a>

<b>Form Name</b>	<b>Form Link</b>
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	<a href="#">DMS-679A</a>
Amplification/Assistive Technology Recommendation Form	<a href="#">DMS-686</a>
Application for WebRA Hardship Waiver	<a href="#">DMS-7736</a>
Approval/Denial Codes for Inpatient Psychiatric Services	<a href="#">DMS-2687</a>
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	<a href="#">DDS/FS#0001.a</a>
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	<a href="#">DMS-844</a>
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	<a href="#">DMS-845</a>
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	<a href="#">DMS-846</a>
ARKids First Behavioral Health Services Provider Qualification Form	<a href="#">DMS-612</a>
Authorization for Automatic Deposit	<a href="#">autodeposit</a>
Authorization for Payment for Services Provided	<a href="#">MAP-8</a>
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	<a href="#">DMS-2633</a>
Certification of Schools to Provide Comprehensive EPSDT Services	<a href="#">CSPC-EPSDT</a>
Certification Statement for Abortion	<a href="#">DMS-2698</a>
Change of Ownership Information	<a href="#">DMS-0688</a>
Child Health Management Services Enrollment Orders	<a href="#">DMS-201</a>
Child Health Management Services Discharge Notification Form	<a href="#">DMS-202</a>
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	<a href="#">DMS-699A</a>
CHMS Request for Prior Authorization	<a href="#">DMS-102</a>
Claim Correction Request	<a href="#">DMS-2647</a>
Consent for Release of Information	<a href="#">DMS-619</a>
Contact Lens Prior Authorization Request Form	<a href="#">DMS-0101</a>
Contract to Participate in the Arkansas Medical Assistance Program	<a href="#">DMS-653</a>
DDTCS Transportation Log	<a href="#">DMS-638</a>
DDTCS Transportation Survey	<a href="#">DMS-632</a>
Dental Treatment Additional Information	<a href="#">DMS-32-A</a>
Disclosure of Significant Business Transactions	<a href="#">DMS-689</a>
Disproportionate Share Questionnaire	<a href="#">DMS-628</a>
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	<a href="#">DMS-693</a>

<b>Form Name</b>	<b>Form Link</b>
Early Childhood Special Education Referral Form	<a href="#">ECSE-R</a>
EPSDT Provider Agreement	<a href="#">DMS-831</a>
Explanation of Check Refund	<a href="#">HP-CR-002</a>
Gait Analysis Full Body	<a href="#">DMS-647</a>
Home Health Certification and Plan of Care	<a href="#">CMS-485</a>
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	<a href="#">DMS-2685</a>
Individual Renewal Form for School-Based Audiologists	<a href="#">DMS-7782</a>
Lower-Limb Prosthetic Evaluation	<a href="#">DMS-650</a>
Lower-Limb Prosthetic Prescription	<a href="#">DMS-651</a>
Media Selection/E-Mail Address Change Form	<a href="#">HP-MS-005</a>
Medicaid Claim Inquiry Form	<a href="#">HP-CI-003</a>
Medicaid Form Request	<a href="#">HP-MFR-001</a>
Medical Equipment Request for Prior Authorization & Prescription	<a href="#">DMS-679</a>
Medical Transportation and Personal Assistant Verification	<a href="#">DMS-616</a>
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	<a href="#">DMS-633</a>
Notice Of Noncompliance	<a href="#">DMS-635</a>
NPI Reporting Form	<a href="#">DMS-683</a>
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	<a href="#">DMS-640</a>
Ownership and Conviction Disclosure	<a href="#">DMS-675</a>
Personal Care Assessment and Service Plan	<a href="#">DMS-618 English</a> <a href="#">DMS-618 Spanish</a>
Practitioner Identification Number Request Form	<a href="#">DMS-7708</a>
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	<a href="#">DMS-2615</a>
Primary Care Physician Managed Care Program Referral Form	<a href="#">DMS-2610</a>
Primary Care Physician Participation Agreement	<a href="#">DMS-2608</a>
Primary Care Physician Selection and Change Form	<a href="#">DMS-2609</a>
Procedure Code/NDC Detail Attachment Form	<a href="#">DMS-664</a>
Provider Application	<a href="#">DMS-652</a>
Provider Communication Form	<a href="#">AAS-9502</a>
Provider Data Sharing Agreement – Medicare Parts C & D	<a href="#">DMS-652-A</a>
Provider Enrollment Application and Contract Package	<a href="#">Application Packet</a>
Quarterly Monitoring Form	<a href="#">AAS-9506</a>
Referral for Audiology Services – School-Based Setting	<a href="#">DMS-7783</a>

<b>Form Name</b>	<b>Form Link</b>
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	<a href="#">DMS-2634</a>
Referral for Medical Assistance	<a href="#">DMS-630</a>
Request for Appeal	<a href="#">DMS-840</a>
Request for Extension of Benefits	<a href="#">DMS-699</a>
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	<a href="#">DMS-671</a>
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	<a href="#">DMS-602</a>
Request for Molecular Pathology Laboratory Services	<a href="#">DMS-841</a>
Request For Orthodontic Treatment	<a href="#">DMS-32-0</a>
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	<a href="#">DMS-2692</a>
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	<a href="#">DMS-601</a>
Research Request Form	<a href="#">HP-0288</a>
Service Log – Personal Care Delivery and Aides Notes	<a href="#">DMS-873</a>
Sterilization Consent Form	<a href="#">DMS-615 English</a> <a href="#">DMS-615 Spanish</a>
Sterilization Consent Form – Information for Men	<a href="#">PUB-020</a>
Sterilization Consent Form – Information for Women	<a href="#">PUB-019</a>
Upper-Limb Prosthetic Evaluation	<a href="#">DMS-648</a>
Upper-Limb Prosthetic Prescription	<a href="#">DMS-649</a>
Vendor Performance Report	<a href="#">Vendorperformreport</a>
Verification of Medical Services	<a href="#">DMS-2618</a>

## In order by form number:

<a href="#">AAS-9502</a>	<a href="#">DMS-2633</a>	<a href="#">DMS-618</a>	<a href="#">DMS-675</a>	<a href="#">DMS-873</a>
<a href="#">AAS-9506</a>	<a href="#">DMS-2634</a>	<a href="#">Spanish</a>	<a href="#">DMS-673</a>	<a href="#">ECSE-R</a>
<a href="#">AAS-9559</a>	<a href="#">DMS-2647</a>	<a href="#">DMS-619</a>	<a href="#">DMS-679</a>	<a href="#">HP-0288</a>
<a href="#">Address</a>	<a href="#">DMS-2685</a>	<a href="#">DMS-628</a>	<a href="#">DMS-679A</a>	<a href="#">HP-AR-004</a>
<a href="#">Change</a>	<a href="#">DMS-2687</a>	<a href="#">DMS-630</a>	<a href="#">DMS-683</a>	<a href="#">HP-CI-003</a>
<a href="#">Autodeposit</a>	<a href="#">DMS-2692</a>	<a href="#">DMS-632</a>	<a href="#">DMS-686</a>	<a href="#">HP-CR-002</a>
<a href="#">CMS-485</a>	<a href="#">DMS-2698</a>	<a href="#">DMS-633</a>	<a href="#">DMS-689</a>	<a href="#">HP-MFR-001</a>
<a href="#">CSPC-EPSDT</a>	<a href="#">DMS-2704</a>	<a href="#">DMS-635</a>	<a href="#">DMS-693</a>	<a href="#">HP-MS-005</a>
<a href="#">DDS/FS#0001.a</a>	<a href="#">DMS-32-A</a>	<a href="#">DMS-638</a>	<a href="#">DMS-699</a>	<a href="#">MAP-8</a>
<a href="#">DMS-0101</a>	<a href="#">DMS-32-0</a>	<a href="#">DMS-640</a>	<a href="#">DMS-699A</a>	<a href="#">Performance</a>
<a href="#">DMS-0688</a>	<a href="#">DMS-601</a>	<a href="#">DMS-647</a>	<a href="#">DMS-7708</a>	<a href="#">Report</a>
<a href="#">DMS-102</a>	<a href="#">DMS-602</a>	<a href="#">DMS-648</a>	<a href="#">DMS-7736</a>	<a href="#">Provider</a>
<a href="#">DMS-201</a>	<a href="#">DMS-612</a>	<a href="#">DMS-649</a>	<a href="#">DMS-7782</a>	<a href="#">Enrollment</a>
<a href="#">DMS-202</a>	<a href="#">DMS-615</a>	<a href="#">DMS-650</a>	<a href="#">DMS-7783</a>	<a href="#">Application</a>
<a href="#">DMS-2606</a>	<a href="#">English</a>	<a href="#">DMS-651</a>	<a href="#">DMS-831</a>	<a href="#">and Contract</a>
<a href="#">DMS-2608</a>	<a href="#">DMS-615</a>	<a href="#">DMS-652</a>	<a href="#">DMS-840</a>	<a href="#">Package</a>
<a href="#">DMS-2609</a>	<a href="#">Spanish</a>	<a href="#">DMS-652-A</a>	<a href="#">DMS-841</a>	<a href="#">PUB-019</a>
<a href="#">DMS-2610</a>	<a href="#">DMS-616</a>	<a href="#">DMS-653</a>	<a href="#">DMS-844</a>	<a href="#">PUB-020</a>
<a href="#">DMS-2615</a>	<a href="#">DMS-618</a>	<a href="#">DMS-664</a>	<a href="#">DMS-845</a>	
<a href="#">DMS-2618</a>	<a href="#">English</a>	<a href="#">DMS-671</a>	<a href="#">DMS-846</a>	

## Arkansas Medicaid Contacts and Links

Click the link to view the information.

[American Hospital Association](#)

[Americans with Disabilities Act Coordinator](#)

[Arkansas Department of Education, Health and Nursing Services Specialist](#)

[Arkansas Department of Education, Special Education](#)

[Arkansas Department of Finance Administration, Sales and Tax Use Unit](#)

[Arkansas Department of Human Services, Division of Aging and Adult Services](#)

[Arkansas Department of Human Services, Appeals and Hearings Section](#)

[Arkansas Department of Human Services, Division of Behavioral Health Services](#)

[Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit](#)

[Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit](#)

[Arkansas Department of Human Services, Children's Services](#)

[Arkansas Department of Human Services, Division of County Operations, Customer Assistance Section](#)

[Arkansas Department of Human Services, Division of Medical Services](#)

[Arkansas DHS, Division of Medical Services Director](#)

[Arkansas DHS, Division of Medical Services, Benefit Extension Requests, UR Section](#)

[Arkansas DHS, Division of Medical Services, Dental Care Unit](#)

[Arkansas DHS, Division of Medical Services, HP Enterprise Services Provider Enrollment Unit](#)

[Arkansas DHS, Division of Medical Services, Financial Activities Unit](#)

[Arkansas DHS, Division of Medical Services, Hearing Aid Consultant](#)

[Arkansas DHS, Division of Medical Services, Medical Assistance Unit](#)

[Arkansas DHS, Division of Medical Services, Medical Director for Clinical Affairs](#)

[Arkansas DHS, Division of Medical Services, Pharmacy Unit](#)

[Arkansas DHS, Division of Medical Services, Program Communications Unit](#)

[Arkansas DHS, Division of Medical Services, Program Integrity Unit \(PI\)](#)

[Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit](#)

[Arkansas DHS, Division of Medical Services, Third-Party Liability Unit](#)

[Arkansas DHS, Division of Medical Services, UR/Home Health Extensions](#)

[Arkansas DHS, Division of Medical Services, Utilization Review Section](#)

[Arkansas DHS, Division of Medical Services, Visual Care Coordinator](#)

[Arkansas Department of Health](#)

[Arkansas Department of Health, Health Facility Services](#)

[Arkansas Department of Human Services, Accounts Receivable](#)

[Arkansas Foundation For Medical Care](#)

[Arkansas Foundation for Medical Care, Retrospective Review for Therapy and Prior Authorization for Personal Care for Under Age 21](#)

[Arkansas Hospital Association](#)

[ARKids First-B](#)

[ARKids First-B ID Card Example](#)

[Central Child Health Services Office \(EPSDT\)](#)

[ConnectCare Helpline](#)

[County Codes](#)

[Dental Contractor](#)

[HP Enterprise Services Claims Department](#)

[HP Enterprise Services EDI Support Center \(formerly AEVCS Help Desk\)](#)

[HP Enterprise Services Inquiry Unit](#)

[HP Enterprise Services Manual Order](#)

[HP Enterprise Services Provider Assistance Center \(PAC\)](#)

[HP Enterprise Services Supplied Forms](#)

[Example of Beneficiary Notification of Denied ARKids First-B Claim](#)

[Example of Beneficiary Notification of Denied Medicaid Claim](#)

[First Connections Infant & Toddler Program, Developmental Disabilities Services](#)

[First Connections Infant & Toddler Program, Developmental Disabilities Services, Appeals](#)

[Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment](#)

[Health Care Declarations](#)

[Immunizations Registry Help Desk](#)

[Magellan Pharmacy Call Center](#)

[Medicaid ID Card Example](#)

[Medicaid Managed Care Services \(MMCS\)](#)

[Medicaid Reimbursement Unit Communications Hotline](#)

[Medicaid Tooth Numbering System](#)

[National Supplier Clearinghouse](#)

[Partners Provider Certification](#)

[Primary Care Physician \(PCP\) Enrollment Voice Response System](#)

[Provider Qualifications, Division of Behavioral Health Services](#)

[Select Optical](#)

[Standard Register](#)

[Table of Desirable Weights](#)

[U.S. Government Printing Office](#)

[ValueOptions](#)

[Vendor Performance Report](#)





**Division of Medical Services**  
**Program Development & Quality Assurance**

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437  
501-320-6428 · Fax: 501-404-4619  
TDD/TTY: 501-682-6789



**TO:** Arkansas Medicaid Health Care Providers – All Providers

**EFFECTIVE DATE:** January 1, 2016

**SUBJECT:** Provider Manual Update Transmittal SecV-3-15

**REMOVE**

<b>Section</b>	<b>Effective Date</b>
500.000	—
HP-MC-001	—
HP-MC-003	—

**INSERT**

<b>Section</b>	<b>Effective Date</b>
500.000	—
—	—
—	—

**Explanation of Updates**

Section 500.000 is updated to indicate that the Inpatient Services Medicare – Medicaid Crossover Invoice (Form HP-MC-001) and the Outpatient Services Medicare – Medicaid Crossover Invoice (Form HP-MC-003) have been discontinued. Providers should use form CMS-1450 (UB-04) to file Medicare – Medicaid crossover claims for inpatient and outpatient services.

Forms HP-MC-001 and HP-MC-003 have been discontinued.

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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).

Thank you for your participation in the Arkansas Medicaid Program.

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Dawn Stehle  
Director



**Division of Medical Services**  
**Program Development & Quality Assurance**



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**TO:** Arkansas Medicaid Health Care Providers – Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)

**EFFECTIVE DATE:** January 1, 2016

**SUBJECT:** Provider Manual Update Transmittal HOSPITAL-7-15

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
—	—	250.102	1-1-16

**Explanation of Updates**

Section 250.102 is added to include policy for Medicaid reimbursement of Medicare Part A coinsurance and deductibles related to inpatient hospital services.

The paper version of this update transmittal includes revised pages that may be filed 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.

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Thank you for your participation in the Arkansas Medicaid Program.

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Dawn Stehle  
Director

*TOC required*

**250.102 Medicare Crossover Inpatient Hospital Services Reimbursement 1-1-16**

Effective for all claims and claim adjustments with dates of service on and after January 1, 2016, the Division of Medical Services will implement Medicaid reimbursement for Medicare Part A coinsurance and deductibles related to inpatient hospital services to the lesser of the Medicaid allowed amount minus the Medicare payment or the sum of the Medicare coinsurance and deductible. If the Medicaid allowed amount minus the Medicare paid amount is zero or a negative number, Medicaid's reimbursement will be zero.