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Section	Date	Section	Date
—	—	212.511	6-1-06
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—	—	212.550	6-1-06
217.110	10-13-03	217.110	6-1-06
—	—	217.140	6-1-06
—	—	250.624	6-1-06
—	—	250.701	6-1-06
—	—	272.461	6-1-06

Explanation of Updates

Section 201.220: This section redefines hospital and critical access hospital limited services providers and establishes new enrollment and participation requirements and procedures.

Section 201.221: This section is deleted pursuant to revisions to section 201.220.

Section 204.120: This section defines End-Stage Renal Disease limited services providers and sets forth enrollment and participation requirements and procedures.

Section heading 210.000: This heading is included in order to correct it.

Section 210.100: This section replaces former section 211.000 and adds clarifying information regarding medical necessity and financial liability.

Sections 212.500 through 212.550: These sections replace sections 212.410 through 212.418, which have been deleted, and set forth new rules regarding the QIO’s method of determining medically necessary lengths of inpatient stays, reconsiderations of certification denials, appeals of denials and requests for continuation of services pending the outcome of an appeal.

Section 217.110: This section has been rewritten for the purpose of clarification.

Section 217.140: This is a new section setting forth rules regarding coverage of Verteporfin.

Section 250.624: This is a new reimbursement section regarding inpatient adjustments for non-state public hospitals.

Section 250.622: Information has been added regarding the determination of the most recent audited cost report.

Section 250.623: Information has been added regarding the determination of the most recent audited cost report. Section 250.701: This new section explains when the cost of a hospital private room is allowable and when it is not allowable.

Section 272.461: This new section explains billing procedures for Verteporfin.

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 – HOSPITAL / CRITICAL ACCESS HOSPITAL (CAH) / END-STAGE RENAL DISEASE (ESRD)

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201.220

Hospitals in States Not Bordering Arkansas

6-1-06

- A. Hospitals 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 hospital 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 Provider Enrollment Unit Contact information.](#)
 2. Alternatively, a non-bordering state hospital 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 hospital keeps the provider file current.
 2. During its enrollment period the provider may file any subsequent claims directly to EDS.
- C. 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.

204.120 ESRD Providers in States not Bordering Arkansas

6-1-06

- A. ESRD facilities 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 ESRD facility may send a claim to Provider Enrollment ([View or print Provider Enrollment Unit Contact information](#)) and Provider Enrollment will forward a provider manual and a provider application and contract.
 2. Alternatively, a non-bordering state ESRD facility 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 hospital keeps the provider file current.
 2. During its enrollment period the provider may file any subsequent claims directly to EDS.
- C. 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.

210.000 PROGRAM COVERAGE – HOSPITAL AND CRITICAL ACCESS HOSPITAL

6-1-06

210.100 Introduction

6-1-06

The Medical Assistance (Medicaid) Program helps eligible individuals obtain necessary medical care.

A. Medicaid coverage is based on medical necessity.

1. See Section IV of this manual for the Medicaid Program's definition of medical necessity.
2. Some examples of services that are not medically necessary are treatments or procedures that are cosmetic or experimental or that the medical profession does not generally accept as a standard of care (e.g., an inpatient admission to treat a condition that requires only outpatient treatment).

B. Medicaid denies coverage of services that are not medically necessary. Denial for lack of medical necessity is done in several ways.

1. When Arkansas Medicaid's Medical Director determines that a service is never medically necessary, the Division of Medical Services (DMS) enters the service's procedure code, revenue code and/or diagnosis code into the Medicaid Management Information System (MMIS) as non-payable, which automatically prevents payment.
2. A number of services are covered only with the Program's prior approval or prior authorization. One of the reasons for requiring prior approval of payment or prior authorization for a service is that some services are not always medically necessary and Medicaid wants its own medical professionals to review the case record before making payment or before the service is provided.
3. Lastly, Medicaid retrospectively reviews medical records of services for which claims have been paid in order to verify that the medical record supports the service(s) for which Medicaid paid and to confirm or refute the medical necessity of the services documented in the record.

C. Unless a service's medical necessity or lack of medical necessity has been established by statute or regulation, medical necessity determinations are made by the Arkansas Medicaid Program's Medical Director, by the Program's Quality Improvement Organization (QIO) –currently Arkansas Foundation for Medical Care, Inc. (AFMC) –and/or by other qualified professionals or entities authorized and designated by the Division of Medical Services.

D. When Arkansas Medicaid's Medical Director, QIO or other designee determines –whether prospectively, concurrently or retrospectively –that a hospital service is not medically necessary, Medicaid covers neither the hospital service nor any related physician services.

212.500 Medicaid Utilization Management Program (MUMP) 6-1-06

The Quality Improvement Organization (QIO), Arkansas Foundation for Medical Care, Inc. (AFMC), under contract to the Arkansas Medicaid Program, determines covered lengths of stay in acute care/general and rehabilitative hospitals in Arkansas and states bordering Arkansas, in accordance with the guidelines of the Arkansas Medicaid Utilization Management Program (MUMP).

A. MUMP guidelines do not apply to lengths of stay in psychiatric facilities.

Sections 212.501 through 212.507 generally set forth MUMP guidelines. Sections 212.510 through 212.550 address specific issues and procedures.

212.501 Length of Stay Determination 6-1-06

A. AFMC uses the *Solucient Length of Stay by Diagnosis and Operation Data Files* to assist non-physician reviewers in determining appropriate MUMP lengths of stay. [View or print Solucient, LLC contact information.](#)

B. AFMC's nurse-reviewers are not authorized to deny certification requests.

1. The nurse-reviewer refers to an in-house physician adviser, cases in which
 - a. The length of stay requested is beyond that indicated by the Solucient guide or
 - b. A beneficiary's medical condition does not appear to meet the guidelines or
 - c. It technically meets the guidelines, but in the nurse's judgment inpatient care may not be necessary.
2. The in-house physician adviser determines, based on his or her medical judgment, whether to approve, partially approve or deny the certification request.

212.502 Reconsiderations 6-1-06

Once per admission, the QIO will reconsider a denied extension.

A. AFMC must receive the reconsideration request within 30 days of the first business day following the date of the postmark on the envelope in which the provider received the denial confirmation.

B. When requesting reconsideration, a provider must submit the complete medical record of the admission.

212.503 Paper Review After Reconsiderations: Special Cases 6-1-06

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 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 days.

- D. In order to give due consideration to cases of true medical necessity while avoiding repeated reviews of the same admission, AFMC has established the following procedure for reviewing cases of this nature.
- E. After the beneficiary's discharge, the provider may submit the medical record for the entire admission to AFMC and indicate in writing the dates to be considered for certification.
 - 1. AFMC will consider for possible authorization only the dates requested by the provider.
 - 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

6-1-06

- 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.](#)

212.505 Requesting Continuation of Services Pending the Outcome of an Appeal

6-1-06

- 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.

212.506 Unfavorable Administrative Decisions – Judicial Relief

6-1-06

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.*

212.507 Post Payment Review

6-1-06

A post payment review of a random sample is conducted on all admissions, including inpatient stays of four days or less, to ensure that medical necessity for the services is substantiated.

212.510 MUMP Applicability

6-1-06

- A. Medicaid covers up to 4 days of inpatient service with no certification requirement, except in the case of a transfer, subject to retrospective review for medical necessity.
- B. If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified by AFMC.
- C. When a patient is transferred from one hospital to another, the stay must be certified from the first day.

212.511 MUMP Exemptions

6-1-06

- A. Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age 1, are subject to this policy. Medicaid beneficiaries under age 1 at the time of admission are exempt from MUMP requirements for dates of service before their first birthday.
 - 1. When a Medicaid beneficiary reaches age 1 during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the MUMP.
 - 2. The MUMP becomes effective on the one-year birthday.
 - a. The patient's birthday is the first day of the four days not requiring MUMP certification.
 - b. If the patient is not discharged before or during the fourth day following the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.
- B. The MUMP does not apply to inpatient stays for bone marrow, liver, liver/bowel, heart, lung, skin and pancreas/kidney transplant procedures.
- C. When there is primary coverage by a third party resource and the provider seeks secondary coverage by Medicaid, Medicaid covers the same number of inpatient days as the primary resource whether the number of covered days is less than, equal to or greater than four.
 - 1. Therefore, MUMP certification is not required in this circumstance.
 - 2. Medicaid processes the provider's claim in accordance with regulations governing third party liability.

212.520 MUMP Certification Request Procedure

6-1-06

When a patient is transferred from another hospital (see section 212.530 below) or when a patient's attending physician determines the patient should not be discharged by the fifth day of hospitalization, utilization review or case management personnel may contact AFMC and request an extension of inpatient days.

- A. The following information is required.
 - 1. Patient name and address (including ZIP code)
 - 2. Patient birth date
 - 3. Patient Medicaid number
 - 4. Admission date

5. Hospital name
 6. Hospital Medicaid provider number
 7. Attending physician Medicaid provider number
 8. Principal diagnosis and other diagnoses influencing this stay
 9. Surgical procedures performed or planned
 10. The number of days being requested for continued inpatient care
 11. All available medical information justifying or supporting the necessity of continued stay in the hospital.
- B. AFMC may be contacted between 8:30 a.m. and 5:00 p.m., Monday through Friday, except **State** holidays. [View or print AFMC contact information.](#) Calls are limited to 10 minutes to allow equal access to all providers.
- C. Calls for extension of days may be made at any time during the inpatient stay, except in the case of a transfer from another hospital ([see section 212.530](#)).
1. If the provider delays calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable.
 2. If the fifth day of the admission is a Saturday, Sunday or holiday, it is recommended that the hospital provider call for an extension before the fifth day if the physician has recommended a continued stay.
- D. The AFMC reviewer assigns an authorization control number to an approved extension request, orally advises the provider of the control number and number of days certified and forwards to the hospital written confirmation of that information on the next business day.
- E. When an extension of days is denied or only partially approved, the AFMC reviewer so advises the provider during the telephone call and forwards, on the next business day, to the hospital, the attending physician and the beneficiary, written notification that includes the reason(s) for the denial or partial approval.
- F. Additional extensions may be requested as needed.
- G. The **MUMP** certification process is separate from prior authorization requirements.
1. Prior authorization for medical procedures must be obtained by the appropriate providers.
 2. Hospital stays for restricted procedures **are** disallowed **when** required prior authorizations are not obtained.
- H. Except for the exemptions listed in section 212.511, Medicaid does not cover fifth and subsequent days of inpatient hospital admissions unless they have been certified by the QIO in accordance with applicable procedures in this manual for concurrent and/or retroactive MUMP certification.

212.521 Non-Bordering State Admissions

6-1-06

Inpatient hospital admissions in states not bordering Arkansas are reviewed retrospectively to determine the medical necessity of stays of any length.

212.530 Transfer Admissions

6-1-06

- A. When a patient is transferred from one hospital to another, the receiving facility must contact AFMC within 24 hours of admission to certify the inpatient stay.

- B. When a transfer admission occurs on a weekend or holiday, the provider must contact AFMC before 4:30 PM of the first working day following the weekend or holiday.

212.540 Post Certification Due to Retroactive Eligibility

6-1-06

- A. When eligibility is determined while the patient is still an inpatient, the hospital may request post-certification of inpatient days beyond the first 4 (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed.
- B. When eligibility is determined after discharge, the hospital may call AFMC for post-certification of inpatient days beyond the first 4 (or for all days if the admission was by transfer).
- C. When eligibility is determined after discharge and the provider is seeking certification of a stay longer than 30 days, the provider must submit the entire medical record to AFMC for review.

212.550 Third Party and Medicare Primary Claims

6-1-06

If a provider did not request MUMP certification of an inpatient stay because of apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted etc., post-certification required by the MUMP may be obtained as follows:

- A. Send a copy of the third party payer's denial notice to AFMC. [View or print AFMC contact information.](#)
 - 1. Include a written request for post-certification.
 - 2. Include complete provider contact information (full name and title, telephone number and extension).
- B. An AFMC coordinator will call the provider contact for the certification information.
- C. If a third party insurer pays the provider for an approved number of days, Medicaid will not grant an extension of days beyond the number of days approved by the private insurer.

217.110 Determining Inpatient and Outpatient Status

6-1-06

In parts A, B, C and D below, the words “deems” and “deemed” mean that Medicaid or its designee, when reviewing medical records, ascribes inpatient or outpatient status to hospital encounters based on the descriptions in this section. Deemed status is not a claim processing function; it is applied during retrospective review to determine whether a claim was submitted correctly.

- A. When a patient is expected to remain in the hospital for less than 24 consecutive hours and that expectation is realized, the patient is deemed an outpatient unless the attending physician admits him or her as an inpatient before discharge.
- B. When the attending physician expects the patient to remain in the hospital for 24 hours or longer, Medicaid deems the patient admitted at the time the patient’s medical record indicates that expectation, whether or not the physician has formally admitted the patient.
- C. Medicaid deems a patient admitted to inpatient status at the time he or she has remained in the hospital for 24 consecutive hours, whether or not the attending physician expected a stay of that duration.
- D. When a patient receives outpatient services and is subsequently admitted as an inpatient on the same date of service (whether by deemed admission or by formal admission), the patient is an inpatient for that entire date of service.

217.140 Verteporfin (Visudyne)

6-1-06

- A. Arkansas Medicaid covers Verteporfin for all ages for certain diagnoses and subject to certain conditions and documentation requirements.
- B. Coverage of Verteporfin is separate from coverage of the injection procedure (the injection procedure is covered as an outpatient surgery).
- C. The provider's medical record on file must contain documentation of an eye exam by which was made one of the following diagnoses.
 - 1. Predominantly classic subfoveal choroidal neovascularization due to age-related macular degeneration
 - 2. Pathologic myopia
 - 3. Presumed ocular histoplasmosis
- D. The lesion size determination must be included in the documentation of the exam.
 - 1. The eye or eyes to be treated by Verteporfin administration must be documented, with current visual acuity noted.
 - 2. If previous treatments with other modalities have been attempted, those attempts and outcomes must be documented as well.

250.622 Arkansas State Operated Teaching Hospital Adjustment

6-1-06

Effective May 9, 2000, Arkansas State Operated Teaching Hospitals qualify for an inpatient rate adjustment.

- A. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit.
- B. The adjustment is calculated as follows:
 1. Using the most current audited data, Arkansas Medicaid determines each State Operated Teaching Hospital's base Medicare per discharge rate and base Medicaid per-discharge rate.
 - a. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.
 - b. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
 - c. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1st of the state fiscal year (SFY) for which the adjustment payments will be made.
 2. The base per-discharge rates are trended forward to the current fiscal year using an annual Consumer Price Index inflation factor.
 3. Once the per-discharge rates have been trended forward, the Medicare per-discharge rate is divided by the Medicare case mix index and the Medicaid per-discharge rate is divided by the Medicaid case mix index.
 - a. The Medicare case mix index reflects the hospital's average diagnosis related group (DRG) weight for Medicare patients.
 - b. The Medicaid case mix index reflects the hospital's average DRG weight for Medicaid patients using the Medicare DRGs.
 4. The base Medicaid per-discharge rate is subtracted from the base Medicare per discharge rate.
 5. The difference is multiplied by the hospital's Medicaid case mix index.
 6. The adjusted difference is multiplied by the number of Medicaid discharges at the hospital for the most recent fiscal year.
 7. The result is the amount of the annual State Operated Teaching Hospital Adjustment.
 8. Payment is made on an annual basis before the end of the state fiscal year (June 30).

250.623 Private Hospital Inpatient Adjustment

10-13-03

All Arkansas private acute care and critical access hospitals (that is, all acute care and critical access hospitals within the state of Arkansas that are neither owned nor operated by state or local government), with the exception of private pediatric hospitals, qualify for a private hospital inpatient rate adjustment.

All Arkansas private inpatient psychiatric and rehabilitative hospitals (that is, all inpatient psychiatric and rehabilitative hospitals within the state of Arkansas that are neither owned nor operated by state or local government) shall also qualify for a private hospital inpatient rate adjustment.

The adjustment shall be equal to each eligible hospital's pro rata share of a funding pool, based on the hospital's Medicaid discharges. The amount of the funding pool shall be determined annually by Arkansas Medicaid, based on available funding. The adjustment shall be calculated as follows:

- A. Arkansas Medicaid shall annually determine the amount of available funding for the private hospital adjustment funding pool.
- B. For each private hospital eligible for the adjustment, Arkansas Medicaid shall determine the number of Medicaid discharges for the hospital for the most recent audited fiscal period.

1. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.
2. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
3. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1st of the state fiscal year (SFY) for which the adjustment payments will be made.
4. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

For hospitals that filed a partial year cost report for the most recently audited cost report year, such partial year cost report data shall be annualized to determine their rate adjustment, provided that such hospital was licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

For private inpatient psychiatric and rehabilitative hospitals for the SFY 2003 adjustment, discharges will be included as prorated proportional to the August 1, 2002, effective date.

- C. For each eligible private hospital, Arkansas Medicaid shall determine its pro rata percentage which shall be a fraction equal to the number of the hospital's Medicaid discharges divided by the total number of Medicaid discharges of all eligible hospitals.
- D. The amount of each eligible hospital's payment adjustment shall be its pro rata percentage multiplied by the amount of available funding for the private hospital adjustment pool determined by Arkansas Medicaid.

Arkansas shall determine the aggregate amount of Medicaid inpatient reimbursement to private hospitals. Such aggregate amount shall include all private hospital payment adjustments, other Medicaid inpatient reimbursement to private hospitals eligible for this adjustment and all Medicaid inpatient reimbursement to private hospitals not eligible for this adjustment; but this shall not include the amount of the pediatric inpatient payment adjustment. Such aggregate amount shall be compared to the Medicare-related upper payment limit for private hospitals specified in 42 C.F.R. 447.272. Respective Case Mix Indexes (CMI) shall be applied to both the base Medicare per discharge rates and base Medicaid per discharge rates for comparison to the Medicare-related upper payment limit. These case mix adjustments are necessary in order to neutralize the impact of the differential between Medicare and Medicaid patients.

To the extent that this private hospital adjustment results in payments in excess of the upper payment limit, such adjustments shall be reduced on a pro rata basis according to each hospital's Medicaid discharges. Such reduction shall be no more than the amount

necessary to ensure that aggregate Medicaid inpatient reimbursement to private hospitals is equal to but not in excess of the upper payment limit.

- E. Payment shall be made on a quarterly basis within 15 days after the end of the previous quarter. Payment for SFY 2001 shall be prorated proportional to the number of days between April 19, 2001, and June 30, 2001, to the total number of days in SFY 2001

250.624 Non-State Public Hospital Inpatient Adjustment

6-1-06

All Arkansas non-state government-owned or operated acute care and critical access hospitals (that is, all acute care and critical access government hospitals within the state of Arkansas that are neither owned nor operated by the state of Arkansas) shall qualify for a public hospital inpatient rate adjustment.

- A. The adjustment shall result in total payments to each hospital that are equal to but not in excess of the individual facility's Medicare-related upper payment limit, as prescribed in 42 CFR § 447.272. The adjustment shall be calculated as follows.
1. Using data from the hospital's most recent audited cost report, Arkansas Medicaid shall determine each eligible non-state public hospital's base Medicare per discharge rate and its base Medicaid per discharge rate
 - a. Base Medicare and Medicaid per discharge rates will include respective Case Mix Index (CMI) adjustments in order to neutralize the impact of the differential between Medicare and Medicaid case mixes.
 - b. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.
 - c. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
 - d. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1st of the state fiscal year (SFY) for which the adjustment payments will be made.
 2. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.
 3. For a hospital that, for the most recent audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine the hospital's rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year.
 4. Hospitals with partial year cost reports which were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.
- B. The base Medicare per discharge rate shall be multiplied by the applicable upper payment limit (percentage) specified in 42 CFR § 447.272 for non-state government owned or operated hospitals.
1. For example, to the extent that such federal regulation permits Medicaid payments up to 150 percent of the amount that would be paid under Medicare reimbursement principles, the base Medicare per discharge rate shall be multiplied by 150 percent.
 2. The result shall be the adjusted Medicare per discharge rate.
 3. The base Medicaid per discharge rate shall then be subtracted from the adjusted Medicare per discharge rate.

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.
- C. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

250.701 Costs Attributable to Private Room Accommodation

6-1-06

- A. The cost of a private room is allowable when the patient's attending physician certifies that a private room is medically necessary.
- B. When a Medicaid beneficiary is placed in a private room because no semi-private rooms are available, there is no difference in Medicaid cost settlement.

272.461 Verteporfin (Visudyne)

6-1-06

Verteporfin (Visudyne), HCPCS procedure code **J3396**, is payable to outpatient hospitals when furnished to Medicaid beneficiaries of any age when the requirements identified in section 217.140 are met

- A. Verteporfin administration may be billed separately from the related surgical procedure.
- B. Claims for Verteporfin administration must include one of the following ICD-9-CM diagnosis codes.
115.02 **115.12** **115.92** **360.21** **362.50** **362.52**
- C. Use anatomical modifiers to identify the eye(s) being treated.
- D. **J3396** may be billed electronically or on a paper claim.