CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

23. Developmental Rehabilitation Services

Developmental Rehabilitation Services are early intervention services that have been identified as medically necessary and included in the recipient=s Individualized Family Services Plan (IFSP). This program covers two basic services:

1. Developmental Testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report, per hour. (Limited to four (4) one hour units per calendar year.)

2. Therapeutic Activities; direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes. (Limited to two (2) 15-minute units per day, two days per week.)

Developmental Rehabilitation services may be provided in the recipient=s home, in the community, or in a clinical setting. These services require prior authorization.

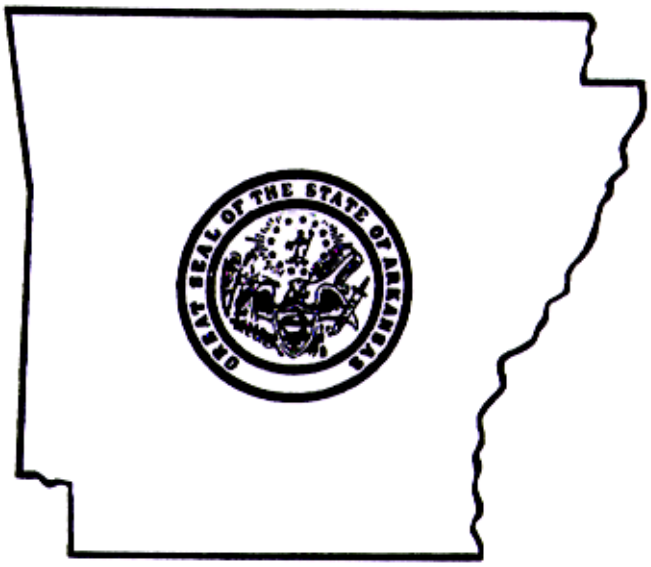
Extension of the benefit limit will be provided if medically necesssary.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

26. Developmental Rehabilitation Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. The Title XIX maximum for these services is based on the Child Health Management (CHMS) reimbursement methodology.

ARKANSAS
MEDICAID PROGRAM



DEVELOPMENTAL REHABILITATION SERVICES PROVIDER MANUAL

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EDS

100 GENERAL INFORMATION

101.000 Introduction

The purpose of Section I is to explain the role the provider plays in the Arkansas Medicaid Program. The information conveyed will provide the users with an understanding of Medicaid program policy. It also contains information the provider may need to answer questions that individuals often ask about the Medicaid Program.

When fully utilized, this manual will be an effective tool for the provider office personnel. For instance, it may serve as a tool for training billing clerks by providing them with a basic knowledge of the Medicaid Program, covered and non-covered services, special billing procedures and detailed instructions for accurate completion of claims. Proper use of this manual will result in a reduction of errors in claim filing, thus expediting payment.

The manual will be an effective tool if it is properly maintained. The fiscal agent, EDS, will mail each provider all manual updates when produced. These updates should be promptly filed in the manual according to the procedures discussed in Section 101.100. Information that has not yet been incorporated into this manual is issued via Official Notices and Remittance Advice (RA) messages. Official Notices and RAs are filed in the back of this manual.

All manuals, Official Notices and RAs are also available for downloading, without charge, from the Medicaid Home Page Web Site at ***www.medicaid.state.ar.us***. These documents are maintained in separate folders on the Web Site. Downloading all three sets of documents for the program in question will ensure the provider of having the most current policy information available.

Three major areas are covered in Section I.

A. General Information about the Program - This area contains information regarding the background and history of the Medicaid Program, method of program operation, eligibility for Medicaid benefits, the Medicaid ID card and a brief discussion of specific Medicaid information.

B. Provider Participation - This area provides data regarding provider enrollment, the conditions that must be met by providers to begin and to maintain participation in the program and the remedies and sanctions available in administering the Medicaid Program.

C. Primary Care Physician (PCP) Managed Care Program - This area defines the scope of the PCP program, physician participation, required recipient participation and selection of a PCP. It includes information regarding services and categories of eligibility that are exempt from PCP referral requirements.

101.100 Updates

The manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. These changes are released to the provider in the form of a manual update, an Official Notice or an RA (remittance advice) message. The fiscal agent, EDS, will issue these changes as directed by the Division of Medical Services (DMS). Periodically, all changes made to Medicaid policy will be promulgated and incorporated into each Medicaid provider manual as policy.

An update transmittal letter will accompany each update to this manual. Updates will have sequential identification numbers assigned, e.g., Update Transmittal #1. The transmittal letter identifies the new page numbers to be added and/or the pages to be replaced and provides any other information about the update being made. An Update Control Log has been provided in the back of the manual to record updates received. When an update package is received, the updated manual pages should be filed in the provider manual, removing the pages being revised. The effective date should be entered on the Update Control Log opposite the appropriate update number. When the update is complete, the transmittal letter should be filed immediately after the update control log in ascending sequence by update number.

Effective for dates of service on or after July 1, 1999, extra copies of paper manuals, manual updates and official notices may be purchased through EDS. EDS will charge $32.50 per manual. There will be an annual charge of $35.00 for manual updates and official notices. The cost for a provider manual with updates/official notices will be $67.50. Requests for manuals, updates and official notices may be sent to **EDS, Manual Order, PO Box 8036, Little Rock, AR 72203-8036.**

All manuals, manual updates, Official Notices and RAs are available for downloading, without charge, from the Arkansas Medicaid Home Page Web Site at ***www.medicaid.state.ar.us***.

102 Legal Basis of the Program

Section 7 of Act 280 of 1939 and Act 416 of 1977 gave authority to the State of Arkansas, the Division of Social Services, now referred to as the Department of Human Services, to establish and maintain a medical care program for the indigent. It also gave authority to the Commissioner of Social Services, now called the Director of the Department of Human Services, to set forth and administer the rules and regulations necessary to carry out such a program. Out of this legislation, the Arkansas Medical Assistance Program was formed.

Title XIX of the Social Security Act provides for federal grants to the states for their medical assistance programs. Originally enacted by the Social Security Amendments of 1965 and Public Law 89-97, Title XIX was approved on July 30, 1965. Although officially entitled "Grants to States for Medical Assistance Programs," this title is popularly called "Medicaid." The stated purpose of Title XIX is to enable the states to furnish the following:

A. Medical assistance to families with dependent children and to the aged, blind or permanently and totally disabled, the medically needy and children under 18 whose income and resources are insufficient to meet the costs of necessary medical services.

B. Rehabilitation and other services to help these families and individuals attain or retain the capability for independence or self-care.

102 Legal Basis of the Program (Continued)

Thus, the Medicaid Program is a joint federal-state program that provides necessary medical services to eligible persons who would not be able to pay for such services.

In Arkansas, the Division of Medical Services administers the program and is responsible for all parts of the program. Within the Division, the Office of Long Term Care is responsible for nursing homes.

103 Scope of Program

The Arkansas Medicaid Program provides, with limitations, the following services:

Federally Mandated Services

* Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Persons Under Age 21 (Child Health Services)
* Family Planning Services
* Federally Qualified Health Center (FQHC) Services
* Home Health Services
* Inpatient Hospital Services
* Laboratory and X-Ray Services
* Nurse-Midwife Services
* Nurse Practitioner Services
* Nursing Facility Services for Individuals Age 21 or Older who are categorically eligible (e.g., Aid to the Aged, Blind or Disabled)
* Outpatient Hospital Services
* Physician Services
* Rural Health Clinic Services

Optional Services

* Ambulatory Surgical Center Services
* Audiological Services (Arkansas Medicaid limits this service to persons under 21 in the Child Health Services (EPSDT) Program)
* Targeted Case Management for Pregnant Women
* Targeted Case Management Services for Adults with a Developmental Disability
* Targeted Case Management Services for Recipients Age 60 and Older
* Certified Registered Nurse Anesthetist (CRNA)
* Child Health Management Services (Arkansas Medicaid limits this service to persons under 21 in the Child Health Services (EPSDT) Program)
* Chiropractic Services
* Dental Services (Arkansas Medicaid limits this service to persons under 21 in the Child Health Services (EPSDT) Program)
* Developmental Day Treatment Clinic Services (DDTCS)
* Domiciliary Care Services
* Durable Medical Equipment

103 Scope of Program (Continued)

Optional Services (Continued)

* End-Stage Renal Disease (ESRD) Facility Services
* Hyperalimentation Services
* Hospice Services
* Inpatient Psychiatric Services for Individuals Under Age 21
* Inpatient Rehabilitative Hospital Services
* Intermediate Care Facility Services for Mentally Retarded
* Medical Supplies
* Nursing Facility Services for patients under 21 years of age
* Occupational, Physical, Speech Therapy Services (Arkansas Medicaid limits this service to persons under 21 in the Child Health Services (EPSDT) Program)
* Personal Care Services
* Podiatrist Services
* Portable X-Ray Services
* Private Duty Nursing Services (for Ventilator-Dependent of all ages and High-Technology Non-Ventilator Dependent for persons under 21 in the Child Health Services (EPSDT) Program)
* Prescription Drugs
* Psychologist Services (Arkansas Medicaid limits this service to persons under 21 in the Child Health Services (EPSDT) Program)
* Rehabilitative Services for Persons with Mental Illness (RSPMI)
* Rehabilitative Services for Persons with Physical Disabilities (RSPD)
* Transportation Services (Ambulance, Non-Public)
* Ventilator Equipment
* Visual Services

103.1 Services Available through the Child Health Services (EPSDT) Program

The following Medicaid covered services are available for recipients under age 21 through the Child Health Services (EPSDT) Program:

* Eye Prostheses
* Repairs and Replacements of Eyeglasses
* Hearing Aid Services
  - Medical Clearance
  - Audiological Exam
  - Purchase of Hearing Aid
* Immunizations
* Allergy/Desensitization Injections and Antigens
* Child Health Management Services
* Inpatient Psychiatric Care
* Cochlear Implantation
* Durable Medical Equipment (DME), e.g. specialized wheelchairs
* Psychology Services
* Chiropractic Services
* Occupational, Physical, Speech Therapy Services

103.1 Services Available through the Child Health Services (EPSDT) Program (Continued)

Additional services may be covered if determined to be medically necessary as a result of a Child Health Services (EPSDT) screening/referral. These services include, but are not limited to:

* Targeted Case Management Services for Recipients Under the Age of 21
* Orthotic Appliances
* Prosthetic Devices
* Respiratory Care Services

The Division of Medical Services (DMS) encourages all Medicaid providers to participate in providing Child Health Services (EPSDT) screening services to eligible Medicaid recipients. DMS provides patient outreach, including assistance in scheduling screening appointments and providing transportation for the recipients to all providers' offices. Except in certain counties that require a primary care physician (PCP) referral, recipients have **freedom of choice** in selecting a provider for screening services. To make certain this occurs, all local county offices will be given lists of providers who have agreed to accept referrals and provide Child Health Services (EPSDT) screenings. This list will be updated as additions, deletions and address and/or telephone number changes occur. Information regarding PCP referrals is located in Sections 180 through 187. The list of counties requiring a PCP referral is located in Section 184.

A complete screening package includes the following components as appropriate for the age and sex of the child:

1. Comprehensive Health and Developmental History (including assessment of both physical and mental health development)
2. Comprehensive Unclothed Physical Exam
3. Vision Assessment
4. Hearing Assessment
5. Oral Assessment
6. Laboratory procedures appropriate for age and population groups (i.e., anemia, lead toxicity)
7. Appropriate Immunizations according to age and health history
8. Health Education

All of the components listed above are required for a complete Child Health Services (EPSDT) medical screen. The tests and procedures used in screening are intended to be quick, inexpensive and easy to administer. They are not necessarily intended to provide conclusive proof of a problem or abnormality, only the indication that one may exist.

Cases, in which problems or abnormalities are indicated, should be referred for diagnosis. If the child is receiving care from a participating Child Health Services (EPSDT) Medicaid provider, then screening, diagnosis and treatment may be provided by that same practitioner.

103.1 Services Available through the Child Health Services (EPSDT) Program (Continued)

Providers billing Medicaid for diagnosis or treatment must certify that their services result from a Child Health Services (EPSDT) screening or referral. The certification is a matter of entering "Y" in the "EPSDT Indicator" field in the AEVCS format. Field numbers (#s) and valid values for each claim type/provider type are:

1. HCFA-1500 (12-90) claim form - Field 24H - Enter an "E" in this field if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
   AEVCS - Enter an "E" in Field HCS0640.

2. Dental (ADA) claim form - Field 2 - Enter an "X" under the word "Child."
   AEVCS - Enter "Y" or "N" in Field DES0120.

3. Visual (SS-26V) claim form - Field 9 - Enter an "X" in "Y" or "N."
   AEVCS - Enter "Y" or "N" in Field VIS0140.

4. UB-92 claim form - Enter code "A1" in one of the form locators 35-39.
   AEVCS - Enter "A1" in Field IPS0420.

Individuals interested in providing Child Health Services (EPSDT) screening services or receiving more information, may call (501) 682-8297 or 1-800-482-1141.

103.2 Services Available through Home and Community Based 2176 Waivers

The following services are available for eligible recipients through Medicaid Home and Community Based 2176 Waivers:

1. ElderChoices Home and Community Based 2176 Waiver

ElderChoices has been designed for individuals age 65 and over, who, without the services, would require an intermediate level of care in a nursing home. The services listed below are designed to maintain Medicaid eligible individuals at home in order to preclude or postpone institutionalization.

1. Adult Foster Care
2. Homemaker Services
3. Chore Services
4. Home Delivered Meals
5. Personal Emergency Response System
6. Adult Day Care
7. Adult Day Health Care
8. Respite Care

ElderChoices eligibility requires a determination of categorical eligibility, a level of care determination, the development of a plan of care, a cost comparison to determine the cost-effectiveness of the plan of care and notification of a choice between home and community-based services and institutional services.

More detailed information may be found in the ElderChoices manual.

2. DDS Alternative Community Services (ACS) 2176 Waiver

The Developmental Disability Services Alternative Community Services (DDS-ACS) waiver has been designed for individuals who, without the services, would require institutionalization and could not otherwise reside in the community. Individuals eligible for the services must not be residents of a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF/MR).

DDS-ACS eligibility requires a determination of categorical eligibility, a level of care determination, the development of a plan of care, a cost comparison to determine the cost-effectiveness of the plan of care and notification of a choice between home and community-based services and institutional services.

103.2 Services Available through Home and Community Based 2176 Waivers (Continued)

2. DDS Alternative Community Services (ACS) 2176 Waiver (Continued)

Services supplied through this program are:

1. Case Management
2. Respite Care
3. In-Home Services (personal care, homemaker services, residential habilitation)
4. Day Habilitation Services
5. Consultation Services
6. Alternative Living Services (supportive living, specialized family care for children)
7. Non-Medical Transportation
8. Physical Adaptations/Adaptive Aids

More detailed information may be found in the DDS-ACS manual.

3. Alternatives for Adults with Physical Disabilities Waiver

The Alternatives for Adults with Physical Disabilities (APD) Waiver has been designed for disabled individuals age 21 through 64, who receive Supplemental Security Income, or are Medicaid eligible by virtue of their disability and who, without the provision of the services, would require a nursing facility level of care.

APD eligibility requires a determination of categorical eligibility, a level of care determination, the development of a plan of care, a cost comparison to determine the cost-effectiveness of the plan of care and notification of a choice between home and community-based services and institutional services.

The services offered through the waiver are:

1. Environmental Adaptations
2. Attendant Care

More detailed information may be found in the APD manual.

103.3 Services Available through 1915(b) Waivers

The following services are available for eligible recipients through Medicaid 1915(b) waivers:

A. Primary Care Physician (PCP) Managed Care Program

In the Primary Care Physician Managed Care Program, a Medicaid recipient chooses a physician or single-entity provider who is responsible for the management of the recipient's total health care. The primary care physician provides primary care services, health education and referrals to other needed medical services when necessary. The PCP also coordinates and monitors prescribed medical and rehabilitation services on behalf of the recipient.

More detailed information, including exemptions in the PCP Program, may be found in Sections 180 through 187 of this manual.

B. Non-Emergency Transportation Services (NET)

The Medicaid Non-Emergency Transportation (NET) Waiver Services for Medicaid recipients have been established statewide. The program requires Medicaid recipients to contact a local transportation broker to obtain non-emergency transportation for appointments to Medicaid covered services. Transportation brokers are individuals who have contracted with the Division of Medical Services (DMS) to supply the non-emergency transportation (NET) services. The NET broker must provide transportation to and from medical providers for Medicaid covered services.

Transportation providers for the Developmentally Disabled (DD) population may choose to provide services for the Developmentally Disabled population as a fee-for-service provider for transportation to and from a Developmental Day Treatment Clinic Service (DDTCS) facility or contract with the transportation broker in their region to provide non-emergency transportation services. The broker must provide transportation to and from medical providers for Medicaid covered services. Active Children's Medical Services (CMS) recipients may still use CMS vans for transportation.

The Arkansas Medicaid Non-Emergency Transportation Waiver Program does not include services for Nursing Facility residents, Intermediate Care Facilities for Mentally Retarded (ICF-MR) residents, Qualified Medicare Beneficiaries (QMBs), Special Low Income Qualified Medicare Beneficiaries (SMBs), Qualifying Individuals-1s and 2s (QI-1s and 2s), ARKids First participants or Family Planning Waiver recipients.

More detailed information may be found in the Transportation manual and on the Arkansas Medicaid Home Page at ***www.medicaid.state.ar.us***.

103.4 Services Available through 1115 Research and Demonstration Waiver Programs

The following services are available for eligible individuals through 1115 Research and Demonstration Waiver Programs:

A. ARKids First

ARKids First was designed to integrate uninsured children, age 18 and under, into the health care system. ARKids First benefits are comparable to those of State employees/Teachers insurance program.

ARKids First providers must be enrolled in the Arkansas Medicaid Program.

Eligibility criteria for ARKids First are:

1. Family income must be at or below 200% of the Federal Poverty Level (FPL).
2. Applicants must be age 18 and under.
3. Applicants must have had no health insurance that covers comprehensive medical services, other than Medicaid, within the preceding 12 months (unless insurance coverage was lost through no fault of the applicant).

ARKids First participants are required to select a Primary Care Physician at the time of application.

For more information, refer to the ARKids First provider manual and to the Arkansas Medicaid Home Page at ***www.medicaid.state.ar.us***.

B. Family Planning Demonstration Waiver

The Arkansas Department of Human Services, in collaboration with the Arkansas Department of Health, established the Family Planning demonstration Waiver Program (Category 69). Eligibility for the program is limited to women of childbearing age who are not currently certified in any other Medicaid category. The target population is women age 14 to age 44, but all women at risk of unintended pregnancy will be allowed to apply for the program. The family income must be at or below 133% of the Federal Poverty Level.

Recipients are not required to have a photo Medicaid identification card. Their Medicaid coverage entitles them to only family planning services with the provider of their choice. They are not required to select a Primary Care Physician (PCP).

Eligible Family Planning Waiver Services recipients remain Medicaid-eligible for the duration of the five year waiver, implemented September 1, 1997, with no reevaluation or change-in-status reporting requirements. Loss of eligibility will occur only when a woman moves from the state, becomes Medicaid eligible in another aid category, becomes pregnant, or requests that her case be closed.

104.000 Utilization Review

The Utilization Review Section of the Arkansas Medicaid Program has the responsibility for assuring quality medical care for its recipients along with protecting the integrity of both state and federal funds supporting the Medical Assistance Program. The tasks of the Utilization Review Section are mandated by federal regulations. To realize completion of the tasks assigned, a system has been developed which retrospectively evaluates medical practice patterns by comparing each provider's pattern to norms and limits set by all providers of the same specialty. This system utilizes the information that appears on the Medicaid claim. Utilization Review reports are then printed for all providers who exceed the norms or limits established by their peers. The staff evaluating these computerized reports are experienced medical review analysts who work under the direction of the Medicaid Program's Medical Director, and who have access to the expertise of a Peer Review Committee plus a full complement of specialty consultants on an as-needed basis.

Review analysts may, from time to time, contact a provider to supply the provider with information from these reports as well as to request additional information regarding their medical practice. The provider's cooperation in responding to these contacts will allow for greater accuracy in evaluation.

The Utilization Review Section is also responsible for conducting on-site medical audits for the purpose of verifying the nature and extent of services paid for by the Medicaid Program. This section is responsible for researching all inquiries from recipients in response to the Explanation of Medicaid Benefits (EOMB) and for approving requests for procedures requiring prior authorization.

Providers to be reviewed on-site are selected based on Surveillance and Utilization Review Subsystem (SURS) exceptions (the peer weighted computerized program), random sample selection and community referrals. Providers selected for an on-site audit will not be notified in advance.

Providers are reminded that pertinent records concerning the provision of Medicaid covered health care services are to be made available during regular business hours to all Division of Medical Services staff acting within the scope and course of their employment. Pertinent records are also to be made available to the Division's contractual review organization, i.e. Arkansas Foundation for Medical Care, Inc./Professional Review Organization (AFMC/PRO). All Medicaid providers are required to keep and maintain records that fully disclose the type and extent of services provided to an Arkansas Medicaid recipient. The nature of the reviews will be to primarily review documentation for services provided, but will, at certain times, be used to evaluate the medical necessity of the delivered services in the view of the professional staff and consultants of the Medicaid Program.

When records are stored off-premise or in active use, the audited provider may certify, in writing, that the records in question are in active use or off-premise storage and set a date and hour within three (3) working days, at which time the records will be available. However, the audited provider will not be allowed to delay production for matters of convenience, including availability of personnel.

104.100 Utilization Review Recoupment Process

The Utilization Review Section is responsible for recovering Medicaid funds from providers when necessary. Situations resulting in recoupment include, but are not limited to, the following:

A. When duplicate payments are made.

B. When Professional Review Organization (PRO) denies all or part of a hospital admission.

C. When medical consultants to the Medicaid Program determine lack of medical necessity.

D. When Medicaid, Medicare or the Attorney General's Medicaid Fraud Unit discovers evidence of overpayment.

E. When documentation of a billed service is inadequate or non-existent.

When recoupment is deemed appropriate, Utilization Review forwards an Explanation of Recoupment to the provider. This explanation includes the name(s) of the patient(s), date(s) of service, date(s) of payment and the reason for the repayment request. Upon receipt of this notice, the provider has thirty days to forward a check for the refund amount or advise the Utilization Review Section of their wish to appeal the recoupment action. Failure to respond to the recoupment notice will result in the recoupment amount being deducted from future Medicaid reimbursement.

104.200 Recoupment Appeal Process

Upon receipt of an Explanation of Recoupment, the provider has thirty (30) days in which to supply written notice of appeal. The appeal process is fully explained in the letter that accompanies the Explanation of Recoupment. In brief, the process is as follows:

A. PRO Denials- In situations where the PRO agent, Arkansas Foundation for Medical Care, Inc. (AFMC), denies all or part of a hospital admission, the Utilization Review Section recoups any Medicaid funds expended in connection with those services. In these situations, all appeals should be directed to AFMC, in writing, within thirty days of receiving the denial by AFMC.

B. Utilization Review Denials- Denials by utilization review result from two instances: (1) failure to comply with administrative policy or (2) lack of documented medical necessity or adequate justification.

1. Administrative policy denials- Denials resulting from failure to comply with administrative policy are not subject to appeal by the provider.

104.200 Recoupment Appeal Process (Continued)

2. Lack of medical necessity or adequate justification denials- Denials resulting from a lack of medical necessity or adequate justification are determined by the appropriate Medicaid Program consultant. The provider is entitled to submit any documentation to the Utilization Review Section refuting the stated reason for recoupment. The appeal and related documentation will be reviewed by the Medical Director and/or the appropriate Medicaid program consultant(s). In the event the original decision is upheld, the provider will be notified in writing. If a further appeal is desired, the Utilization Review Section must receive the written request within thirty days of the provider's notification of the review decision. If desired, the provider may request an appeal of the action before the appropriate peer review committee's next scheduled meeting. These committees are composed of the executive officers of the appropriate professional organization, e.g., the Arkansas Medical Society, the Arkansas Dental Association, the Arkansas Optometric Association, etc. The committee will review all submitted documentation and make a recommendation to the Medicaid Program regarding the service in question. The Medicaid Program will advise the provider of its decision once the recommendation has been received and considered.

105 Recipient Education/Restriction

An eligible recipient who abuses his program benefits may be required to participate in a recipient education/restriction program. Abusive patterns exhibited include pharmacy "shopping" for drugs. Caseworkers will be used on the local level to provide individual counseling on proper use of Medicaid benefits. Continued abuse of Medicaid services after the counseling sessions may result in restriction to only one of each of the provider type(s) abused.

In cases of provider restriction, the eligible recipient will select one provider, for example, one pharmacy provider. The provider selected will be notified prior to the actual "lock-in," so adequate time is allowed for selection of another provider should the first provider find he cannot provide the needed services.

When a recipient is involved in restriction, the eligibility verification transaction will reflect "lock-in to other provider." The restriction will be removed after demonstration by the recipient that the abusive situation has been corrected.

Every effort will be made to provide adequate utilization control procedures before recipient restriction becomes necessary. When this step becomes essential, the cooperation of all providers will be necessary to make this an effective method of curbing over-utilization. Any provider who believes a particular recipient should be a candidate for recipient education or provider restriction should notify the Utilization Review Section, Division of Medical Services, by calling (501) 682-8334.

110 SOURCES OF INFORMATION

111 Provider Enrollment Unit

Any questions regarding provider enrollment, participation requirements and/or contracts should be directed to this unit. Their office may be contacted at (501) 682-8502 or 1-800-482-1141 (In-State WATS).

112 Provider Relations and Claims Processing Contractor

EDS, a contractor, performs provider relations and the processing of Medicaid claims. EDS Provider Representatives are available to assist providers with detailed billing or policy questions and to schedule on-site technical assistance with AEVCS and NECS software. To contact a representative, providers may call the Provider Assistance Center at 1-800-457-4454 (In-State WATS) or (501) 376-2211 (local or out-of-state). Representatives can be reached directly by calling (501) 374-6609.

113 Children's Medical Services (CMS)

Children's Medical Services (CMS) assists providers with questions regarding prior authorization of services for individuals under age 21 in several programs. The programs involved are Targeted Case Management, Personal Care, Private Duty Nursing and Occupational, Physical and Speech Therapy and for certain prosthetic items in the Prosthetics program. They assist providers with questions regarding extension of benefits for the Prosthetics program, the Personal Care and Private Duty Nursing programs and with supplies in the Home Health program. The community based CMS nurse is responsible for prior authorizations. Providers may call (501) 682-2277, (501) 682-2270 or 1-800-482-5850, extension 22277. Extension 22270 may be utilized to obtain the telephone number for the community based organization for a specific child. CMS Central Office may be contacted by FAX at (501) 682-8247 or (501) 682-1779.

114 Utilization Review

The Utilization Review Section of the Division of Medical Services is available to assist providers with questions regarding extension of benefits and prior authorization of services for individuals age 21 and over, and for specified services for individuals under age 21, with the exception of prescription drug prior authorizations. Utilization Review may be contacted directly by calling (501) 682-8340. Providers may call 1-800-482-1141 (toll free within Arkansas) and leave a message. The call will be returned as soon as possible. The Personal Care, Inpatient Psychiatric and Home Health Units are sections within Utilization Review. The Arkansas Foundation for Medical Care, Inc. performs medical/surgical prior authorizations. AFMC's telephone numbers are: (501) 649-8501 for general questions, for procedure precertification and length of stay review (MUMP), 1-800-426-2234 for In-State and Out-of-State, and (501) 649-0715 in the Fort Smith area.

115 Customer Assistance

Customer Assistance, a Section of the Division of County Operations, investigates recipient inquiries regarding Medicaid eligibility and I.D. card inquiries. Recipients may call 1-800-482-8988 toll free, or TDD 1-501-682-8275.

116 Americans with Disabilities Act

Any materials needed in an alternate format, such as large print, can be obtained by contacting the Americans with Disabilities Act Coordinator at (501) 682-8365 (voice) or (501) 682-6789 (TDD).

117 Program Communications Unit

This unit responds to Medicaid recipient inquiries regarding Medicaid coverage and benefits, assists out-of-state providers with claim filing procedures, verifies recipient eligibility, and maintains recipient correspondence files. Recipients may contact this unit at 1-800-482-5431 (In-State WATS) or (501) 682-8502. Providers may contact this unit at (501) 682-8502, 1-800-482-1141 (In-State WATS) or 1-800-482-5850, extension 28502 (Out-of-State WATS).

118 Dental and Visual Care Units

The Dental Coordinator assists providers with questions regarding dental services. The Dental Coordinator may be contacted directly by calling (501) 682-8336, (501) 682-8332 or (501) 682-8502.

The Visual Care Coordinator assists providers with questions regarding visual care services. The Visual Care Coordinator may be contacted directly by calling (501) 682-8342 or (501) 682-8502.

Providers may also reach the Dental and Visual Care Units by calling In-State WATS 1-800-482-1141 or Out-of-State WATS 1-800-482-5850, Ext. 28502.

119 Accessibility

EDS, the fiscal agent, has a Provider Assistance Center that is available for billing questions and can be reached at (501) 376-2211 or In-State WATS 1-800-457-4454 between the hours of 8:00 AM and 4:30 PM, Monday through Friday except for the following holidays:

New Year's Day
Good Friday
Memorial Day
Independence Day
Labor Day
Thanksgiving Day and Friday after
Christmas Eve and Christmas Day

The State's Program Communications Unit is available to answer providers' questions and direct their telephone calls at (501) 682-8502, In-State WATS 1-800-482-1141 or Out-of-State WATS 1-800-482-5850, ext. 28502, Monday through Friday from 8:00 AM through 4:30 PM, except for the following holidays:

New Year's Day
Martin Luther King, Jr. Day
President's Day
Memorial Day
Independence Day
Labor Day
Veterans Day
Thanksgiving Day (and Friday after*)
Christmas Eve and Christmas Day
* given at the Governor's discretion

120 RECIPIENT ELIGIBILITY

121 Introduction

The Department of Human Services (DHS) County Office or the District Social Security Office determines recipient eligibility certification. The category of aid each office is responsible for is described below.

122 Department of Human Services County Offices

Family Support Specialists in the DHS County Offices have the responsibility of evaluating the circumstances of an individual or family to determine the proper category through which aid should be received. The Medicaid recipient aid categories are listed in Section 136 of this manual.

After evaluation, the DHS County Office establishes Medicaid eligibility dates in accordance with State and Federal policy and regulations.

123 District Social Security Offices

Social Security Representatives have the responsibility of evaluating an individual's circumstances to determine eligibility for the Supplementary Security Income (SSI) program administered by the Social Security Administration. The following are SSI aid categories:

1. Aged
2. Blind
3. Disabled

SSI entitlement also establishes Medicaid eligibility.

124 Date Specific Medicaid Eligibility

Recipient eligibility in the Arkansas Medicaid Program is date specific. Medicaid eligibility may begin or end on any day of a month. An AEVCS eligibility verification transaction response displays the current eligibility period through the date of the inquiry.

125 Retroactive Medicaid Eligibility

Medicaid recipients may be eligible for Medicaid benefits for the three-month period prior to the date of application when eligibility requirements for that three-month period are met. The DHS County Office establishes retroactive eligibility.

130 MEDICAID IDENTIFICATION CARD

131 Explanation of Medicaid Identification Card

Medicaid recipients are issued a magnetic identification card similar to a credit card. Each identification card displays a hologram, and for most Medicaid categories, a picture of the recipient. Children under the age of five and nursing home/waiver recipients are not pictured. New recipients of the Family Planning Wavier (Category 69) are not pictured unless they were certified using an existing case number and have a previously issued photo ID card. The Division of County Operations issues the Medicaid identification card to Medicaid recipients. **THE MEDICAID IDENTIFICATION CARD DOES NOT GUARANTEE ELIGIBILITY FOR A RECIPIENT.** Payment is subject to verification of recipient eligibility at the time services are provided. The eligibility transaction is accomplished at the point-of-sale (POS) device by swiping the card and performing a few simple keystrokes. If the recipient does not have a Medicaid ID card, the Medicaid identification number can be typed in. This will require a point-of-sale (POS) device, EDS supplied software for a personal computer (PC) or an office management system modified to process an eligibility verification transaction. Refer to Section 133 for verification of recipient eligibility procedures, and to Section 301 for additional POS device information.

The following is an explanation of information contained on a Medicaid ID card:

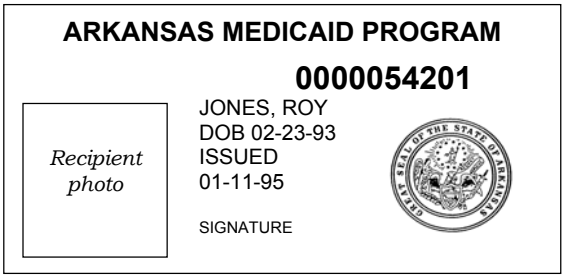
1. IDENTIFICATION NUMBER - A unique ten-digit number assigned to each individual Medicaid recipient by the Arkansas Division of County Operations.

2. NAME OF ELIGIBLE RECIPIENT - Identifies the name of the recipient who is eligible to receive Medicaid benefits. This card reflects the recipient's name at time of issuance.

3. BIRTH DATE - MONTH/DAY/YEAR - This date represents the month, day and year of birth of the recipient listed.

4. DATE OF ISSUANCE - This date represents the month, day and year the card was issued to the recipient.

5. SIGNATURE - This is the signature of the recipient named on the I.D. card.



NOTE: ARKids First identification cards have a different appearance than the Medicaid identification card. See pages I-3 and I-4 of the ARKids First Manual for more information.

132 Non-Receipt or Loss of Card by Recipient

When recipients report non-receipt or loss of a Medicaid card, refer the recipients to the local DHS County Office or the Division of County Operations, Customer Assistance, at its toll free number 1-800-482-8988 or TDD 1-501-682-8275. To receive a photo ID, the recipient must go to the Revenue Office or DHS County Office two days after approval notification by the DHS County Office.

133 Verification of Eligibility

The Division of Medical Services has implemented the Automated Eligibility Verification and Claims Submission (AEVCS) technology. With AEVCS, Medicaid providers are able to verify a patient's Medicaid eligibility for a specific date or range of dates, including retroactive eligibility for the past year. Providers may obtain other useful information, such as the status of benefits used during the current fiscal year, other insurance or Medicare coverage, etc. See Section III of this manual for further information on AEVCS.

EDS and the Division of Medical Services (DMS) will verify Medicaid eligibility by telephone only for "Limited Services Providers" (see Section II) in non-bordering states and in the case of retroactive eligibility with dates of service one year prior to card issuance.

134 (Reserved)

135 Reporting Suspected Misuse of I.D. Card

When a provider suspects misuse of a Medicaid Identification Card, the provider should contact the Utilization Review Section of Arkansas Division of Medical Services by calling 1-800-482-1141 toll free or (501) 682-8218. An investigation will then be made.

136 Medicaid Recipient Aid Categories

The following is a list of recipient aid categories. As categories of eligibility are added or deleted, providers will be notified.

Category	Description	
01 AK	ARKids First	AK-No Grant
11 AA	Aid to the Aged	AA-No Grant
13 AI	Aged SSI Individual	AA-Grant
14 AS	Aged SSI Spouse	AA-Grant
16 AA-EC	Aged Exceptional Category	AA-MN
17 AA-SD	Aged Spend Down	AA-MN
18 AA-QMB	Aged Qualified Medicare Beneficiary (QMB)	AA-No Grant
20 TEA	Transitional Employment Assistance Grant and/or Medicaid	TEA-Grant TEA-No Grant
25 TM	Transitional Medicaid	AFDC-No Grant
26 AFDC-EC	AFDC Exceptional Category	AFDC-MN
27 AFDC-SD	AFDC Spend Down	AFDC-MN
31 AB	Aid to the Blind	AB-No Grant
33 BI	Blind SSI Individual	AB-Grant
34 BS	Blind SSI Spouse	AB-Grant
35 BC	Blind SSI Child	AB-Grant
36 AB-EC	Blind Exceptional Category	AB-MN
37 AB-SD	Blind Spend Down	AB-MN
38 AB-QMB	Blind Qualified Medicare Beneficiary (QMB)	AA-No Grant
41 AD	Aid to the Disabled	AD-No Grant
43 DI	Disabled SSI Individual	AD-Grant
44 DS	Disabled SSI Spouse	AD-Grant
45 DC	Disabled SSI Child	AD-Grant
46 AD-EC	Disabled Exceptional Category	AD-MN
47 AD-SD	Disabled Spend Down	AD-MN
48 AD-QMB	Disabled Qualified Medicare Beneficiary (QMB)	AD-No Grant
49 TEFRA	Disabled TEFRA Child	AD-No Grant
51 U-18	Under Age 18 No Grant	U-18-No Grant
52 NB	Newborn	NB-No Grant
56 U-18 EC	Under Age 18 Exceptional Category	U-18-MN
57 U-18 SD	Under Age 18 Spend Down	U-18-MN
58 QI-1	Qualifying Individual - 1	QI-1
61 PW-PL	Pregnant Women Infants & Children Poverty Level (SOBRA)	PW-No Grant
62 PW-PE	Pregnant Women Presumptive Eligibility	PW-No Grant
63 PW-NB	SOBRA Newborn	PW-No Grant
65 PW-NG	Pregnant Women No Grant	PW-No Grant
66 PW-EC	Pregnant Women Exceptional Category	PW-MN
67 PW-SD	Pregnant Women Spend Down	PW-MN
69 FP	Family Planning Waiver	FP-W

136 Medicaid Recipient Aid Categories (Continued)

Category	Description	
76 UP-EC	Unemployed Parent Exceptional Category	UP-MN
77 UP-SD	Unemployed Parent Spend Down	UP-MN
78 QI-2	Qualifying Individual - 2	QI-2
80 RRP-GR	Refugee Resettlement Grant	RRP-Grant
81 RRP-NG	Refugee Resettlement No Grant	RRP-No Grant
86 RRP-EC	Refugee Resettlement Exceptional Category	RRP-MN
87 RRP-SD	Refugee Resettlement Spend Down	RRP-MN
88 SMB	Specified Low Income Qualified Medicare Beneficiary (SMB)	SMB
91 FC	Foster Care	FC-No Grant
92 IV-E-FC	IV-E Foster Care	FC-No Grant
96 FC-EC	Foster Care Exceptional Category	FC-MN
97 FC-SD	Foster Care Spend Down	FC-MN

136.1 Waiver Eligibility - Home and Community Based Waivers

The Health Care Financing Administration (HCFA) permits states to cover a number of home and community-based services to individuals who would otherwise reside in nursing homes. To allow this coverage, HCFA waives the regulation requiring actual residence in a nursing facility as a prerequisite for Medicaid eligibility. The Medicaid Program refers to these home and community-based programs as "waiver" programs. There are a number of waivers available to states, each with its own guidelines and restrictions and each having special recipient eligibility restrictions for services.

Individuals eligible for Medicaid under a waiver program have in their Medicaid eligibility file a waiver indicator. The indicator appears on the AEVCS eligibility verification transaction response after the words "WAIVER ELIGIBLE." When a recipient's eligibility file contains a waiver indicator, denoting participation in a home and community-based waiver, that recipient is eligible for only the Medicaid-covered services listed in their plan of care. A nurse or other professional manages the recipient's case and maintains their plan of care. The case manager lists in the plan of care all medical services the client is to receive, whether or not Medicaid covers the services.

A written individual plan of care for each participating recipient is an absolute requirement of a home and community-based waiver. The plan of care must include an assessment of the patient to determine the services necessary to prevent institutionalization. It must also list the medical and other services the patient will require, as well as the frequency of each service and the type of provider to furnish the service. The patient may choose the provider of each service from among those available.

When a Medicaid recipient participates in a home and community-based waiver program, Medicaid reimburses providers for only those Medicaid-covered services listed in the participant's plan of care. Medicaid providers must document in the waiver program participant's record that all services rendered are part of the participant's plan of care. Medicaid will recoup payments for services not listed in the plan of care.

136.1 Waiver Eligibility - Home and Community Based Waivers (Continued)

Medicaid requires waiver program clients to choose a primary care physician (PCP). See Section 180 for complete information regarding the Primary Care Physician Managed Care Program.

137 Point of Sale Device Eligibility Verification Transaction Format

The following shows the descriptions and values for each of the fields associated with an eligibility verification request transaction.

Field #	Field Name	Values/Comments	Required Field
EVS0010	Transaction Code	Code associated with type of transaction. "AREV"	Yes
EVS0020	Software Version	"00"	Yes
EVS0030	Terminal ID	Number that identifies the user's terminal. EDS will assign this number at the time of testing and certification.	Yes
EVS0040	Filler	Not Used	
EVS0050	Filler	Not Used	
EVS0060	Transaction Type	Number to identify the type of transaction sent. "00" = Eligibility Verification	
EVS0070	Filler	Not Used	
EVS0080	Pay To Provider Number	Provider's Medicaid ID Number 9 digit numeric i.e., 100000001.	Yes
EVS0090	Filler	Not Used	
EVS0100	Recipient ID	Recipient's Medicaid ID Number. 10 digit numeric, ID i.e., 0100000101	Yes
EVS0110	Filler	Not Used	
EVS0120	Filler	Not Used	
EVS0130	Filler	Not Used	

137 Point of Sale Device Eligibility Verification Transaction Format (Continued)

Field #	Field Name	Values/Comments	Required Field
EVS0140	Filler	Not Used	
EVS0150	Filler	Not Used	
EVS0160	Filler	Not Used	
EVS0170	Filler	Not Used	
EVS0180	"From" Date of Service	"From" date of service. Format = CCYYMMDD	Yes
EVS0190	"To" Date of Service	"To" date of service. Format = CCYYMMDD	Yes
EVS0200	Screen Type	Type of EPSDT screening information being requested. "M" = Medical "V" = Vision "D" = Dental "H" = Hearing Blank = None	Yes

138 Point of Sale Device Recipient Eligible Response Format - Non-Nursing Home

The following shows the descriptions and values for each of the fields associated with an eligibility verification response transaction when the recipient is eligible.

Field #	Field Name	Values/Comments
EVA0010	POS Return	If non-zero, a system error has occurred.
EVA0020	Filler	Not Used
EVA0030	Transaction ID	Number to identify the type of transaction reviewed. "00" = Eligibility Verification
EVA0040	Return Code	Code assigned by the OLTP to identify the status. "E" = Eligible "R" = Rejected
EVA0050	Authorization Code	Code given by the OLTP for an accepted eligibility transaction. Used internally by EDS.
EVA0060	Filler	Not Used
EVA0070	Full First Name	Recipient's full first name.
EVA0080	Full Last Name	Recipient's full last name.
EVA0090	Sex	Indicates whether the recipient is male or female. "M" = Male "F" = Female

138 Point of Sale Device Recipient Eligible Response Format - Non-Nursing Home (Continued)

Field #	Field Name	Values/Comments
EVA0100	Screen Type	Indicates the type of screening information the provider has requested. "V" = Vision "D" = Dental "H" = Hearing "M" = Medical Blank = None
EVA0110	Screen Date	Indicates the date of the last screening for the screen type requested by the provider. Format = CCYYMMDD
EVA0120	Buy-In Code	Indicates whether the recipient has Medicare buy-in segments. "A" = Part-A "B" = Part-B "X" = Both "N" = None "C" = Call for additional information
EVA0130	Third Party/Absent Parent	Indicates whether the recipient has other insurance through an absent parent. "Y" = Yes "N" = No
	Eligibility Segment	Occurs 4 times.
EVA0140	Aid Category	Indicates the aid category for the recipient's eligibility segment. "62" = PW/PE "18", "38" or "48" = QMB

138 Point of Sale Device Recipient Eligible Response Format - Non-Nursing Home (Continued)

Field #	Field Name	Values/Comments
EVA0150	Eligibility Begin Date	Indicates the begin date of the eligibility segment. Format = CCYYMMDD
EVA0160	Eligibility End Date	Indicates the end date of the eligibility segment. Format = CCYYMMDD
EVA0170	County and District	Indicates county (first two digits) and district (last digit) of residence for the recipient. County codes are found on page I-24 of this manual.
EVA0180	Additional Eligibility	Indicates if the recipient has additional eligibility segments. "Y" = Yes "N" = No
EVA0190	Lock-In	Indicates if a recipient is locked into a specific provider. "O" = Another provider "Y" = You "N" = Not a Lock-in "C" = Call for additional information (Multiple Lock-in segments or locked-in for part of dates)
EVA0200	Waiver Indicator	Indicates if recipient is Waiver Eligible. "N" = Not eligible "Y" = Yes "C" = Call for additional information "B" = Both W1 and W2 (Eligible for specific waiver type)

138 Point of Sale Device Recipient Eligible Response Format - Non-Nursing Home (Continued)

Field #	Field Name	Values/Comments
EVA0210	Waiver Type	Indicates the type of waiver service the recipient has. "W1" =W1 Waiver "W2" =W2 Waiver
EVA0220	Waiver Amount	Not Used
EVA0230	Spenddown	Indicates if recipient has spenddown. "N" = None "Y" = Yes "C" = Call for additional information (More spenddown information exists)
EVA0240	Spenddown Amount	Indicates the amount of spenddown the recipient has.
EVA0250	Spenddown End Date	Indicates the end date for the spenddown segment. Format = CCYYMMDD
The following fields are unique for each provider type		
		Pharmacy (07)
EVA0260	Prescriptions Used	Number of prescriptions the recipient has used in a month.
EVA0270	LTC Indicator	Indicates if the recipient has Long Term Care benefits. "N" = None "Y" = Yes "C" = Call for additional information (Eligible for part of dates)

138 Point of Sale Device Recipient Eligible Response Format - Non-Nursing Home (Continued)

Field #	Field Name	Values/Comments
EVA0280	Filler	Not Used
		Physician (01, 02, 03, 04)
EVA0290	Outpatient Visits Used	Number of outpatient visits the recipient has used towards the benefit limit as of the last cycle.
EVA0300	Physician Visits Used	Number of physician visits the recipient has used towards the benefit limit as of the last claims processing cycle.
EVA0310	Hospital Days Used	Number of hospital days the recipient has used towards the benefit limit as of the last claims processing cycle.
EVA0320	Lab and X-Ray Amount Used	Total dollar amount for Lab and X-Ray used by the recipient towards the benefit limit as of the last claims processing cycle.
EVA0330	Consultations Used	Number of consultations used by the recipient towards the benefit limit as of the last claims processing cycle.
		Hospital (05)
EVA0340	Outpatient Visits Used	Number of outpatient visits the recipient has used towards the benefit limit as of the last claims processing cycle.

138 Point of Sale Device Recipient Eligible Response Format - Non-Nursing Home (Continued)

Field #	Field Name	Values/Comments
EVA0350	Physician Visits Used	Number of physician visits the recipient has used towards the benefit limit as of the last claims processing cycle.
EVA0360	Hospital Days Used	Number of hospital days the recipient has used towards the benefit limit as of the last claims processing cycle.
EVA0370	Lab and X-Ray Amount Used	Total dollar amount for Lab and X-Ray used by the recipient towards the benefit limit as of the last claims processing cycle.
EVA0380	Consultations Used	Number of consultations used by the recipient towards the benefit limit as of the last claims processing cycle. **Independent Lab and Radiology (09, 10)**
EVA0390	Lab and X-Ray Amount Used	Total dollar amount for Lab and X-Ray used by the recipient towards the benefit limit as of the last claims processing cycle.
EVA0400	Filler	Not Used

138 Point of Sale Device Recipient Eligible Response Format - Non-Nursing Home (Continued)

Field #	Field Name	Values/Comments
		Optometrist/Optician (22)
EVA0410	Vision Exam	Indicates the date of the recipient's last vision examination. Format = CCYYMMDD
EVA0420	Filler	Not Used
		Other
EVA0430	Filler	Not Used
EVA0440	TPL Count	Number of TPL segments that this recipient has.
	TPL Segments	Occurs 0-3 times
EVA0450	TPL Company Code	Code assigned to identify the specific third party carrier.
EVA0460	TPL Company Name	Name of the third party carrier.
EVA0470	TPL Address	Street address of the third party carrier.
EVA0480	TPL City	City of the third party carrier.
EVA0490	TPL State	State of the third party carrier.
EVA0500	TPL Zip	Zip code of the third party carrier.
EVA0510	TPL Policy	Policy number with the third party carrier.

138 Point of Sale Device Recipient Eligible Response Format - Non-Nursing Home (Continued)

Field #	Field Name	Values/Comments
EVA0520	TPL Group Policy	Group policy number with third party carrier.
EVA0530	TPL Group Name	Name of the third party group.
EVA0540	TPL Subscriber Number	Subscriber's ID number.
EVA0550	TPL Subscriber Name	Subscriber's name.
EVA0560	TPL Relation Code	Recipient's relationship to the subscriber.
EVA0570	TPL Begin Date	Date the third party coverage began. Format = CCYYMMDD
EVA0580	TPL End Date	Date the third party coverage ended. Format = CCYYMMDD
EVA0590	TPL Coverage Code1	Identifies the type of services covered by the third party carrier.
EVA0600	TPL Coverage Code2	Identifies the type of services covered by the third party carrier.
EVA0610	TPL Coverage Code3	Identifies the type of services covered by the third party carrier.

139 Point of Sale Device Recipient Ineligible/Error Response Format

The following shows the descriptions and values for each of the fields associated with an eligibility verification response transaction when the recipient is ineligible.

Field #	Field Name	Values/Comments
EVR0010	POS Return	If non-zero, a system error has occurred.
EVR0020	Filler	Not Used
EVR0030	Transaction Type	Number to identify the type of transaction received. "00" = Eligibility Verification
EVR0040	Return Code	Code assigned by the OLTP to identify the status. "R" = Rejected
EVR0050	Error Count	Number of errors to follow.
	Error Segments	Occurs 1-9 times
EVR0060	Error Code	Code associated with the errors found on this transaction.
EVR0070	Detail Number	Location on the transaction where the error has occurred. "00" = Header

140 PROVIDER PARTICIPATION

141 Provider Enrollment

Any provider of services must be enrolled in the Arkansas Medicaid Program prior to reimbursement being made for any services provided to Arkansas Medicaid recipients.

All providers must complete an application and a provider contract and return them to the Division of Medical Services within 30 days from the date they were sent from the Enrollment Unit. Please review Section II of this manual relative to provider participation requirements.

Upon receipt and approval of the above information by the Enrollment Unit, a provider number will be assigned to each approved provider. This number must be used on all claims and correspondence submitted to Arkansas Medicaid.

Provider eligibility will be retroactive 6 months from the date the provider agreement was received by the Division of Medical Services, the effective date of the provider's license or certification, or the date the service became a part of the Arkansas Medicaid Program, whichever date is the most current.

Instructions for billing and specific details concerning the Arkansas Medicaid Program are contained within this manual. Please read all sections of the manual **before** signing the contract. The manual is an extension of your Medicaid contract and must be complied with in order to participate in the Arkansas Medicaid Program.

On the following pages, you will find a copy of the provider application and contract and instructions for completing these forms.

All providers must sign an Arkansas Medicaid Provider Contract. The signature must be an original signature of the individual provider. The contract for a group practice, hospital, other institution or agency must be signed by the authorized representative of the provider.

DIVISION OF MEDICAL SERVICES
MEDICAL ASSISTANCE PROGRAM
PROVIDER APPLICATION

As a condition for entering into or renewing a provider agreement all applicants must complete this provider application. A true, accurate and complete disclosure of all requested information is required by the Federal and State Regulations that govern the Medical Assistance Program. Failure of an applicant to submit the requested information or the submission of inaccurate or incomplete information may result in refusal by the Medical Assistance program to enter into, renew or continue a provider agreement with the applicant. Furthermore, the applicant is required by Federal and State Regulations to update the information submitted on the Provider Application.

Whenever changes in this information occur, please submit the change in writing to:

Division of Medical Services
Provider Enrollment Unit
P. O. Box 1437, Slot 1101
Little Rock, AR 72203-1437

All dates, except where otherwise specified, should be written in the month/day/year (MMDDYY) format. Please print all information.

This information is divided into sections. The following describes which sections are to be completed by the applicant:

Section I	-	All providers
Section II	-	Facilities Only
Section III	-	Pharmacists/Registered Respiratory Therapist Only
Section IV	-	Provider Group Affiliations
Electronic Fund Transfer		
Managed Care Agreement	-	Primary Care Physician
W-9 Tax Form	-	All Providers
Contract	-	All Providers

FOR OFFICE USE ONLY

Provider Number _____	Pending _____
Specialty Code _____	Computer _____
Provider Type _____	OK to Key _____
	Keyed _____
Effective Date _____	Maintenance Checked _____

SECTION I: ALL PROVIDERS

This section **MUST** be completed by all providers.

(1) **Date of Application:** Enter the current date in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(2) **Last Name, First Name, Middle Initial, Title:** Enter the legal name of the applicant. The title spaces are reserved for designations such as MD, DDS, CRNA or OD. If the space is insufficient, please abbreviate.

If entering any other name such as an organization, corporation or facility, enter the full name of the entity in item 3. NOTE: Item 2 or 3 must be completed, <u>BUT NOT BOTH</u>.

_____ _____ ____ _____
Last Name First Name M. I. Title

(3) **Group, Organization or Facility Name:** Enter full name of the entity.
Examples: John R. Doe, PA; Adam B. Corn, Inc.; Arkansas Emer. Phys. Group; Pulaski County Hospital; John Thompson, M. D., DBA Thompson Clinic

_____
Corporation Name

_____
Fictitious Name

Must submit documentation that the above Fictitious name is registered with the appropriate board within your state, (i.e., Secretary of State's, County Clerk) of the county in which the corporation's registered office is located.

(4) **Application Type:** Circle one of the following codes which coincide with fields 2 or 3:

0 = Individual Practitioner (i.e., physician, dentist, a licensed, registered or certified practitioner)
1 = Sole Proprietorship (This includes individually owned businesses.)
2 = Government Owned
3 = Business Corporation, for profit
4 = Business Corporation, non-profit **<u>* copy of Tax Form 501 (c) (3) must accompany this application</u>**
5 = Private, for profit
6 = Private, non-profit **<u>* copy of Tax Form 501 (c) (3) must accompany this application</u>**
7 = Partnership
8 = Trust
9 = Chain

<u>* NOTE: IF THE TAX FORM IS NOT ATTACHED THE APPLICATION WILL BE DENIED</u>

(5) **Place of Service - Street Address**

(A) Enter the applicant's service location address, include suite number if applicable. THIS FIELD IS MANDATORY.

_____

(B) Enter any additional street address. (MAY REFLECT POST OFFICE BOX IF UNDELIVERABLE TO A STREET ADDRESS)

_____

(C) City, State, Zip Code - enter the applicant's city, state and zip code. Use the Post Office's two letter abbreviation for State. If the applicant's zip code is not the expanded nine digits enter the correct five digit zip code.

_____ __ _____
City State Zip Code

(D) Telephone Number - enter the area code and telephone number of the location in which the services are provided.

_____ _____
Area Code Telephone Number

(6) **Billing Street Address:** This is the billing address where your Medicaid checks, Remittance Statements (RA) and information will be sent. Use the same format as the place of service address, P. O. Box may be entered in billing address.

_____

_____ _____ _____
City State Zip Code

_____ _____
Area Code Telephone Number

(7a) **Medicare Number:** Enter the Medicare Number assigned to the applicant. (See attached Medicare form.)

_____

(7b) **Unique Physician Identification Number (UPIN):** Enter the UPIN assigned (individual practitioner's only.)

_____

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

MEDICARE VERIFICATION FORM

MUST BE COMPLETED FOR MEDICARE PROVIDERS **PHYSICALLY LOCATED OUTSIDE OF THE BOUNDARIES OF ARKANSAS**

Before we can enroll a provider who is not physically located in Arkansas, as an Arkansas Medicaid provider, we must have verification of Medicare enrollment. **If you have documentation i.e., EOMB, Medicare letter that reflects the Medicare number and name of the enrolling provider,** please attach a copy of the information to the application. If you do not have documentation, please submit this form to your Medicare intermediary and instruct them to complete the information requested below. After Medicare has completed the requested information and returned this form to you, you must then return this form along with your completed Medicaid application. **If your application is not returned with Medicare verification, enrollment in the Arkansas Medicaid Program will be denied.**

Provider's Name _____

(l) _____ _____ _____
Medicare Number/UPIN Effective Date End Date

(2) _____ _____
Social Security Number Tax I.D. Number

(3) _____
Specialty of Practice

This inquiry was completed by:

Name of Medicare Intermediary _____

Address _____

Telephone # _____

Signature of Medicare Representative _____

_____
(Typed or Printed Name)

Date _____

(8) **County:** From the following list of codes, indicate the county that coincides with the place of service. If the services are provided in a bordering or out-of-state location, please use the county codes designated at the end of the code list. _____

County	County Code	County	County Code	County	County Code
Arkansas	01	Garland	26	Newton	51
Ashley	02	Grant	27	Ouachita	52
Baxter	03	Greene	28	Perry	53
Benton	04	Hempstead	29	Phillips	54
Boone	05	Hot Spring	30	Pike	55
Bradley	06	Howard	31	Poinsett	56
Calhoun	07	Independence	32	Polk	57
Carroll	08	Izard	33	Pope	58
Chicot	09	Jackson	34	Prairie	59
Clark	10	Jefferson	35	Pulaski	60
Clay	11	Johnson	36	Randolph	61
Cleburne	12	Lafayette	37	Saline	62
Cleveland	13	Lawrence	38	Scott	63
Columbia	14	Lee	39	Searcy	64
Conway	15	Lincoln	40	Sebastian	65
Craighead	16	Little River	41	Sevier	66
Crawford	17	Logan	42	Sharp	67
Crittenden	18	Lonoke	43	St. Francis	68
Cross	19	Madison	44	Stone	69
Dallas	20	Marion	45	Union	70
Desha	21	Miller	46	Van Buren	71
Drew	22	Mississippi	47	Washington	72
Faulkner	23	Monroe	48	White	73
Franklin	24	Montgomery	49	Woodruff	74
Fulton	25	Nevada	50	Yell	75

State	County Code	State	County Code	State	County Code
Louisiana	91	Oklahoma	94	All other states	97
Missouri	92	Tennessee	95		
Mississippi	93	Texas	96		

(9) **Provider Category (A-C)**

Enter the two-digit code(s) from the following list identifying the service(s) the applicant will provide.

A) _____ B) _____ C) _____

Code	Category Description
03	Allergy/Immunology
A8	Alternatives for Adults with Physical Disabilities (Alternatives): Environmental Adaptations
A9	Alternatives for Adults with Physical Disabilities (Alternatives): Attendant Care Services
A4	Ambulatory Surgical Center
AA	Adolescent Medicine
05	Anesthesiology
64	Audiologist
06	Cardiovascular Disease
C4	Child Health Management Services
35	Chiropractor
C3	CRNA
HA	DDS ACS Waiver: Physical Adaptations
HB	DDS ACS Waiver: Specialized Medical Supplies
HC	DDS ACS Waiver: Case Management Services
HE	DDS ACS Waiver: Supported Employment
H7	DDS ACS Waiver: Integrated Supports
H8	DDS ACS Waiver: Crisis Abatement Services
H9	DDS ACS Waiver: Consultation Services
HF	DDS ACS Waiver: Organized Health Care
V2	Dental
X5	Dental: Oral Surgeon
V6	Dental: Orthodontia
07	Dermatology
V3	Developmental Day Treatment Clinic
DR	Developmental Rehabilitation Services
V5	Domiciliary Care
V4	Durable Medical Equipment, Medical Supplies and Accessories
E4	ElderChoices H&CB 2176 Waiver: Chore Services
E5	ElderChoices H&CB 2176 Waiver: Adult Foster Care
E6	ElderChoices H&CB 2176 Waiver: Home Maker
E7	ElderChoices H&CB 2176 Waiver: Home-delivered Hot Meals
EC	ElderChoices H&CB 2176 Waiver: Home-delivered Frozen Meals
E8	ElderChoices H&CB 2176 Waiver: Personal Emergency Response Systems (PERS)
E9	ElderChoices H&CB 2176 Waiver: Adult Day Care

9) Provider Category (Continued)

Code	Category Description
EA	ElderChoices H&CB 2176 Waiver: Adult Day Health Care
EB	ElderChoices H&CB 2176 Waiver: Respite Care
E1	Emergency Medicine
E2	Endocrinology
E3	EPSDT (Early and Periodic Screening, Diagnosis and Treatment)
F1	Family Planning
08	Family Practice
F2	Federally Qualified Health Center
10	Gastroenterology
01	General Practice
38	Geriatrics
16	Gynecology–Obstetrics
H1	Hearing Aid Dealer
H2	Hematology
H5	Hemodialysis
H3	Home Health
H6	Hospice
A5	Hospital: Arkansas State-Operated Teaching Hospital
W6	Hospital: Inpatient
W7	Hospital: Outpatient
CH	Hospital: Critical Access
P7	Hospital: Pediatric Inpatient
R7	Hospital: Rural Inpatient
H4	Hyperalimentation
V8	Immunization: Arkansas Department of Health only
69	Independent Lab
55	Infectious Diseases
W3	Inpatient Psychiatric: Under 21
WA	Inpatient Psychiatric: Residential Treatment Unit within an inpatient psychiatric hospital
WB	Inpatient Psychiatric: Residential Treatment Center
WC	Inpatient Psychiatric: Sexual Offender Program
W4	Intermediate Care Facility
W5	Intermediate Care Facility / Mentally Retarded (ICF/MR)
11	Internal Medicine
L1	Laryngology
M1	Maternity Clinic: Arkansas Department of Health only
M4	Medicare/Medicaid Crossover Only

9) **Provider Category (Continued)**

Code	Category Description
WI	Mental Health Practitioner: Licensed Certified Social Worker
W2	Mental Health Practitioner: Licensed Professional Counselor
R5	Mental Health Practitioner: Licensed Marriage and Family Therapist
62	Mental Health Practitioner: Psychologist
N1	Neonatology
39	Nephrology
13	Neurology
N2	Nurse Midwife
N3	Nurse Practitioner: Pediatric
N4	Nurse Practitioner: OB/GYN
N6	Nurse Practitioner: Family Practice
N7	Nurse Practitioner: Gerontological
RK	Offsite Intervention Service: Outpatient Mental and Behavioral Health (ARKids First only)
X1	Oncology
18	Ophthalmology
X4	Optometrist
X6	Orthopedic
Z1	Orthotic Appliances
12	Osteopathy: Manipulative Therapy
X7	Osteopathy: Radiation Therapy
X8	Otology
X9	Otorhinolaryngology
22	Pathology
37	Pediatrics
P1	Personal Care Services
PA	Personal Care Services: Area Agency on Aging
PD	Personal Care Services: Developmental Disability Services
PE	Personal Care Services: Private Care Agency (Week-end only)
R3	Personal Care Services: Residential Care Facility
PS	Personal Care Services: Public School or Education Service Cooperative
P2	Pharmacy
P3	Physical Medicine
48	Podiatrist
63	Portable X-ray Services

9) **Provider Category (Continued)**

Code	Category Description
P6	Private Duty Nursing
PF	Private Duty Nursing: Public School or Education Service Cooperative
28	Proctology
P4	Prosthetic Devices
26	Psychiatry
P5	Psychiatry: Child
29	Pulmonary Diseases
R9	Radiation Therapy: Complete
RA	Radiation Therapy: Technical
30	Radiology: Diagnostic
31	Radiology: Therapeutic
R1	Rehabilitative Hospital
RH	Rehabilitative Hospital: Extended Services
R6	Rehabilitative Services for Persons with Mental Illness (RSPMI)
RC	Rehabilitative Services for Persons with Physical Disabilities (RSPD)
RL	Rehabilitative Services for Youth: DYS
RJ	Rehabilitative Services for Children: DCFS
R4	Rheumatology
R2	Rural Health Clinic: Provider Based
R8	Rural Health Clinic: Independent ("Freestanding")
S7	School Based Health Clinic: Child Health Services (EPSDT)
S8	School Based Health Clinic: Hearing Screener
S9	School Based Health Clinic: Vision Screener
SA	School Based Health Clinic: Vision & Hearing Screener
VV	School Based Mental Health Services
S5	Skilled Nursing Facility
S6	SNF Hospital: Distinct Part Bed
S1	Surgery: Cardiac
S2	Surgery: Colon & Rectal
02	Surgery: General
14	Surgery: Neurological

9) **Provider Category (Continued)**

Code	Category Description
20	Surgery: Orthopedic
53	Surgery: Pediatric
54	Surgery: Oncology
24	Surgery: Plastic & Reconstructive
33	Surgery: Thoracic
S4	Surgery: Vascular
C5	Targeted Case Management: Ages 60 and Older
C6	Targeted Case Management: Ages 0 through 20
C7	Targeted Case Management: Ages 21 through 59
T6	Therapy: Occupational
T1	Therapy: Physical
T2	Therapy: Speech Pathologist
TO	Therapy: Occupational Therapy Assistant
TP	Therapy: Physical Therapy Assistant
TS	Therapy: Speech Pathologist Assistant
A1	Transportation: Ambulance, Emergency
A2	Transportation: Ambulance, Non-emergency
A6	Transportation: Advanced Life Support with EKG
A7	Transportation: Advanced Life Support without EKG
TA	Transportation: Air Ambulance, Helicopter
TB	Transportation: Air Ambulance, Fixed Wing
TC	Transportation: Non-emergency
T5	Transportation: Non-public
T7	Transportation: Intra-state authority
T8	Transportation: Disabled-Accessible Van, Intra-city
T9	Transportation: Disabled-Accessible Van, Intra-state authority
34	Urology
V7	Ventilator Equipment
ZZ	Other

(10) **SSN/FEIN Number:** Enter the Social Security Number of the applicant or the Federal Employer Identification Number of the applicant. **IF ENROLLING AN INDIVIDUAL APPLICANT THIS FIELD MUST REFLECT A SOCIAL SECURITY NUMBER.**

____ _____ _____ - _____ _____ - _____ _____ _____ _____
Social Security Number

NOTE: If an individual has a Federal Employee Identification Number, you will need to complete two (2) applications and two (2) contracts. One (1) as an individual and one (1) as an organization.

____ _____ - _____ _____ _____ _____ _____ _____ _____
Federal Employee Identification Number

(11) **Certification Code:** This code identifies the type of provider the certification number in field 12 defines. If an entry is made in this field (11), an entry **MUST** be made in field 12 and 13 unless the entry is a 5. Please check the appropriate code.

0 = Mental Health ☐
1 = Home Health ☐
2 = CRNA ☐
3 = Nursing Home ☐
4 = Other ☐
5 = Non-applicable ☐

(12) **Certification Number:** If applicable, enter the certification number assigned to the applicant by the appropriate certification board/agency.

A CURRENT COPY OF THIS CERTIFICATION MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(13) **End Date:** Enter the expiration date of the applicant's current certification number in month/day/year format.

_____/_____/_____
MM DD Year

(14) **Fiscal Year:** Enter the date of the applicant's fiscal year end. This date is in month/day format.

_____/_____
MM DD

(15) **DEA Number:** If applicable, enter the number assigned to the applicant by the Federal Drug Enforcement Agency. Pharmacies must submit this information to be enrolled.

Required for Pharmacies only
A CURRENT COPY OF THIS CERTIFICATE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____

(16) **End Date:** Enter the expiration date of the current DEA Number in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(17) **License Number:** If applicable, enter the license number assigned to the applicant by the appropriate state licensure board. If the license issued is a temporary license enter **TEMP**. If the license number is smaller than the fields allowed, leave the last spaces blank.

A CURRENT COPY OF THIS LICENSE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(18) **End Date:** Enter the expiration date of the applicant's current license in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(19) **CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA):** If applicable, enter the CLIA number assigned to the applicant. **A copy of the CLIA certificate is required in order to have your laboratory test paid**.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

FOR OFFICE USE ONLY

Provider Number _____ Pending _____
Computer _____
Provider Name _____ OK to Key _____
Keyed _____
Maintenance Checked _____

SECTION II: FACILITIES ONLY

(20) **Special Facility Program:** Check the appropriate value to depict if the applicant's facility is indigent care, teaching facility/university or UR plan. Special facility program values include:

*A	=	indigent care only	[]
**B	=	teaching facility/university only	[]
***C	=	UR plan only	[]
D	=	A/B	[]
E	=	A/C	[]
F	=	B/C	[]
G	=	A/B/C	[]
N	=	No special program	[]

* Indigent Care - Indicate whether the facility is qualified for the indigent care allowance.

NOTE: Facilities which serve a disproportionate number of indigent patients (defined as exceeding 20% Medicaid days as compared to a total patient day) may qualify for an indigent care allowance. If the facility meets the above criteria, please send the appropriate excerpt from the most current cost report that reflects total Medicaid days and total patient days.

** Teaching/University Facility - Indicate whether the facility is designated as a teaching/university affiliated institution and participates in three or more residency training programs.

*** Utilization Review Plan - Does the facility have a Utilization Review Plan applicable to all Medicaid patients?

(21) **Total Beds:** Enter the total number of beds in the facility.

_____
# of Beds

FOR OFFICE USE ONLY

Provider Number ______________________ Pending ______________
Computer ______________
Provider Name ______________________ OK to Key ______________
Keyed ______________
Maintenance Checked ______________

SECTION III: PHARMACISTS/REGISTERED RESPIRATORY THERAPIST ONLY

PHARMACIES - PLEASE INDICATE IF THIS APPLICANT IS A CHAIN-OWNED PHARMACY WITH 11 OR MORE RETAIL PHARMACIES NATIONALLY. (FRANCHISES WHICH ARE INDIVIDUALLY OWNED ARE NOT CHAIN-OWNED UNLESS ONE INDIVIDUAL OR CORPORATION OWNS 11 OR MORE RETAIL STORES.)

☐ **YES** ☐ **NO**

(22) Please list each pharmacists/registered respiratory therapist name, Social Security Number, license number and effective date of employment.

Please indicate by the pharmacist name whether that pharmacist is certified to administer Vaccines. If you are providing Vaccines, the pharmacy will need to be enrolled in the Medicare program. Please include the pharmacy Medicare number in Section I item 7a.

A copy of current registered respiratory therapist is required. Subsequent renewal must be provided when issued.

NOTE: Registered Respiratory Therapists must enter registration number in license number field.

______________________ ______________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number — ______ yes ______ no

______________________ ______________________
License/Registration Number — Effective Date of employment

______________________ ______________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number — ______ yes ______ no

______________________ ______________________
License/Registration Number — Effective Date of employment

______________________ ______________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number — ______ yes ______ no

______________________ ______________________
License/Registration Number — Effective Date of employment

______________________ ______________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number — ______ yes ______ no

______________________ ______________________
License/Registration Number — Effective Date of employment

FOR OFFICE USE ONLY

Provider Number _____ Pending _____
Computer _____
Provider Name _____ OK to Key _____
Keyed _____
Maintenance Checked _____

SECTION IV: PROVIDER GROUP AFFILIATIONS

(23) If the applicant is affiliated with a group practice or an organization that is authorized to submit Medicaid claims on their behalf, the applicant must complete this section and sign the Appointment of Billing Intermediary Statement. Add extra sheets if necessary.

_____ _____ _____ _____
Last Name First Name M. I. Title

_____
Group Organization Name

_____
Effective Date (Applicant Joined Group)

_____
Group AR Medicaid Provider Number

_____
Expiration Date (Applicant Left Group)

_____ _____ _____
City State Zip Code

The undersigned Provider authorizes the above-listed Group Practice Organization to submit claims to the Arkansas Division of Medical Services (hereinafter the Division) on his/her/its behalf, in accordance with the applicable Division regulations. The Provider also authorizes the Division to issue payment checks on his/her/its behalf to the above listed Group Practice Organization, in accordance with applicable Division requirements.

The Provider accepts full liability to the Division for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules or regulations governing the Medical Assistance Program or the Provider's agreement with the Division, the Provider shall be fully liable to the Division as if such acts were the Provider's own acts.

The Provider agrees to notify the Division at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

An original signature of the individual provider is mandatory (no stamped or copied signature is allowed.)

_____ _____ _____
Signature Title Date

_____
Typed or Printed Name Arkansas Medicaid Provider Number

FOR OFFICE USE ONLY

Provider Number _____ Pending _____
Computer _____
Provider Name _____ OK to Key _____
Keyed _____
Maintenance Checked _____

SECTION IV: PROVIDER GROUP AFFILIATIONS (CONTINUED)

(23) If the applicant is affiliated with a group practice or an organization that is authorized to submit Medicaid claims on their behalf, the applicant must complete this section and sign the Appointment of Billing Intermediary Statement. Add extra sheets if necessary.

_____ _____ _____ _____
Last Name First Name M. I. Title

_____
Group Practice Organization Name

_____
Effective Date (Applicant Joined Group)

_____
Group AR Medicaid Provider Number

_____
Expiration Date (Applicant Left Group)

_____ _____ _____
City State Zip Code

The undersigned Provider authorizes the above-listed Group Practice Organization to submit claims to the Arkansas Division of Medical Services (hereinafter the Division) on his/her/its behalf, in accordance with the applicable Division regulations. The Provider also authorizes the Division to issue payment checks on his/her/its behalf to the above listed Group Practice Organization, in accordance with applicable Division requirements.

The Provider accepts full liability to the Division for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules or regulations governing the Medical Assistance Program or the Provider's agreement with the Division, the Provider shall be fully liable to the Division as if such acts were the Provider's own acts.

The Provider agrees to notify the Division at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

An original signature of the individual provider is mandatory (no stamped or copied signature is allowed.)

_____ _____ _____
Signature Title Date

_____ _____
Typed or Printed Name Arkansas Medicaid Provider Number

Dear Provider:

Providers are encouraged to utilize **Electronic Fund Transfer** (EFT). EFT allows your Medicaid payments to be directly deposited into your bank account. You will notice a difference in your cash flow with EFT because it makes your money available sooner than the actual clearance date of paper checks. Your Medicaid Remittance Advice (RA) will continue to be mailed to the mailing address listed on your enrollment application.

If you wish to have your Medicaid payment automatically deposited, please complete the Authorization for Automatic Deposit and attach a **VOIDED CHECK OR DEPOSIT SLIP.**

If you choose not to enroll in EFT, your checks along with your Medicaid RA will be mailed to you. **Please note that since EFT is available, checks will not be available for pick-up at the EDS office.**

If you have any further questions concerning this letter, please contact the EDS Provider Assistance at (501) - 376-2211 (local or out-of-state) or 1-800-457-4454 (in-state WATS).

Sincerely,

Arkansas Department of Human Services

Authorization for Automatic Deposit

Name of Medicaid Provider_____ Medicaid Provider #_____

Provider Address_____ Telephone Number _____

City, State_____ Zip Code_____

Type of Authorization ☐ New ☐ Change ☐ Cancel

☐ Checking ☐ Savings **(if not indicated will be automatically entered as checking)**

ABA Transit Number _____ Bank Account Number _____

A COPY OF A VOIDED CHECK or DEPOSIT SLIP IS REQUIRED TO VERIFY THESE NUMBERS. THE NAME ON THE VOIDED CHECK or DEPOSIT SLIP SHOULD MATCH THE NAME OF THE MEDICAID PROVIDER STATED ABOVE. TEMPORARY CHECKS OR DEPOSIT SLIPS ARE INVALID.

Name of Bank _____

Bank Address _____

City, State _____ Zip Code _____

I hereby authorize the Arkansas Medicaid Program/Title XIX, to initiate credit entries to my bank account as indicated above and the depository named above to credit the same to such account. I understand I am responsible for the validity on this form.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.

_____
Provider's Original Signature (required)

Please return this form to:

Division of Medical Services
ATTN: Provider Enrollment
P. O. Box 1437, Slot 1101
Little Rock, AR 72203-1437

MANAGED CARE PROGRAM

PRIMARY CARE PHYSICIAN

Family Practitioner
General Practitioner (including osteopath)
*** Internal Medicine**
*** Obstetrician**
*** Gynecologist**
Pediatrician

If your specialty of practice is listed above, you **MUST** complete the Primary Care Physician Participation Agreement and the EPSDT Agreement to participate in the Arkansas Medicaid Program. Please refer to Section I of your Arkansas Medicaid Provider manual for information concerning the Primary Care Physician Program.

*** NOTE *** Providers whose specialty is either Internal Medicine or Obstetrician/Gynecology have the option of enrolling in the Child Health Services (EPSDT) program, please review the Primary Care Physicians policy.

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM
PRIMARY CARE PHYSICIAN PARTICIPATION AGREEMENT

This agreement is made and entered into between _____
(Please print, stamp or type physician's name)

hereafter called provider, and the Arkansas Division of Medical Services, hereafter called Medicaid.

The provider in consideration of the material benefits to be derived, and the rules and regulations of the Medicaid Program agrees as follows:

A. To be a Medicaid enrolled Physician provider and comply with all pertinent Medicaid policies, regulations and State Plan standards.

B. To be a Medicaid enrolled Early Periodic Screening Diagnosis and Treatment (EPSDT) provider and to comply with all pertinent Medicaid policies, regulations and State Plan standards. (Internists, Obstetricians/Gynecologists are exempt from this requirement.)

C. To perform various services as a primary care physician under the guidelines of the Primary Care Physician Managed Care Program and to comply with all pertinent Medicaid policies, regulations and State Plan standards.

D. To authorize their name be listed as a primary care physician and consent to release their name to interested parties.

Please indicate the maximum number of Medicaid recipients you are willing to accept for primary care services. (a maximum of 1000):_____

Please indicate all the counties in Arkansas in which you will provide primary care physician services by circling the county codes designated on the following page or by listing the county or county codes in the space that follows:

_____

_____

Please indicate the **Medicaid identification** number (individual or group) for payment of your management fee and inclusion on a Federal 1099 Tax Form: _____.

Physicians without hospital admitting privileges, please list the name of the enrolled PCP with admitting privileges who has agreed to be responsible for your recipient inpatient admissions: **_____. An agreement signed by the PCP and the Admitting physician is required.**

_____	_____	_____
Medicaid Physician Provider Number	Primary Care Physician Signature	Date
_____	_____	_____
Division of Medical Services Signature	Title	Date

County Codes

County	County Code	County	County Code	County	County Code
Arkansas	01	Garland	26	Newton	51
Ashley	02	Grant	27	Ouachita	52
Baxter	03	Greene	28	Perry	53
Benton	04	Hempstead	29	Phillips	54
Boone	05	Hot Spring	30	Pike	55
Bradley	06	Howard	31	Poinsett	56
Calhoun	07	Independence	32	Polk	57
Carroll	08	Izard	33	Pope	58
Chicot	09	Jackson	34	Prairie	59
Clark	10	Jefferson	35	Pulaski	60
Clay	11	Johnson	36	Randolph	61
Cleburne	12	Lafayette	37	Saline	62
Cleveland	13	Lawrence	38	Scott	63
Columbia	14	Lee	39	Searcy	64
Conway	15	Lincoln	40	Sebastion	65
Craighead	16	Little River	41	Sevier	66
Crawford	17	Logan	42	Sharp	67
Crittenden	18	Lonoke	43	St. Francis	68
Cross	19	Madison	44	Stone	69
Dallas	20	Marion	45	Union	70
Desha	21	Miller	46	Van Buren	71
Drew	22	Mississippi	47	Washington	72
Faulkner	23	Monroe	48	White	73
Franklin	24	Montgomery	49	Woodruff	74
Fulton	25	Nevada	50	Yell	75

State	County Code	State	County Code	State	County Code
Louisiana	91	Oklahoma	94	Texas	96
Missouri	92	Tennessee	95		
Mississippi	93				

Please note: Per Section I, page 84, subsection 185.12, item 2 of the Arkansas Medicaid Physicians provider manual, A PCP must be physically located in the State of Arkansas, or in a bordering state trade-area city. The trade-area cities are:

- **Monroe and Shreveport, Louisiana**
- **Clarksdale and Greenville, Mississippi**
- **Poplar Bluff, Missouri**
- **Poteau and Salisaw, Oklahoma**
- **Memphis, Tennessee**
- **Texarkana, Texas**

FORM W-9

REQUEST FOR TAXPAYER

IDENTIFICATION NUMBER AND CERTIFICATION

The Department of Finance and Administration and the Department of Human Services have mandated that an IRS form W-9 be completed by all vendors doing business with the Department of Human Services.

NOTE:

TO ENSURE CORRECT PROCESSING OF THE 1099 --- PLEASE REVIEW THE FOLLOWING: WHEN BILLING FOR SERVICES UNDER CLINIC NAME AND IRS NUMBER, THE CLINIC AND EACH INDIVIDUAL PROVIDER (i.e., physician, therapist, dentist, etc.) MUST ENROLL BY COMPLETING A SEPARATE APPLICATION AND CONTRACT. A CLINIC MEDICAID NUMBER WILL BE ISSUED AND LINKED WITH EACH INDIVIDUAL'S MEDICAID NUMBER WITHIN THAT GROUP. THE CLINIC MEDICAID NUMBER MUST BE PLACED IN THE PAY TO FIELD AND THE INDIVIDUAL PROVIDER NUMBER MUST BE PLACED IN THE PERFORMING FIELD. THIS WILL ENSURE THAT THE 1099 REFLECTS THE CORRECT TAX NUMBER. PLEASE REFER TO YOUR PROVIDER MANUAL FOR CLAIMS PROCESSING INSTRUCTIONS.

Form **W-9**
(Rev. April 1990)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give this form to the requester. Do NOT send to IRS.

Please print or type

Name (If joint names, list first and circle the name of the person or entity whose number you enter in Part I below. See instructions under "Name" if your name has changed.)

Address (number and street)

List account number(s) here (optional)

City, state, and ZIP code

Part I **Taypayer Identification Number (TIN)**

Enter your taxpayer identification number in the appropriate box. For individuals and sole proprietors, this is your social security number. For other entities, it is your employer identification number. If you do not have a number, see *How to Obtain a TIN*, below.

Social security number

OR

Employer Identification number

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Part II **For Payees Exempt From Backup Withholding (See Instructions)**

Requester's name and address (optional)

Certification.—Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**

(2) I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions.—You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For real estate transactions, item (2) does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (Also see *Signing the Certification* under *Specific Instructions*, on page 2.)

Please Sign Here **Signature ▸** **Date ▸**

Instructions

(Section references are to the Internal Revenue Code.)

Purpose of Form.—A person who is required to file an information return with IRS must obtain your correct taxpayer identification number (TIN) to report income paid to you, real estate transactions, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to an individual retirement arrangement (IRA). Use Form W-9 to furnish your correct TIN to the requester (the person asking you to furnish your TIN), and, when applicable, (1) to certify that the TIN you are furnishing is correct (or that you are waiting for a number to be issued), (2) to certify that you are not subject to backup withholding, and (3) to claim exemption from backup withholding if you are an exempt payee. Furnishing your correct TIN and making the appropriate certifications will prevent certain payments from being subject to the 20% backup withholding.

Note: *If a requester gives you a form other than a W-9 to request your TIN, you must use the requester's form.*

How to Obtain a TIN.—If you do not have a TIN, apply for one immediately. To apply, get **Form SS-5**, Application for a Social Security Number Card (for individuals), from your local office of the Social Security Administration, or **Form SS-4**, Application for Employer Identification Number (for businesses and all other entities), from your local Internal Revenue Service office.

To complete Form W-9 if you do not have a TIN, write "Applied For" in the space for the TIN in Part I, sign and date the form, and give it to the requester. Generally, you will then have 60 days to obtain a TIN and furnish it to the requester. If the requester does not receive your TIN within 60 days, backup withholding, if applicable, will begin and continue until you furnish your TIN to the requester. For reportable interest or dividend payments, the payer must exercise one of the following options concerning backup withholding during this 60-day period. Under option (1), a payer must backup withhold on any withdrawals you make from your account after 7 business days after the requester receives this form back from you. Under option (2), the payer must backup withhold on any reportable interest or dividend payments made to your account, regardless of whether you make any withdrawals. The backup withholding under option (2) must begin no later than 7 business days after the requester receives this form back. Under option (2), the payer is required to refund the amounts withheld if your certified TIN is received within the 60-day period and you were not subject to backup withholding during that period.

Note: *Writing "Applied For" on the form means that you have already applied for a TIN* ***OR*** *that you intend to apply for one in the near future.*

As soon as you receive your TIN, complete another Form W-9, include your TIN, sign and date the form, and give it to the requester.

What Is Backup Withholding?—Persons making certain payments to you are required to withhold and pay to IRS 20% of such payments under certain conditions. This is called "backup withholding." Payments that could be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee compensation, and certain payments from fishing boat operators, but do not include real estate transactions.

If you give the requester your correct TIN, make the appropriate certifications, and report all your taxable interest and dividends on your tax return, your payments will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

(1) You do not furnish your TIN to the requester, or

(2) IRS notifies the requester that you furnished an incorrect TIN, or

(3) You are notified by IRS that you are subject to backup withholding because you failed to report all your interest and dividends on your tax return (for reportable interest and dividends only), or

(4) You fail to certify to the requester that you are not subject to backup withholding under (3) above (for reportable interest and dividend accounts opened after 1983 only), or

(5) You fail to certify your TIN. This applies only to reportable interest, dividend broker, or barter exchange accounts opened after 1983, or broker accounts considered inactive in 1983.

Except as explained in (5) above, other reportable payments are subject to backup withholding only if (1) or (2) above applies.

Certain payees and payments are exempt from backup withholding and information reporting. See *Payees and Payments Exempt From Backup Withholding*, below, and *Exempt Payees and Payments* under Specific Instructions, on page 2, if you are an exempt payee.

Payees and Payments Exempt from Backup Withholding.—The following is a list of payees exempt from backup withholding and for which no information reporting is required. For interest and dividends, all listed payees are exempt except item (9). For broker transactions, payees listed (1) through (13) and a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker are exempt. Payments subject to reporting under sections 6041 and 6041A are generally exempt from backup withholding only if made to payees described in items (1) through (7), except that a corporation that provides medical and health care services or bills and collects payments for such services is not exempt from

backup withholding or information reporting. Only payees described in items (2) through (6) are exempt from backup withholding for barter exchange transactions, patronage dividends, and payments by certain fishing boat operators.

(1) A corporation.

(2) An organization exempt from tax under section 501(a), or an individual retirement plan (IRA), or a custodial account under 403(b)(7).

(3) The United States or any of its agencies or instrumentalities.

(4) A state, the District of Columbia, a possession of the United Sates, or any of their political subdivisions or instrumentalities.

(5) A foreign government or any of its political subdivisions, agencies, or instrumentalities.

(6) An international organization or any of its agencies or instrumentalities.

(7) A foreign central bank of issue.

(8) A dealer in securities or commodities required to register in the U.S. or a possession of the U.S.

(9) A futures commission merchant registered with the Commodity Futures Trading Commission.

(10) A real estate investment trust.

(11) An entity registered at all times during the tax year under the Investment Company Act of 1940.

(12) A common trust fund operated by a bank under section 584(a).

(13) A financial institution.

(14) A middleman known in the investment community as a nominee or listed in the most recent publication of the American Society of Corporate Secretaries, Inc., Nominee List.

(15) A trust exempt from tax under section 664 or described in section 4947.

Payments of **dividends** and **patronage dividends** generally not subject to backup withholding also include the following:

- Payments to nonresident aliens subject to withholding under section 1441
- Payments to partnerships not engaged in a trade or business in the U.S. and that have at least one nonresident partner.
- Payments of patronage dividends not paid in money.
- Payments made by certain foreign organizations.

Payments of interest generally not subject to backup withholding include the following:

- Payments of interest on obligations issued by individuals. **Note:** *You may be subject to backup withholding if this interest is $600 or more and is paid in the course of the payer's trade or business and you have not provided your correct TIN to the payer.*
- Payments of tax-exempt interest (including exempt-interest dividends under section 852).
- Payments described in section 6049(b)(5) to nonresident aliens.
- Payments on tax-free covenant bonds under section 1451.
- Payments made by certain foreign organizations.
- Mortgage interest paid by you.

Payments that are not subject to information reporting are also not subject to backup withholding. For details, see sections 6041, 6041A(a), 6042, 6044, 6045, 6049, 6050A, and 6050N, and the regulations under those sections.

Penalties

Failure to Furnish TIN.—If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil Penalty for False Information With Respect to Withholding.—If you make a false statement with no reasonable basis that results in no imposition of backup withholding, you are subject to a penalty of $500.

Criminal Penalty for Falsifying Information.—Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Specific Instructions

Name.—If you are an individual, you must generally provide the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, please enter your first name and both the last name shown on your social security card and your new last name.

Signing the Certification.—

(1) Interest, Dividend, and Barter Exchange Accounts Opened Before 1984 and Broker Accounts That Were Considered Active During 1983.—You are not required to sign the certification; however, you may do so. You are required to provide your correct TIN.

(2) Interest, Dividend, Broker and Barter Exchange Accounts Opened After 1983 and Broker Accounts That Were Considered Inactive During 1983.—You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item (2) in the certification before signing the form.

(3) Real Estate Transactions.—You must sign the certification. You may cross out item (2) of the certification if you wish.

(4) Other Payments.—You are required to furnish your correct TIN, but you are not required to sign the certification unless you have been notified of an incorrect TIN. Other payments include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services, payments to a nonemployee for services (including attorney and accounting fees), and payments to certain fishing boat crew members.

(5) Mortgage Interest Paid by You, Acquisition or Abandonment of Secured Property, or IRA Contribution.—You are required to furnish your correct TIN, but you are not required to sign the certification.

(6) Exempt Payees and Payments.—If you are exempt from backup withholding, you should complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "EXEMPT" in the block in Part II, sign and date the form. If you are a nonresident alien or foreign entity not subject to backup withholding, give the requester a completed **Form W-8**, Certificate of Foreign Status.

(7) TIN "Applied For."—Follow the instructions under *How to Obtain a TIN*, on page 1, sign and date this form.

Signature.—For a joint account, only the person whose TIN is shown in Part I should sign the form.

Privacy Act Notice.—Section 6109 requires you to furnish your correct taxpayer identification number (TIN) to persons who must file information returns with IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to an individual retirement arrangement (IRA). IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 20% of taxable interest, dividend, and certain other payments to a payee who does not furnish a TIN to a payer. Certain penalties may also apply.

What Name and Number to Give the Requester

For this type of account:	Give the name and SOCIAL SECURITY number of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4.a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give the name and EMPLOYER IDENTIFICATION number of:**
6. A valid trust, estate, or pension trust	Legal entity (Do not furnish the identification number of the personal representative or trustee unless the legal entity itself is not designated in the account title.)[4]
7. Corporate	The corporation
8. Association, club, religious, charitable, educational, or other tax exempt organization	The organization
9. Partnership	The partnership
10. A broker or registered nominee	The broker or nominee
11. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish.

[2] Circle the minor's name and furnish the minor's social security number.

[3] Show the individual's name.

[4] List first and circle the name of the legal trust, estate, or pension trust.

Note: *If no name is circled when there is more than one name, the number will be considered to be that of the first name listed.*

U.S.GPO:1990-0-265-091

CONTRACT

TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE PROGRAM ADMINISTERED BY THE DIVISION OF MEDICAL SERVICES UNDER TITLE XIX (MEDICAID)

INSTRUCTIONS

Please ensure that the Provider name on the front page of the contract is identical to that listed in item #2 or item #3 of the application.

If these two names do not match, your enrollment will be denied and the enrollment packet will be returned.

CONTRACT
TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE PROGRAM
ADMINISTERED BY THE DEPARTMENT OF HUMAN SERVICES
TITLE XIX (MEDICAID)

The following agreement is entered into between _____, hereinafter called Provider, and the Department of Human Services, hereafter called Department:

1. Provider, in consideration of the material benefits to be derived, and the covenants and undertakings of the Department agrees to the following:

   A. To keep all records, as set forth in the appropriate Arkansas Medicaid Provider Manual, Official Notice and Remittance Advice Message, to fully disclose the extent of services provided to individuals receiving assistance under the State Plan.

   B. To make available all records herein specified to satisfy audit requirements under the Program, to furnish all such records for audits conducted periodically by the Department, the Medicaid Fraud Division of the Attorney General, or their designated agents, and/or representatives. For all Medicaid recipients these records include, but are not limited to those records which are defined in Section "A" of this contract. For patients who are not Medicaid recipients, the only records which must be furnished are financial records of charges billed to private patients to ensure that charges billed to Medicaid do not exceed charges billed to private patients.

   C. To accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any appropriate deductible, or coinsurance which may be due and payable under Title XIX (Medicaid).

   D. To bill Medicaid only after a service has been provided, or as otherwise specified in the appropriate Arkansas Medicaid Provider Manual, Official Notice, Remittance Advice Message.

   E. To accept payment from Medicaid as payment in full for a covered service, and to make no additional charges to the patient or accept any additional payment from the patient for that service which is covered under the Medicaid Program.

   F. To take assignment and file claims with third party sources (medical, liability insurance, etc.), and if third party payment is made to the Provider, to reimburse Medicaid up to the amount Medicaid paid for the services; to make no claims against third party sources for services for which a claim has been submitted to Medicaid; and to notify Medicaid of the identity of each third party sources discovered after submission of a claim or claims to Medicaid.

   G. To make no charge to a patient for a claim or a portion of a claim when a determination that the service was not medically necessary is made based on the professional opinion of appropriate and qualified medical persons on a committee which performs peer review of Medicaid cases either for the Division of Medical Services or for Peer Review Organizations (PRO); except that such charge can be made to the patient when he/she has requested the service and has prior knowledge that he/she will be responsible for the cost of such service; and to reimburse the Division of Medical Services for all monies paid for claims for services that later were determined to be "not medically necessary".

   H. To provide all services without discrimination on the grounds of race, color, national origin, or physical or mental 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.

   I. To accept all changes legally made in the Program, and recognize and abide by such changes upon being notified by the Medicaid Program in the form of an update to, or an Official Notice/Remittance Advice Message pertaining to, the appropriate Arkansas Medicaid Provider Manual.

   J. That the Department has furnished the Provider with a copy of the Arkansas Medicaid Provider Manual containing the rules, regulations and procedures pertaining to his/her profession. The Provider agrees that the terms and conditions contained therein shall be a part of this contract if the same were set out verbatim herein. The Provider states that he/she is currently licensed to practice in Arkansas or within the State where services were rendered and agrees to promptly notify the Department if his/her license is revoked or suspended. The Provider acknowledges by signature on this contract that he/she has received a copy of the appropriate Arkansas Medicaid Provider Manual.

   K. To conform to all Medicaid requirements covered in Federal or State laws, regulations or manuals.

   L. To certify by original signature within 48 hours of claims being submitted by an electronic media, a claim count and dollar amount billed, that the information on the claims submitted is true, accurate and complete. The Provider agrees to maintain this as a matter of record for all claims submitted electronically, by any media.

M. To notify the Department prior to any change of ownership or operating status. Upon change of ownership or operating status the successor owner or operator shall, as a condition of assumption of this agreement, hold the Department harmless for any rate or payment increases, decreases, or adjustments without respect to whether the increase, decrease, or adjustment relates to services delivered prior to the change in ownership or operating status.

N. FOR HOSPITALS ONLY
To understand that the Peer Review Organization (Arkansas Foundation for Medical Care, Inc.) is responsible for the review of Medicaid admissions to inpatient hospital facilities, specifically for length of stay purposes, medical necessity and as otherwise specified in the Memorandum of Understanding between the individual hospital and Arkansas Foundation for Medical Care, Inc.

II. The Department, in consideration of the material benefits and the covenants and undertakings of the Provider, agrees as follows:

A. To make payment to the above named Provider for the appropriate Medicaid Services provided to eligible Medicaid recipients in accordance with the current Medicaid pricing index in effect at the time of billing, and in accordance with the manual of rules, regulations and procedures that is a part of this contract.

B. To notify the above named Provider of appropriate changes in Medicaid rules and regulations as they occur.

C. To safeguard the confidentiality of any Medicaid record(s) received by the Department, or its fiscal intermediary as specified in Federal and State regulations.

III. This contract may be terminated or renewed in accordance with the following provisions:

A. This contract may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party;

B. This contract will be automatically renewed for one year on July 1 of each year if neither party gives notice requesting termination;

C. This contract may be terminated immediately by the Department for the following reasons:
1) Sanction of provider
2) Returned mail
3) Death of provider
4) Change of ownership
5) Other reasons set out in the appropriate Arkansas Medicaid Provider Manual, Official Notice/Remittance Advice Message.
6) Failure to conform to the terms or requirements of this contract.

If the Provider is a legal entity other than a person, the person signing this Provider Contract on behalf of the Provider warrants that he/she has legal authority to bind the Provider. The signature of the Provider or the person with the legal authority to bind the Provider on this contract certifies the Provider understands that payment and satisfaction of these claims will be made from the Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws.

PROVIDER	**DEPARTMENT OF HUMAN SERVICES**
By: _____ (Signature)	By: _____ (Signature)
Name: _____ (Typed Name)	Name: _____ (Typed Name)
Title: _____	Title: _____
Date: _____	Date: _____ (Effective Date of Contract)

142 Conditions of Participation

Providers enrolled in the Arkansas Medicaid Program must agree to the following conditions of participation:

1. Providers must be licensed and/or certified, as required by law, to practice in the State of Arkansas or in the state in which they practice.

2. Providers are required to keep records that fully disclose the extent of services provided to eligible recipients. All services billed must be documented in the recipient's medical record.

3. Furnish these records, upon request, to authorized representatives of the Division of Medical Services or their designated representatives, State Medicaid Fraud Control Unit and/or representatives of the Department of Health and Human Services. This request may be in the form of written correspondence or on-site audits. Such medical and/or financial audits will be performed to verify services were provided to Medicaid recipients as billed.

4. Furnish records, upon request, which will ensure that charges billed to Medicaid recipients do not exceed charges billed to private patients.

5. The provider must retain all records for five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.

6. Accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any appropriate deductible or coinsurance due and payable under Title XIX (Medicaid).

7. 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. 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.

8. All services provided must be based on medical necessity. The recipient may not be held liable for a claim or portion of a claim when a determination that the services were not medically necessary is made based on the professional opinion of appropriate and qualified persons on a committee which performs Peer Review of Medicaid cases, and/or Medicaid professional staff or consultants.

9. 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.

142 Conditions of Participation (Continued)

10. Claims for services provided to eligible Medicaid recipients must be submitted to the Medicaid claims processing contractor, EDS, within twelve months from the date of service.

11. The provider will notify the Division of Medical Services in writing immediately regarding any changes to their application or contract, such as:

    a. Change of address

    b. Change in members of group, professional association or affiliations

    c. Change in practice or specialty

    d. Change in Internal Revenue Service (IRS) number or Federal Employee Identification Number (FEIN) number

    e. Retirement or death of provider

    f. Change of ownership

12. In the event of a change of ownership or retirement, a provider must continue to retain all Medicaid recipients' records unless an alternative method of providing for the maintenance of the records has been established in writing and approved by the Division of Medical Services.

13. Any provider who engages in fraudulent billing practices will be immediately suspended from participation until these practices are evaluated and resolved. Also, any provider discovered to be involved in fraudulent billing practices or found to be accepting or soliciting unearned rebates, refunds or other unearned considerations, whether in the form of money or otherwise, will be referred to the appropriate legal agency for prosecution under applicable Federal or State laws.

14. Any provider who engages in abuse and/or over-utilization of services provided to Medicaid recipients, when such abuse and/or over-utilization has been determined by a Peer Review Committee, Medicaid professional staff or medical consultants, may be terminated from participation in the Medicaid Program, required to repay monies paid by the Medicaid Program for such services or may have other appropriate action taken upon recommendation of the above referenced parties.

15. 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.

142 Conditions of Participation (Continued)

16. 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.

17. 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.

18. Failure to comply with the above requirements may result in termination from the Medicaid Program and/or recovery of money paid for services by the Division of Medical Services.

19. Except where participation has been terminated, each provider who has been sanctioned may be required to participate in a provider education program as a condition of continued participation. Provider education programs will include, at a minimum:

    a. Instruction on admissions and authorization for payments

    b. Instruction on the use and format of required program forms

    c. Instruction on key provisions of the Medicaid Program

    d. Instruction on reimbursement rates

    e. Instruction on how to inquire about program requirements, payment or billing problems and the overall operation of the program

20. 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.

21. 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 and (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.

142.1 Mandatory Assignment of Claims for "Physician" Services

The Omnibus Budget Reconciliation Act of 1989 requires the mandatory assignment of Medicare claims for "physician" services furnished to individuals who are eligible for Medicare and Medicaid, **including those eligible as Qualified Medicare Beneficiaries (QMB's)**. According to Medicare regulations, "physician" services, for the purpose of this policy, are services furnished by physicians, dentists, optometrists, chiropractors and podiatrists.

As described above, "physician" services furnished to an individual enrolled under Medicare who is also eligible for Medicaid, including Qualified Medicare Beneficiaries, may only be made on an assignment related basis.

143.000 Responsibilities of the Medicaid Recipient

143.100 Charges That Are Not the Responsibility of the Recipient

A. The recipient has no responsibility to pay for Medicaid covered services except in the following situations:

1. Individuals may be billed only if they are ineligible or if they have chosen to receive and agreed to pay for care not covered by the Medicaid Program.

2. If the provider chooses not to accept the recipient as a Medicaid patient in advance of providing the service, the recipient may be billed for care he/she has chosen to receive as a private pay patient.

B. The recipient may not be held liable for a claim or portion of a claim when a determination that the services were not medically necessary is made based on the professional opinion of appropriate and qualified persons performing peer review of Medicaid cases.

C. The recipient may not be held liable for billed charges above the Medicaid maximum allowable.

D. The recipient will not be responsible for billings denied because of provider errors. It is the responsibility of the provider to file claims in a timely manner, correct inappropriate codes and typographical errors and to provide essential information necessary to process the Medicaid claim.

E. The recipient will not be responsible for billings denied because of errors made by Medicaid or the fiscal agent or due to changes in State or Federal mandates.

F. The recipient may not be billed for services denied because a provider failed to request required approval for a service or failed to meet procedural requirements. For instance, a provider may not bill a recipient for a non-emergency surgery for which prior approval is required but was not requested.

G. Medicaid will pay the full amount of the Medicare Part A deductible and/or coinsurance submitted to Medicaid by Medicare.

H. Medicaid payment on Medicare Part B deductible and coinsurance amounts will be the full amount submitted to Medicaid by Medicare. (See Section 144 for Qualified Medicare Beneficiary (QMB) Benefits.)

143.100 Charges That Are Not the Responsibility of the Recipient (Continued)

I. The recipient may not be billed 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.

143.200 Charges That Are the Responsibility of the Recipient

A. The recipient is responsible for all expenses for non-covered services, such as services that are not covered under the scope of the Medicaid Program, services received in excess of Program benefit limitations or services received for which the provider and recipient agreed the Medicaid program would not be billed.

B. The recipient is responsible for charges incurred during a time of ineligibility.

C. The recipient is responsible for the spend down liability on the first day of spend down eligibility.

D. The recipient is responsible for any applicable cost-sharing amount applied by the Medicaid Program.

Section 1902(a) (14) of the Social Security Act permits States to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, copayments or similar cost sharing charges.

If an individual who makes payment at the time of service is later found to be Medicaid eligible and Medicaid is filed, the individual must be refunded the full amount of his/her payment for covered services. If it is agreeable with the individual, these funds may be credited against unpaid non-covered services that are the responsibility of the recipient.

Information relating to cost sharing follows in Sections 143.210 through 143.240.

143.210 Coinsurance

143.211 Inpatient Hospital Coinsurance Charge to Medicaid-Only Recipients

A. Inpatient Admissions through October 31, 2001

For inpatient admissions on and before October 31, 2001, the coinsurance charge per admission for Medicaid recipients is **22%** of the hospital's per diem amount, applied on the first Medicaid covered day.

Example:

A Medicaid recipient is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem amount is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1890.00, the recipient will pay $110.00 (22% Medicaid coinsurance rate).

1. Four (**4** days) times **$500.00** (the hospital per diem) = **$2000.00** (hospital allowed amount).

2. Twenty-two percent (**22%** Medicaid coinsurance rate) of **$500.00** = **$110.00**.

3. Two thousand dollars (**$2000.00** hospital allowed amount) minus **$110.00** (coinsurance) = **$1890.00** (Medicaid payment).

B. Inpatient Admissions on and After November 1, 2001

For inpatient admissions on or after November 1, 2001, the coinsurance charge per admission for Medicaid recipients is **10%** of the hospital's per diem amount, applied on the first Medicaid covered day.

Example:

A Medicaid recipient is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem amount is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1950.00; the recipient will pay $50.00 (10% Medicaid coinsurance rate).

1. Four (**4** days) times **$500.00** (the hospital per diem) = **$2000.00** (hospital allowed amount).

2. Ten percent (**10%** Medicaid coinsurance rate) of **$500.00** = **$50.00** coinsurance.

3. Two thousand dollars (**$2000.00** hospital allowed amount) minus **$50.00** (coinsurance) = **$1950.00** (Medicaid payment).

143.212 Inpatient Hospital Coinsurance Charge to Medicare-Medicaid Dually Eligible Recipients

A. Inpatient Admissions through October 31, 2001

For inpatient admissions on or before October 31, 2001, the coinsurance charge per admission for Medicaid recipients who are also Medicare Part A beneficiaries, is **22%** of the hospital's Arkansas Medicaid per diem amount, applied on the first Medicaid covered day only.

Example:

A Medicare beneficiary, also eligible for Medicaid, is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem amount is $500.00.

1. This is a patient's first hospitalization for the Medicare benefit year; so the patient has not met their Medicare Part A deductible.

2. Medicare pays the hospital its allowed Part A charges, less the **$760.00** deductible, and forwards the payment information to Medicaid.

3. Twenty-two percent (**22%** Medicaid coinsurance rate) of **$500.00** (the Arkansas Medicaid hospital per diem) = **$110.00** (Medicaid coinsurance). Medicaid coinsurance is due for the first day only of each admission covered by Medicare Part A.

4. Seven hundred sixty dollars (**$760.00** Medicare Part A deductible) minus **$110.00** (Medicaid coinsurance) = **$650.00** (Medicaid payment).

If, on a subsequent admission, Medicare Part A assesses coinsurance; Medicaid will deduct from the Medicaid payment, an amount equal to **22%** of one day's Medicaid per diem, for inpatient admissions through October 31, 2001. The patient will be responsible for that amount.

B. Inpatient Admissions On and After November 1, 2001

Effective for dates of service on or after November 1, 2001, the coinsurance charge per admission for Medicaid recipients who are also Medicare Part A beneficiaries, is **10%** of the hospital's Arkansas Medicaid per diem amount, applied on the first Medicaid covered day only.

143.212 Inpatient Hospital Coinsurance to Medicare-Medicaid Dually Eligible Recipients (Continued)

Example:

A Medicare beneficiary, also eligible for Medicaid, is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem amount is $500.00.

1. This is a patient's first hospitalization for the Medicare benefit year; so the patient has not met their Medicare Part A deductible.

2. Medicare pays the hospital its allowed Part A charges, less the **$760.00** deductible, and forwards the payment information to Medicaid.

3. Ten percent (**10%** Medicaid coinsurance rate) of **$500.00** (the Arkansas Medicaid hospital per diem) = **$50.00** (Medicaid coinsurance). Medicaid coinsurance is due for the first day only of each admission covered by Medicare Part A.

4. Seven hundred sixty dollars (**$760.00** Medicare Part A deductible) minus **$50.00** (Medicaid coinsurance) = **$710.00** (Medicaid payment).

If, on a subsequent admission, Medicare Part A assesses coinsurance; Medicaid will deduct from the Medicaid payment, an amount equal to 10% of one day's Medicaid per diem. The patient will be responsible for that amount.

143.220 Copayment of Prescription Drugs

Arkansas Medicaid has a recipient copayment policy in the Pharmacy Program. The copayment amount for the Pharmacy Program is applied per prescription. The recipient is responsible for paying the provider a copayment amount based on the following table:

Medicaid Maximum Amount	Recipient Copay
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

143.230 Exclusions

As required by 42 CFR 447.53(b), the following services are excluded from the recipient cost sharing coinsurance/copayment policy:

A. Services provided to individuals under 18 years of age;

B. Services provided to pregnant women;

C. Emergency services - Services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) Placing the patient's health in serious jeopardy (2) Serious

impairment to bodily functions (3) Serious dysfunction of any bodily organ or part;

143.230 Exclusions (Continued)

D. Services provided to individuals who are inpatients in a hospital, a long term care facility (nursing facility and intermediate care/MR facility) or other medical institution, when, as a condition for receiving the institutional services, the individual is required to spend all but a minimal amount of his/her personal need income for medical care costs.

The fact that a recipient is a resident of a nursing facility does not on its own exclude the Medicaid services provided to the recipient from the cost sharing policy. Unless a Medicaid recipient has applied for long term care assistance through the Arkansas Medicaid Program, been found eligible and Medicaid is making a vendor payment to the nursing facility (NF or ICF/MR) for the recipient, the Medicaid services are not excluded from the cost sharing policy.

E. Family planning services and supplies provided to individuals of childbearing age;

F. Services provided by a Health Maintenance Organization (HMO) to individuals enrolled in the HMO;

G. Services provided to individuals receiving hospice care.

The provider must maintain sufficient documentation in the recipient's medical record which substantiates the exclusion from the recipient cost sharing policy.

143.240 Collection of Coinsurance/Copayment

In the absence of knowledge or indication to the contrary, the provider may accept the recipient's assertion that he/she can not afford to pay the cost sharing coinsurance/copayment amount. The provider may not deny services to any eligible individual due to the individual's inability to pay the cost of the coinsurance/copayment amount. However, the individual's inability to pay does not eliminate his/her liability for the coinsurance/copayment charge. The recipient's inability to pay the coinsurance/copayment amount will not alter the Medicaid reimbursement amount for the claim. Unless the recipient or service is excluded from the coinsurance/copayment policy as listed in Section 143.230, the Medicaid reimbursement amount will be calculated according to current reimbursement methodology minus the appropriate coinsurance amount or appropriate copayment amount.

The method of collecting the coinsurance/copayment amount from the recipient is the responsibility of the provider. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing coinsurance/copayment from the recipient will remain the responsibility of the provider.

144 Qualified Medicare Beneficiary (QMB) Program

The Qualified Medicare Beneficiary (QMB) program was created by the Medicare Catastrophic Coverage Act and uses Medicaid funds to assist low income Medicare beneficiaries. If a person is eligible for the QMB program, Medicaid will pay the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance on other medical services. Medicaid will also pay the Medicare Part A premium, the Medicare Part A hospital deductible and the Medicare Part A coinsurance.

To be eligible, the individuals must be age 65 or older, blind or disabled and enrolled in Medicare Part A or conditionally eligible for Medicare Part A. Their countable income may equal, but cannot exceed the Federal Poverty Level (FPL).

Countable resources may equal but cannot exceed twice the current Supplemental Security Income (SSI) resource limitations.

With the exception of medically needy spend-down categories, individuals may not be certified in a QMB category and in another Medicaid category for simultaneous periods. QMBs do not receive the full range of Medicaid benefits.

For a QMB eligible, Medicaid pays only **Medicare** covered services.

144 Qualified Medicare Beneficiary (QMB) Program (Continued)

Qualified Medicare Beneficiaries do not receive prescription drug benefits through the Medicaid program, however, individuals eligible for QMB receive a plastic Medicaid ID card. Providers must view the AEVCS eligibility display to verify the QMB category of service. The category of service for a QMB will reflect AA-QMB, AB-QMB or AD-QMB. QMB eligibles are limited to cost sharing of Medicare services. The AEVCS system will display the current eligibility.

Not all providers are mandated to accept Medicare assignment on QMB eligibles (See Section 142.1). However, if a non-physician desires Medicaid reimbursement for coinsurance or deductible on a Medicare claim, he/she must accept assignment on that claim and enter the information required by Medicare on assigned claims.

When treated by a provider who must accept Medicare assignment according to Section 142, Conditions of Participation, the recipient is not responsible for the difference between the billed charges and the Medicare allowable amount.

Interested individuals may apply for the QMB program at their local Department of Human Services (DHS) county office.

145 Specified Low Income Medicare Beneficiaries (SMB) Program

The Specified Low Income Medicare Beneficiaries Program (SMB) was mandated by Section 4501 of the Omnibus Budget Reconciliation Act of 1990, effective January 1, 1993.

Individuals eligible as SMBs are not eligible for the full range of Medicaid benefits. They are eligible for only the payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered. SMB individuals do not receive a Medicaid card.

Eligibility criteria for the SMB program are similar to that of the QMB program. The individuals must be age 65 or older, blind or disabled and receiving Medicare Part A Hospital Insurance and Medicare Part B Medical Insurance. Their countable income must be greater than, but not equal to 100% of the current Federal Poverty Level, and less than, but not equal to 120% of the current Federal Poverty Level.

145 Specified Low Income Medicare Beneficiaries (SMB) Program (Continued)

The resource limit may be equal to but cannot exceed twice the current SSI resource limitations.

Interested individuals may apply for services at their local Department of Human Services (DHS) county office.

146 Qualifying Individuals-1 (QI-1) Program

The Balanced Budget Act of 1997, Section 4732, (Public law 105-33) created the Qualifying Individuals-1 (QI-1) program. Individuals eligible as QI-1 are not eligible for Medicaid benefits. They are eligible only for the payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered. Individuals eligible for QI-1 will not receive a Medicaid card, and, unlike QMBs and SMBs, may not be certified in another Medicaid category for simultaneous periods. Individuals who are eligible for both QI-1 and spend down will have to choose which coverage is wanted for a particular period of time.

Eligibility for the QI-1 program is similar to that of the QMB program. The individuals must be age 65 or older, blind or disabled and entitled to receive Medicare Part A Hospital Insurance and Medicare Part B Medical Insurance. Countable income must be at least 120%, but less than 135% of the current Federal Poverty Level.

Countable resources may equal but cannot exceed twice the current SSI resource limitations.

Individuals interested in the program may apply for services at their local DHS county office.

147 Qualifying Individuals-2 (QI-2) Program

Section 4732 of the Balanced Budget Act of 1997 (Public Law 105-33) created the Qualifying Individuals-2 (QI-2) program. Individuals eligible as QI-2 are not eligible for Medicaid benefits. They are eligible for payment for only a portion of the Medicare Part B premium. No other Medicare cost sharing charges will be covered. Individuals eligible for QI-2 will not receive a Medicaid card, and, unlike QMBs and SMBs, may not be certified in another Medicaid category for simultaneous periods. Individuals who are eligible for both QI-2 and spend down will have to choose which coverage is wanted for a particular period of time.

Eligibility for the QI-2 program includes the following criteria: The individuals must be age 65 or older, blind or disabled and entitled to receive Medicare Part A Hospital Insurance and Medicare Part B Medical Insurance. Countable income must be at least 135% but less than 175% of the Federal Poverty Level.

Countable resources may equal but cannot exceed twice the current SSI resource limitations.

Individuals interested in the program may apply for services at their local DHS county office.

148 Recipient Notification of Denied Medicaid Claim

Due to a Federal court ruling, the Division of Medical Services is required to notify Medicaid recipients when a claim for Medicaid payment is denied. A letter is forwarded to recipients each time a medical claim for payment is denied by the Medicaid Program. The notice includes the recipient's name, provider's name, date of service, explanation of service and reason for denial. The notice includes recipient responsibility regarding payment of the denied Medicaid claim.

If the letter indicates the recipient is not responsible for the unpaid amount, the provider may not request payment from the recipient. If the letter indicates the recipient is responsible for the unpaid amount, the provider is responsible for contacting the recipient for payment. For program information regarding responsibilities of the recipient, please refer to Section 143 of this manual. Please refer to Page I-57 of this manual for an example of the recipient notification of denied Medicaid claim.

If the recipient disagrees with the decision made on the Medicaid claim, he/she may file for a fair hearing with the Department of Human Services.

EXAMPLE OF RECIPIENT NOTIFICATION OF DENIED MEDICAID CLAIMS

ARKANSAS MEDICAID PROGRAM
P.O. Box 431
Little Rock, Arkansas 72203-0431

07/25/95

Bonnie B. Butler
221 S. Tara
Atlanta, AR

REFERENCE INFORMATION	
Process Date:	07/28/95
Provider #:	112234002
Medicaid ID #:	0501244201
ICN Claim #:	9895261124450
Letter #:	95271007088

Re: Denial of Payment for Medical Services Provided to Bonnie B. Butler

Seymour Bucks, M.D., an Arkansas Medicaid Provider, has filed a request for payment for medical service provided to Bonnie B. Butler. This request for payment for medical service has been denied by the Arkansas Medicaid Program.

You are not responsible for paying the provider for the following claim as submitted. See reverse side for additional information.

DTL #	SERVICE DATES	TOS	DESCRIPTION OF SERVICE	BILLED AMOUNT	DENIAL CODE*	EOB CODE
01	07/12/95 - 07/12/95	1	90020 COMPREHENSIVE OFFICE VISIT, NEW PT.	$60.00	E	284
02	07/12/95 - 07/12/95	2	57454 COLPOSCOPY AND BIOPSIES OR CERVIX BIOPSY	$189.00	E	284

EXAMPLE

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-8640 *voice* or 682-8933 *TDD*.

*SEE REVERSE SIDE FOR EXPLANATION OF DENIAL CODES AND FAIR HEARING RIGHTS

DENIAL CODES

A - The provider did not receive prior approval for services provided.
B - The service was not covered by the Medicaid program.
C - The service provided was deemed not medically necessary.
D - The provider/recipient was not eligible for Medicaid benefits on the date of service.
E - The provider did not submit a correct and/or complete claim.
F - The claim denied due to Medicaid provider policy guidelines and/or limitations.
G - For this Medicaid service, the benefit limit has been exceeded.

EXAMPLE

FAIR HEARING RIGHTS

This notice is being sent to you for your information. If you have been billed by or are being held financially responsible for these charges as a result of this denial, you may have a right to appeal. Your appeal rights are set out below.

In the event you wish to request a Fair Hearing to appeal this decision, please note the instructions below which will explain how you may take that action. Any request for a Fair Hearing must be received within thirty (30) days of 09/28/89.

HOW TO FILE FOR A FAIR HEARING

If you are not satisfied with the decision on your case, you may request a Fair Hearing by writing to the following address:

The Appeals and Hearing Section
Office of General Counsel
P.O. Box 1437
Little Rock, Arkansas 72203

YOUR RIGHT TO REPRESENTATION

If you request a Fair Hearing, you have the right to appear in person and to be represented by a lawyer or other person you select. Free legal services are available where you live. You may ask your County Human Services Office for their address and phone number.

PLEASE KEEP THIS FORM FOR YOUR RECORDS

150 ADMINISTRATIVE REMEDIES AND SANCTIONS

151 Sanctions

The following sanctions may be invoked against providers based on the grounds specified in the following sections:

A. Termination from participation in the Medicaid Program;

B. Suspension of participation in the Medicaid Program;

C. Suspension, withholding and/or recovery of payments to a provider;

D. Cancellation of the provider agreement or shortening of an already existing provider agreement;

E. Attendance at provider education sessions;

F. Imposition of prior authorization of services;

G. One-hundred percent review of the provider's entitlement prior to payment;

H. Referral to the State Licensing Board for investigation;

I. Referral to the Fraud Investigation Unit;

J. Transfer to a closed-end provider agreement not to exceed 12 months;

K. Referral to appropriate Federal or State legal agency for prosecution under applicable Federal or State laws.

L. Referral to the appropriate state professional health care association's peer review mechanism.

152 Grounds for Sanctioning Providers

Sanctions may be imposed by the Director against a provider for any one or more of the following reasons:

A. Presenting or causing to be presented for payment any false or fraudulent claim for care, services or merchandise.

B. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including but not limited to, billing for services at a higher level than were actually provided or charging Medicaid patients more than other patients receiving the same service.

152 Grounds for Sanctioning Providers (Continued)

C. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements or obtaining entitlement to payments prior to the true effective date.

D. Failing to disclose or make available, upon request, to the Division of Medical Services or its authorized representative, State Medicaid Fraud Control Unit and/or representatives of the Department of Health and Human Services records of services provided to a Medicaid recipient and records of payments made.

E. Failing to provide and maintain quality services, within accepted medical community standards as adjudged by a body of peers, when documented by repeat discrepancies noted by a Peer Review Committee, Medical Review Teams or Independent Professional Review Organizations (P.R.O.).

F. Engaging in a course of conduct or performing an act deemed improper or abusive to the Medicaid program.

G. Breaching the terms of the Medicaid provider agreement or failing to comply with the certification standards or with the terms of the provider certification on the Medicaid claim form.

H. Over-utilizing the Medicaid program by inducing, furnishing or otherwise causing a recipient to receive service(s) or merchandise not otherwise required or requested by the recipient, attending physician or appropriate Utilization Review Committee; or engaging in over-utilization or abuse, defined as a documented pattern of performing and billing tests, examinations, medical visits and/or surgeries for which there is no demonstrable need when such determination as to demonstrable need is made by a qualified committee of professional peers performing Peer Reviews for the Medicaid Program.

I. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

J. Violating any State or Federal provision of the Title XIX Program or any rule or regulation pertaining to Title XIX.

K. Submitting a false or fraudulent application for provider status.

L. Violating any laws, regulations or Code of Ethics governing the conduct of occupations or professions or regulated industries.

M. Accepting patients for whom all required care and services obviously cannot be provided.

152 Grounds for Sanctioning Providers (Continued)

N. Being convicted of a civil or criminal offense relating to performance of a provider agreement with the State or negligent practice resulting in death or injury or sub-standard care to Medicaid recipients.

O. Failure to meet standards required by State or Federal law for participation (e.g. licensure).

P. Exclusion from Medicare because of fraudulent or abusive practices.

Q. Documented evidence that the provider is not accepting Medicaid payment as payment in full for covered services and is collecting additional payment from recipient or responsible person.

R. Refusal to execute a new provider agreement when requested to do so.

S. Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Division of Medical Services.

T. Formal reprimand or censure by an association of the provider's peers for unethical practices.

U. Suspension or termination from participation in another governmental medical program such as Worker's Compensation, Children's Medical Services, Rehabilitation Services or Medicare.

V. Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patient.

W. Failure to pay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments to the State, recipients or responsible person(s).

X. Billing the State Medicaid Program for services prior to those services being provided.

153 Notice of Sanction

1. When a provider has been sanctioned, the Agency shall notify, as appropriate, the applicable professional society, Board of Registration or Licensure and Federal or State agencies of the findings made and the sanctions imposed.

2. Where a provider's participation in the Medicaid Program has been suspended or terminated, the Agency will notify the recipients for whom the provider claims payment for services that such provider has been suspended or terminated and may include the reason for suspension or termination.

154 Rules Governing the Imposition and Extent of Sanction

A. Imposition of a Sanction

1. The decision as to the sanction to be imposed shall be at the discretion of the Director or the designated representative except as provided in paragraph 3.

2. The following factors shall be considered in determining the sanction(s) to be imposed:

   a. Seriousness of the offense(s);

   b. Extent of violation(s);

   c. History of prior violation(s);

   d. Prior imposition of sanction(s);

   e. Prior provision of provider education;

   f. Provider willingness to obey program rules;

   g. Whether a lesser sanction will be sufficient to remedy the problem; and

   h. Actions taken or recommended by peer review groups, Licensing Boards or the State Nursing Home Advisory Council.

3. Where a provider has been convicted of defrauding the Medicaid Program, has been previously suspended due to program abuse or has been terminated from the Medicare Program for abuse, the Agency shall institute proceedings to terminate the provider from the Medicaid Program.

B. Scope of Sanction

1. A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due regard to all relevant facts and circumstances. The violation, failure or inadequacy of performance may be imputed to a person with whom the provider is affiliated where such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

B. Scope of Sanction (Continued)

2. Suspension or termination from participation of any provider shall preclude such provider from submitting claims for payment, either personally or through claims submitted by a clinic, group, corporation or other association to the Agency for any services or supplies provided subsequent to the suspension or termination.

3. No facility, group, corporation or other association which is a provider of services shall submit claims for payment to the Agency for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid Program except for those services or supplies provided prior to the suspension or termination.

4. When the provisions of paragraph B.3 are violated by a provider of services which is a facility, group, corporation or other association, the Division of Medical Services may suspend or terminate such organization and/or any individual person within said organization who is responsible for such violation.

160 FORMAL HEARINGS

161 Notice of Violation

Should the Division of Medical Services have information that indicates that a provider may have submitted bills and/or has been practicing in a manner inconsistent with program requirements and/or may have received payment for which he may not be properly entitled, appropriate action will be taken to notify the provider of the discrepancies noted. The notification will be in writing and will set forth:

a. the nature of the discrepancies or violations;

b. the dollar value of such discrepancies or violations, if appropriate;

c. the method of computing such dollar value;

d. notification of further actions to be taken or sanctions to be imposed;

e. notification of any actions required of the provider and his right to a formal hearing, if appropriate.

161.1 Suspension or Withholding of Payments Pending a Final Determination

Where the Agency has notified a provider of a violation pursuant to paragraph 161 of an overpayment, payments may be withheld on pending and subsequent entitlements in an amount reasonably calculated to approximate the amounts in question, or payments may be suspended pending a final determination.

Where the Agency intends to withhold or suspend payments, it shall notify the provider in writing and shall include a statement of the provider's right to request formal review of such decision, if appropriate.

161.2 Right to Review

Within 10 calendar days after notice of the Agency's intention to sanction, the provider may request a formal hearing. Such request must be in writing. Within 20 calendar days following date of request for hearing, the provider must submit, in writing, a statement and supporting documents setting forth, with particularity, those asserted violations, discrepancies and dollar amounts which the provider contends are in compliance with all rules and regulations and the reasons for such contentions. Suspension or withholding of payments may continue until such time as a final determination is made regarding the appropriateness of the disagreement or amount in question.

161.2 Right to Review (Continued)

Unless a timely and proper request for a formal hearing is received by the Agency, the findings of the Agency shall be considered a final and binding administrative determination.

No formal review will be granted if the basis for termination is a failure to meet standards (including licensure or registration) required by Federal or State law for participation in the Medicaid program.

161.3 Notice of Formal Hearing

When a formal hearing is scheduled, the Division of Medical Services shall notify the provider and/or his attorney in writing of the date, time and place of the hearing. Notice shall be mailed not less than 10 calendar days before the scheduled date of the hearing.

162 Conduct of Hearing

A. The hearing shall be conducted by a hearing officer who is authorized by the Director of Medical Services to conduct such hearings.

B. Testimony shall be taken only under oath, affirmation or penalty of perjury.

C. Each party shall have the right to call and examine parties and witnesses, to introduce exhibits, to question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination. Each party has the right to impeach any witness regardless of which party first called him to testify. Each party has the right to rebut the evidence against him.

D. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil or criminal actions.

E. The hearing officer may order the taking of interrogatories and depositions and assess the expense to the requesting party when the hearing officer deems it proper.

F. The hearing officer may question any party or witness and may admit any relevant and material evidence.

G. The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. Prior to taking evidence, the hearing officer shall explain the issues and the order in which evidence will be received.

162 Conduct of Hearing (Continued)

H. A party has the burden of proving whatever facts it must establish to sustain its position except that a provider has the burden of proof, which shall be current and convincing, to show that services were, in fact, rendered.

I. The burden of producing evidence as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

162.1 Right to Counsel

Any party may appear and be heard at any proceeding described herein through an attorney-at-law or through a designated representative. All persons appearing in proceedings before the Agency shall conform to the standards of conduct practiced by attorneys before the courts of the States. If a person does not conform to those standards, the hearing officer may decline to permit the person to appear in the proceeding or may exclude the person from the proceeding.

162.2 Appearance in Representative Capacity

A person appearing in a representative capacity shall file a written notice of appearance on behalf of a provider identifying himself by name, address and telephone number; identifying the party represented and shall have a written authorization to appear on behalf of the provider. The Agency shall notify the provider in writing of the name and telephone number of its representative.

163 Form of Papers

All papers filed in any proceeding shall be typewritten on legal sized white paper using one side of the paper only. They shall bear a caption clearly showing the title of the proceeding in connection with which they are filed together with the docket number, if any.

The party, his authorized representative or attorney shall sign all papers, and all papers shall contain his address and telephone number. At least an original and two copies of all papers shall be filed with the Division of Medical Services.

163.1 Notice, Service and Proof of Service

A. All papers, notices and other documents shall be served by the party filing same upon all parties to the proceeding. Proof of such service upon all parties shall be filed with the Division of Medical Services.

B. Service shall be made by delivering, in person or by mail, properly addressed with postage prepaid, one copy to each party entitled thereto. When any party or parties have appeared by attorney, service upon the attorney shall be deemed service upon the party or parties.

163.1 Notice, Service and Proof of Service (Continued)

C. Proof of service of any paper shall be by certificate of attorney, affidavit or acknowledgement.

D. Wherever notice or notification by the agency is indicated or required, notification shall be effective upon the date of first class mailing to a provider's or other party's business address or residence.

E. In addition to the methods provided for in these regulations, a provider may be served in any manner permitted by law.

164 Witnesses

A party shall arrange for the presence of his witnesses at the hearing.

165 Amendments

At any time prior to the completion of the hearing, amendments may be allowed on just and reasonable terms to add any party who ought to have been joined, discontinued as to any party, change the allegations or defenses or add new causes of action of defenses. Where the Agency seeks to add a party or a cause of action or change an allegation, notice shall be given pursuant to Section 161, Notice of Violation, and Section 163.1, Notice, Service and Proof of Service, to the appropriate parties except that the provisions of Section 161.2, Right to Review, and Section 161.3, Notice of Formal Hearings, shall not apply. Where a party other than the Division of Medical Services seeks to add a party or change a defense, notice shall be given pursuant to Section 163.1, Notice, Service and Proof of Service. The hearing officer shall continue the hearing for such time as he deems appropriate, and notice of the new date shall be given pursuant to Section 166, Continuances or Further Hearings.

166 Continuances or Further Hearings

A. The hearing officer may continue a hearing to another time or place or order a further hearing on his own motion or upon showing of good cause at the request of any party.

B. Where the hearing officer determines that additional evidence is necessary for the proper determination of the case, he may, at his discretion:

1. Continue the hearing to a later date and order the party to produce additional evidence; or

2. Close the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to both parties, and each party shall have the opportunity for rebuttal.

166 Continuance or Further Hearings (Continued)

C. Written notice of the time and place of a continued or further hearing shall be given, except that when a continuance or further hearing is ordered following a hearing, oral notice of the time and place of the hearing may be given to each party present at the hearing.

167 Failure to Appear

A. If a provider fails to appear at a hearing, a decision may be issued by the hearing officer dismissing the hearing. A copy of the decision shall be mailed to each party together with a statement of the provider's right to reopen the hearing.

B. Any dismissal may be rescinded if the provider makes application to the hearing officer, in writing, within 10 calendar days after the mailing of the decision, showing good cause for his failure to appear at the hearing.

C. If a party to a hearing other than the provider fails to appear at a hearing, and the Director issues a decision on the merits adverse to that party's interests, the decision shall be accompanied by a statement of the party's right to make application to the Director of the Department of Human Services to vacate the decision.

D. Such application shall be in writing and shall be made within 10 calendar days after the mailing of the notice. Upon a showing of good cause, the Director may vacate his decision, and the case may be set for further hearing.

E. All parties shall be notified, in writing, of an order granting or denying any application to vacate a decision.

168 Record of Hearing

A complete record of the proceedings shall be made. The testimony shall be transcribed, and copies of other documentary evidence shall be reproduced when directed by the hearing officer. The record will also be transcribed and reproduced at the request of a party to the hearing provided he bears the cost thereof.

169 Decision

A. At the conclusion of the hearing, the hearing officer shall take the matter under consideration and shall submit to the Director a proposed decision.

B. The proposed decision shall be in writing and shall contain findings of fact, a determination of the issue presented and an order.

169 Decision (Continued)

C. The Director may adopt the proposed decision, or he may reject the proposed decision and have a decision prepared based upon the record, or he may remand the matter to the hearing officer to take additional evidence. In the latter case, the hearing officer, thereafter, shall submit to the Director a new proposed decision.

D. The decision shall be final upon adoption by the Director except that the Provider may appeal the action of the Director to Circuit Court. Copies of the decision shall be mailed to the provider at his last known address and to any representative thereof.

170 ADVANCE DIRECTIVES

On December 1, 1991, the requirements for advance directives in the Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act 1990, P.L. 101-508 took effect. As of December 1, 1991, Medicaid certified hospitals and other health care providers and organizations are required to give patients information about their right to make their own health decisions, including the right to accept or refuse medical treatment. This legislation does not require individuals to execute advance directives.

Medicaid certified hospitals, nursing facilities, hospices, home health agencies and personal care agencies must conform to the requirements imposed by the Health Care Financing Administration. The federal requirements mandate conformity to current State law. Accordingly, providers must:

* Provide all adult patients (not just Medicaid patients) with written information about their rights under State law to make health care decisions, including the right to accept or refuse medical or surgical treatment and the right to execute advance directives. This information must be provided:

    1. by hospitals at the time of the individual's admission as an inpatient,

    2. by nursing facilities:
        a. when the individual is admitted as a resident or
        b. to existing residents no later than the second quarterly review of care occurring after December 1, 1991,

    3. by a provider of home health or personal care services in advance of the individual receiving care and

    4. by hospices at the time of initial receipt of hospice care.

* Maintain written policies, procedures and materials concerning advance directives to ensure compliance with the law.

* Inform all patients and residents about the provider's policy on implementing advance directives.

* Document in each patient's medical record whether the patient has received information regarding advance directives. Providers must also document whether patients have signed an advance directive and must record the terms of the advance directive.

170 ADVANCE DIRECTIVES (Continued)

* Not discriminate against an individual based on whether they have executed an advance directive. All parties responsible for the patient's care are obligated to honor the patient's wishes as stated in the patient's advance directive. A provider who objects to a patient's advance directive on moral grounds must, as promptly as practicable, take all reasonable steps to transfer care to another provider.

* Educate staff and the community on advance directives.

* Tell patients if they wish to complete a health care declaration, the health care provider will provide them with information and a health care declaration form. Providers should acquire a supply of the declaration forms and become familiar with the form.

* Tell patients they have a right to reaffirm advance directives, to change the advance directive or to revoke the advance directive at any time and in any manner, including an oral statement to the attending physician or other health care provider.

On the following pages are a sample form describing advance directives and a sample declaration form which meets the requirements of law. A description of advance directive must be distributed to each patient.

HEALTH CARE DECLARATIONS IN ARKANSAS

OVERVIEW

Under Arkansas Law*, if you are a competent adult age 18 or older, you have the right to participate in making your own medical treatment decisions, including the right to accept or refuse specific forms of health care. As one means of exercising this right, the law allows you to complete written declarations containing instructions as to the kinds of health care decisions you wish to have made on your behalf if you become terminally ill or permanently unconscious and unable to make such decisions on your own. These declarations serve much the same purpose under Arkansas law as "living wills" serve in other states.

SUGGESTED FORMS OF DECLARATION

Arkansas law specifies two standard forms of declaration, one dealing with the possibility of terminal illness, the other dealing with the possibility of permanent unconsciousness. If you wish to make a declaration, you are free to use either or both of these suggested forms, and you are also free to use different wording. You may obtain the standard forms or information on where to obtain them from your physician or other health care provider or from your attorney.

You should be aware that the standard forms do not necessarily address all of the choices you may have the legal right to make. For example, you may wish to insert more detailed instructions concerning your care, such as whether you do or do not wish to have water and food given to you through artificial means if you become terminally ill or permanently unconscious. If you have questions that your physician or health care provider is unable to answer, or if you wish to modify the standard forms by adding special instructions, you may wish to consult with a lawyer or other qualified professional.

CHOICES CONTAINED IN THE STANDARD FORMS OF DECLARATION

Each of the standard forms of declaration allows you to choose one of the following approaches:

1. To instruct your physician to withhold or withdraw life-sustaining treatments that are no longer necessary for your comfort, care, or the alleviation of pain; or
2. To appoint someone else to act as your health care proxy (representative) in making health decisions, including the decision to withhold or withdraw life-sustaining treatment if you become terminally ill or permanently unconscious.

STEPS FOR COMPLETING A DECLARATION

To be effective, your declaration(s) must be signed by you or by someone else acting at your direction and must be witnessed by two individuals. A declaration becomes effective when both of the following have occurred:

1. The declaration is communicated to your attending physician (the physician primarily responsible for your care); and
2. Your attending physician and another consulting physician together determine that you are in a terminal condition and no longer able to make decisions regarding administration of life-sustaining treatment.

IF YOU WISH TO REVOKE YOUR DECLARATION(s)

If you have completed a health care declaration and later wish to revoke it, you may do so at any time and in any manner, without regard to your mental or physical condition at the time you wish to revoke. A revocation becomes effective when it is communicated to the attending physician or other health care provider by the person who is revoking, or by someone who is a witness to the revocation. Methods of revocation include, for example, a clear written or oral expression of your wish to revoke or physical destruction of the original and any copies of the declaration.

COMPLETING A HEALTH CARE DECLARATION FOR ANOTHER PERSON

In the case of minors and adults who are no longer able to make health care decisions, a declaration may be executed by another person acting on their behalf. Arkansas law establishes the following order of priority and provides that a declaration may be executed by the first of the following individuals, or category of individuals, who exists and is reasonably available for consultation:

1. A legal guardian of the patient, if one has been appointed;
2. The parents of the patient, in the case of an unmarried patient under age 18;
3. The patient's spouse;
4. The patient's adult child (or, if there is more than one, the majority of the patient's adult children participating in the decision);
5. The parents of a patient over the age of 18;
6. The patient's adult sibling (or, if there is more than one, the majority of them participating in the decision);
7. Persons standing "in loco parentis" (in place of the parents) to the patient;
8. A majority of the patient's adult heirs at law who participate in the decision.

SAFEGUARDS

In addition, Arkansas law affords the following protections:

1. A patient, even one who has been determined to be terminally ill, may continue to make decisions regarding life-sustaining treatment so long as he or she is able to do so;
2. The declaration of a terminally ill patient will not be given effect in the case of a woman known to be pregnant, as long as it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment;
3. Any physician or other health care provider who is unwilling to carry out the instructions of a patient or health care proxy under the law has an obligation to take all reasonable steps necessary to transfer the care of such patient to another physician or health care provider who will do so;
4. In Arkansas, it is improper for a health care provider or insurer to either prohibit or require the execution of a declaration as a condition of receiving health insurance coverage or the delivery of health care services.
5. A declaration executed in another state in compliance with the law of that state is also valid for the purposes of Arkansas law.

* A.C.A. 20-17-201, et seq. Other rights of minors are covered in A.C.A. 20-17-214.

DECLARATION

(In the Event of a Terminal Condition)

For Residents of ARKANSAS

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to:

(CHECK ONE BOX)

☐ 1. Withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain;

☐ 2. Follow the instructions of _____
(Name)

_____
(Address) (Phone)

whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____, _____

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____ Witness _____

Address _____ Address _____

DECLARATION

(In the Event of Permanent Unconsciousness)

If I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act to:

(CHECK ONE BOX)

☐ 1. Withhold or withdraw life-sustaining treatments that are no longer necessary to my comfort or to alleviate pain;

☐ 2. Follow the instructions of _____
(Name)

_____
(Address) (Phone)

whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____, _____

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____ Witness _____

Address _____ Address _____

Source: ARC 20-17-202

180 THE ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM

The Arkansas Medicaid Primary Care Physician Managed Care Program is a statewide program. Medicaid recipients must select a primary care physician (PCP). The PCP will provide primary care services and health education, and referral to specialty physicians, hospital care, or other services when necessary. The PCP is to assess the recipient's medical condition and to initiate or recommend treatment or therapy as needed. The PCP must assist the recipient in locating needed medical services. The PCP will also coordinate and monitor, on behalf of the recipient, prescribed medical and rehabilitation services. Recipients participating in the PCP Managed Care Program may receive services only from their PCP unless the PCP refers them to another provider, or unless they access a service not requiring a PCP referral. See Section 184 for services not requiring a PCP referral.

181 Medicaid Recipient Participation

Medicaid recipient participation in the program is mandatory except for:

* Recipients who have Medicare as their primary insurance.
* Recipients who are Children's Medical Services (CMS) clients.
* Recipients who reside in a nursing facility (nursing home).
* Recipients who reside in an intermediate care facility for the mentally retarded (ICF/MR).
* Recipients with Medically Needy-Spend Down categories of eligibility. MN means "Medically Needy." The second digit of the numeric Recipient Aid Category is always 7 for Spend-Down categories. See Section 136 of any Arkansas Medicaid provider manual for aid category information.
* Recipients with a retroactive eligibility period. Medicaid will not require PCP enrollment for the period between the beginning of the retroactive eligibility segment and the date of the eligibility authorization. If eligibility extends beyond the authorization date, Medicaid will require enrollment with a PCP unless the recipient is otherwise exempt from PCP program requirements.
* Recipients who are temporarily outside the State of Arkansas. Medicaid will not require PCP enrollment during the recipient's absence from the state.

182 Recipient Selection of a Primary Care Physician

182.10 Primary Care Physicians and Single-Entity PCP Providers

To ensure the availability of their choice, recipients must select three primary care physicians (PCPs). They must list their choices in the order of their preference. They may choose from among the following types of providers.

* Family practitioner
* General practitioner
* Internal medicine
* Obstetrician/gynecologist
* Pediatrician
* Single-Entity Primary Care Physician Providers

    1. Area Health Education Centers (AHEC)
    2. Federally Qualified Health Centers (FQHC)
    3. Family practice and internal medicine clinics at the University of Arkansas Medical Sciences campus

Medicaid recipients wishing to receive primary health care through a single-entity PCP need not enroll with a specific physician. They may choose an FQHC or one of the designated clinics as their PCP.

If a recipient's first choice is a PCP who already has a maximum Medicaid recipient caseload, the recipient's next selection will be effective. Every individual family member eligible for Medicaid must choose a PCP. The PCP may be the same or different for each family member.

182.20 Proximity Requirement

Recipients must choose a PCP who provides primary care services in the same geographical area as the recipient's residence. Medicaid defines the recipient's geographical area inside the State of Arkansas as the recipient's county of residence, counties adjacent to the county of residence and counties which adjoin the counties adjacent to the county of residence. Recipients whose county of residence is an Arkansas county bordering another state may select a PCP in specific cities (see Section 185.12) in the state bordering their county of residence.

182.30 Selection and Change Form

DHS county office staff will give each Medicaid applicant a written and oral explanation of the PCP program. Applicants must complete form **DMS-2609, Primary Care Physician Selection and Change Form**, while in the DHS office, indicating the first, second and third choices of each Medicaid-eligible family member. Applicants may request and receive a copy of the completed form. The county office must retain a copy of the form in the applicant's file. The DHS office will access the Voice Response System (VRS) and enter the PCP's Medicaid provider number into the Automated Eligibility Verification and Claims Submission (AEVCS) system.

182.40 PCP Verification for Providers

AEVCS will display, on an eligibility verification transaction, the name of the recipient's PCP and the beginning date of the recipient's current enrollment with the PCP. Medicaid will not reimburse providers for PCP-restricted services unless AEVCS displays the PCP name. Medicaid providers who are not PCPs should advise recipients with no PCP that Medicaid will not pay the provider's charges until the recipient selects a PCP and obtains a referral for the service.

A recipient without a PCP may make their selection at the PCP's office. The PCP's office staff will enter the selection via the VRS. The enrollment will be effective immediately upon entry, and its effective date will be the date of entry.

182.50 PCP Selection for SSI Recipients

Individuals covered by Medicaid because they are recipients of Supplemental Security Income (SSI) do not choose a PCP when they apply for SSI. When they become eligible for Medicaid, they must choose a PCP at the DHS office in their county of residence or at the office of their chosen PCP. Recipients will document their PCP choice on the Selection and Change Form. Medicaid provider office staff will copy, for their patient's use, form DMS-2609 from page I-79 of any Medicaid provider manual. The PCP office will access the VRS and enter the PCP's Medicaid provider number. **The telephone number of the VRS is 1-800-805-1512**. The recipient may request and receive a copy of the completed selection form. The PCP office must retain a copy of the form in the recipient's file.

182.60 PCP Enrollment at Participating Hospitals

Effective July 1, 1996, staff at participating acute care hospitals may facilitate PCP selection. Medicaid will cover only approved emergency services for recipients with no PCP. A Medicaid recipient with no PCP, seeking non-emergency services, must complete a selection form. Hospital personnel will enter the PCP selection via the VRS. The enrollment will be effective immediately upon entry, and its effective date will be the date of entry. The recipient may request and receive a copy of the completed selection form. The hospital staff must forward a copy of the selection form to the PCP entered on the VRS.

183 Changing the Selection of a Primary Care Physician

183.10 DHS County Office Procedures

Only DHS county offices may change PCP selection per recipient or PCP request. Recipients and PCPs requesting a change of PCP selection must submit written requests to the DHS office in the recipient's county of residence.

The recipient will complete a Selection and Change Form. County office staff will access the VRS to change the PCP. The recipient may request and receive a copy of the completed selection form. The county office must retain a copy of the form in the recipient's file.

183.10 DHS County Office Procedures (Continued)

PCPs must submit their change requests by letter to the county DHS office. The county office will forward to the recipient, a Selection and Change form by which to indicate their new selection. The PCP must also give the recipient written notice, 30 days in advance of the effective date of the termination, that the PCP has requested removal of the recipient from the PCP's caseload and that the recipient must select another PCP (see Conditions of Participation, Section 185.12).

* It is important to note that county office staff cannot remove a PCP from the computer file; they can only replace a PCP's provider number with that of another PCP. When DHS or a Medicaid provider enrolls a recipient with a PCP, the recipient remains enrolled with that PCP until the recipient's current eligibility ends, until the provider no longer participates, or until a DHS county office enters a different PCP provider number into the VRS.

183.20 PCP Changes for Access Purposes

The recipient or the PCP may change the PCP selection for access purposes.

1. The recipient or PCP may request a change of the PCP as often as necessary because the PCP moves to another county, closes their office, or withdraws from the PCP Managed Care Program; or because the State suspends or terminates them as a PCP or as a Medicaid provider.

2. The recipient may request a change of the PCP as often as necessary because the recipient moves to another county.

183.30 PCP Changes for Cause

The recipient, the PCP or the State may change the PCP selection for cause.

Medicaid defines the expression "for cause," in this context, to mean: "substantive and verifiable reasons other than those regarding recipient access to physician primary care services."

183.31 Recipient Requests to Change PCP for Cause

The recipient may request a change of PCP for cause no more often than every 6 months. The recipient may change their selection of a PCP because their arrangement with the PCP is not acceptable to the recipient. Examples of an unacceptable arrangement include, but are not limited to:

1. It takes too long for the recipient to receive from the PCP, a response appropriate to their need. A patient experiencing an acute episode should expect, on the same working day, to speak with the doctor's nurse, to see the doctor, or to receive a referral to another physician or to a setting appropriate to the complaint. However, a wait of 2 to 4 weeks is not unreasonable for annual physicals or screens, or for other non-urgent care.

183.31 Recipient Requests to Change PCP for Cause (Continued)

2. The recipient is unable to contact the PCP.

3. The PCP provides substandard services. The Medicaid Program will investigate allegations of substandard care. Pending substantiation of the allegations, the recipient must continue to use the same PCP. The Arkansas Medicaid Program will notify the recipient, the PCP and the DHS county office of the results of the investigation.

183.32 PCP Requests to Change PCP Selection for Cause

The PCP may request that the recipient change their selection of a PCP because the arrangement with the recipient is not acceptable to the PCP. Examples of an unacceptable arrangement include, but are not limited to:

1. The recipient fails to appear for 2 or more appointments and does not contact the PCP before the scheduled appointment time.

2. The recipient is abusive to the PCP.

3. The recipient does not comply with the PCP's medical instruction.

The PCP must request the change in writing, forwarding a copy to the recipient and to the DHS office in the recipient's county of residence.

The PCP may request a PCP change for cause no sooner than 6 months after the last requested PCP change for the same recipient. For example, if the physician requests that a patient change PCPs, and subsequently agrees to reenroll them as a PCP Managed Care Program patient, the physician may not request another PCP change for cause until 6 months have elapsed since the date of the previous change request for cause.

It is possible for a Medicaid recipient to enroll or reenroll as a managed care patient with a PCP who has previously dismissed them for cause. If this occurs and the PCP wishes not to renew the relationship, the PCP must again submit a written request to the DHS county office and give the recipient 30 days notice to select another PCP. The 6-month waiting period will not apply to properly documented cases of this nature.

183.33 State-Initiated PCP Changes for Cause

The State may initiate a PCP change request as often as necessary. Examples of reasons the State would ask recipients to change PCPs include, but are not limited to:

1. Proven and consistent excessive utilization, or unnecessarily limited utilization of services to recipients.

2. Failure of the PCP to meet their Medicaid contractual obligations.

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM

PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM

SELECTIONS:

I have picked the three (3) physicians named below in order of my preference to be my primary care physician. I understand only one (1) of them will be my primary care physician.

1. _____
PHYSICIAN NAME

2 . _____
PHYSICIAN NAME

3 . _____
PHYSICIAN NAME

CHANGES:

I want to change my primary care physician because:

_____

_____

_____

_____

_____

_____

_____

_____
RECIPIENT SIGNATURE

_____
MEDICAID RECIPIENT I.D. NUMBER

_____
DATE

DMS-2609 (R. 4/95)

184.000 Services Not Requiring a Primary Care Physician Referral

Medicaid services not generally performed by the PCP require a PCP referral. The services listed below are exempt from this requirement.

A. Alternatives for Adults with Physical Disabilities (Alternatives Program) Waiver services. See Section 184.1 for additional information.

B. Ambulance (emergency and non-emergency) services and medical transportation.

C. Anesthesia services, excluding outpatient pain management.

D. Assessment in the emergency department of an acute care hospital (including the physician's assessment) to determine whether an emergency or non-emergency condition exists. The physician and facility assessment fees are exempt from PCP referral requirements only if the Medicaid recipient is enrolled with a PCP.

E. Child Health Management Services (CHMS) for recipients in the Foster Care Program.

F. Dental services.

G. DDS Alternative Community Services (ACS) Waiver services. See Section 184.1 for additional information.

H. Developmental Day Treatment Clinic Services (DDTCS).

I. Disease control services for communicable diseases, including sexually transmitted diseases, human immunodeficiency virus (HIV), and acquired immune deficiency syndrome (AIDS). Medicaid exempts from the PCP referral requirement, testing for and treatment of diseases that the Arkansas Department of Health requires practitioners to report to the Division of Epidemiology.

J. Domiciliary Care.

K. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens, except those provided to Medicaid-eligible individuals residing in one of the twenty-five counties listed on Page I-81. A primary care physician, or a provider authorized by the PCP's referral, must perform the EPSDT screening services (except dental and visual screens) for residents of the listed counties. For Medicaid-eligible residents of the fifty counties not on the list on Page I-81, clinical laboratory services performed to meet Child Health Services (EPSDT) screen requirements (see Section 215.11 of the Child Health Services (EPSDT) Provider Manual) are exempt from PCP referral requirements. A provider billing for the applicable laboratory services must certify within the claim format that the service was the result of an EPSDT screen/referral (refer to the billing instructions in Section III of the appropriate provider manual).

184.000 Services Not Requiring a Primary Care Physician Referral (Continued)

EPSDT Screens Require PCP Referral for Residents of these Counties:

Benton	Craighead	Grant	Marion	Pulaski
Boone	Crawford	Johnson	Ouachita	Randolph
Carroll	Faulkner	Lawrence	Perry	Saline
Clark	Franklin	Lonoke	Poinsett	Sebastian
Clay	Garland	Madison	Pope	Washington

L. ElderChoices Waiver services. See Section 184.1 for additional information.

M. Emergency services in an acute care hospital emergency department, including physician services.

N. Family Planning services.

O. Gynecological care.

P. With the exception of the ARKids Program, mental health services, including:

1. Chemical dependency services.
2. Child Health Management Services (CHMS) *psychological services*.
3. Inpatient mental health services in an acute care hospital.
4. Inpatient psychiatric services for recipients under age 21.
5. Psychiatry.
6. Psychology.
7. Rehabilitation services for persons with mental illness.

Q. Nursing facility services and intermediate care facility for mentally retarded (ICF/MR) services.

R. Obstetrical (prenatal, delivery and postpartum care) services. Only obstetrical-gynecological services are exempt from the PCP referral requirement. The obstetrician or the PCP may order home health care for postpartum complications. The PCP must perform other medical services for a pregnant woman or refer her to an appropriate provider.

184.000 Services Not Requiring a Primary Care Physician Referral (Continued)

S. Pharmacy services.

T. Physician services for inpatients in an acute care hospital. This includes direct patient care (initial and subsequent evaluation and management services, surgery, etc.) and indirect care (pathology, interpretation of X-rays, etc.).

U. Physician visits in the outpatient departments of acute care hospitals. Medicaid will cover these services without a PCP referral only if the Medicaid recipient is enrolled with a PCP and the services are within applicable benefit limitations.

V. Professional components of diagnostic laboratory, radiology and machine tests in the outpatient departments of acute care hospitals. Medicaid will cover these services without a PCP referral only if the Medicaid recipient is enrolled with a PCP and the services are within applicable benefit limitations.

W. Visual care services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye. Visual care services will not require PCP referral, whether performed by medical doctors or optometrists.

X. Other services, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's interest or to program integrity, or would create unnecessary hardship for service providers. This category currently includes:

1. Critical care (physician critical care services).
2. Sexual abuse examination.
3. Activase injection.

184.100 PCP Referral Exemptions for Waiver Programs

Recipients eligible for Medicaid under the guidelines of the waiver programs specified in Section 184 need no PCP referral for waiver services only. When accessing any other Medicaid services, participants in those waiver programs are subject to all requirements of the PCP Managed Care Program. In addition, case managers of waiver program recipients must list in the recipient's plan of care, all services the recipient receives. Waiver program recipients are not eligible for State Plan services unless those services are part of their plan of care and unless the recipient obtains the necessary referrals and otherwise meets all Medicaid Program requirements.

185 Primary Care Physician Participation

185.10 Mandatory PCP Enrollment

Only those physicians and clinics listed in Section 182.10 may qualify as PCPs. Physicians whose specialty is emergency care or who practice exclusively in hospital emergency departments may not enroll as PCPs. Practitioners in the physician specialties listed in Section 182.10 must enroll as PCPs or DMS will terminate their enrollment in the Arkansas Medicaid Physician Program. Of the specialties eligible to enroll as PCPs, only obstetricians and gynecologists are exempt from mandatory PCP enrollment.

185.11 Recipient Caseload Size

A PCP may have up to 1000 Medicaid recipients on their caseload at one time. The State may, at its discretion, raise the recipient limit per PCP in areas the federal government has designated as medically underserved. The State may, at its discretion, raise the recipient limit for an individual PCP, at that PCP's request, if the limit creates hardship on the PCP's practice.

Each PCP may determine their Medicaid caseload limit up to 1000 recipients. In no instance will DMS require a PCP to accept more recipients on their caseload than the PCP has designated as their limit.

PCPs may increase or decrease their caseload limit by no fewer than 10 slots at a time. A PCP must submit a written request to the Division of Medical Services, Provider Enrollment Unit, to change the size of their caseload.

185.12 Conditions of Participation

1. A PCP agrees to comply with all pertinent Medicaid policies, regulations and State Plan standards as:

   A. An Arkansas Medicaid enrolled physician or Federally Qualified Health Center (FQHC) provider,
   B. A Child Health Services (EPSDT) provider, and
   C. A Primary Care Physician provider.

Internal medicine practitioners, obstetricians and gynecologists are exempt from mandatory Child Health Services (EPSDT) enrollment. Area Health Education Centers (AHECs), and the family practice and internal medicine clinics at the University of Arkansas Medical Sciences campus, are the only physician group providers that may enroll as single-entity primary care physician providers.

185.12 Conditions of Participation (Continued)

2. A PCP must be physically located in the State of Arkansas, or in a bordering state trade-area city. The trade-area cities are Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff, Missouri; Poteau and Salisaw, Oklahoma; Memphis, Tennessee; and Texarkana, Texas. Exception: For the purpose of access to service, Arkansas may enroll as PCPs, physicians in bordering state cities that are not trade-area cities. The State will give individual consideration to requests by physicians in those areas to enroll as PCPs.

3. A PCP must have hospital admitting privileges. The State may waive this requirement when necessary to facilitate recipient's access to service. For example, there may not be a hospital in the county in which the PCP practices. The State will allow a physician to enroll if they list on their primary care physician participation agreement the name of a physician with whom they have a working relationship who has hospital admitting privileges.

4. A PCP may not have an emergency care specialty only.

5. A PCP may not refuse to accept as a patient, and may not otherwise discriminate against, a recipient solely on the basis of age, sex, race, national origin, or type of illness or condition. A PCP may refuse to accept a recipient on their caseload if the PCP's specialty precludes providing care to a particular group of patients. For instance:

   * A pediatrician may refuse to accept a recipient on their caseload if the recipient is 14 years of age or older.
   * An obstetrician/gynecologist may refuse to accept on their caseload a male recipient.
   * An obstetrician/gynecologist may refuse to accept on their caseload a female under the age of 12 years.
   * An internal medicine practitioner may refuse to accept on their caseload a recipient 16 years of age or younger.

6. A PCP agrees to give a recipient written notice, 30 days in advance of the effective date of termination, that the PCP has requested removal of the recipient from the PCP's caseload and that the recipient must select another PCP. The PCP must allow the recipient to stay on the PCP's caseload for the 30 days. Please see Section 183.32 for additional information regarding this requirement.

7. A PCP agrees to perform an examination or make necessary referral within 24 hours of contact by government officials in alleged or substantiated cases of abuse, neglect or severe maltreatment of a recipient or when the State of Arkansas has custody of a recipient.

185.12 Conditions of Participation (Continued)

8. A PCP agrees to contact the Arkansas Department of Health Immunizations Data Entry Office to determine the immunization status and requirements of any recipient, under the age of 21, for whom the PCP does not have this information. The in-state and out-of-state telephone number for the Immunizations Data Entry Office is 1-800-574-4040.

9. A PCP agrees to monitor and maintain the Child Health Services (EPSDT) screening periodicity for all recipients in their care under the age of 21. Providers may obtain the date of the most recent EPSDT screen from the AEVCS system by selecting screen type when verifying eligibility. See page I-18C of any Medicaid provider manual for additional information regarding EPSDT screen inquiry.

185.20 Primary Care Physician Access

185.21 24 Hour Access

A PCP will make available 24 hour, 7 days per week access to service for the recipients in their caseload. Each physician will follow the standards of community practice for the county in which they practice.

185.22 Counties with Adequate Physician Coverage

In counties with adequate physician coverage, PCPs will provide for the after-hours care of their patients. Presently, the following counties have adequate physician coverage: Benton, Craighead, Faulkner, Garland, Jefferson, Miller, Pulaski, Saline, Sebastian, Union, Washington and White. In those counties, when Medicaid recipients present to the emergency department for non-emergency care, hospital staff must remind them to contact their PCP, the PCP's designated substitute or the physician on call for their PCP, regardless of the day or the time of day. Please refer to Sections 185.51, 185.52 and 185.53 for policy information regarding physician substitutes in the PCP Managed Care Program.

185.22 Counties with Adequate Physician Coverage (Continued)

1. Effective for dates of service on or after July 1, 1996, if a non-emergent Medicaid recipient in a hospital emergency department refuses to contact their PCP regarding their current medical need, or insists they are unable to contact their PCP; emergency department personnel will call the PCP, the PCP's designated substitute, or the physician on call for the PCP, at the time of the patient's presentation, to request authorization for treatment.

    a. The PCP or their substitute is under no obligation to refer the recipient to the hospital's emergency department for non-emergency care.
    b. If the PCP, PCP substitute or physician on call for the PCP, authorizes a non-emergency outpatient visit, hospital staff and the PCP must note the referral in their respective patient records.

        * The PCP's documentation must state the nature of the patient's complaint and the hospital medical staff's diagnosis and treatment, including pertinent comments and recommendations, such as suggestions that the patient follow up with a visit to their PCP.
        * Documentation by the PCP's office and the hospital must include the date and the time hospital staff contacts the PCP.

2. In some locales with adequate physician coverage, standards of community practice permit individual physicians to refer all their patients to the hospital emergency department during specified hours. Medicaid prefers that PCPs in those areas not resort to such standing orders. However, the PCP Managed Care Program will not intrude in those arrangements at this time. If the PCP's standing order directs hospital staff not to contact the PCP or a substitute during certain hours, hospital staff must contact the PCP's office on the next working day. Hospital staff and the PCP's office staff must meet the following documentation requirements:

    a. The PCP's documentation must state the nature of the patient's complaint and the hospital medical staff's diagnosis and treatment, including pertinent comments and recommendations, such as suggestions that the patient follow up with a visit to their PCP.
    b. Documentation by the PCP's office and the hospital must include the date hospital staff contacts the PCP.
    c. When a PCP resorts to a standing order to a hospital emergency department, the PCP may not consider the emergency department physician to be a PCP substitute. Documentation requirements are as stated directly above. These documentation provisions take precedence over those in Section 185.52 and 185.53 whenever there might be a perceived conflict between the similar instructions.

If a recipient has no PCP, hospital staff will offer to enroll them with a PCP. Medicaid will provide participating hospitals with current listings of local area PCPs. Hospital personnel will enter the recipient's selection via the Voice Response System (VRS), and the enrollment will be effective immediately.

185.23 Counties with Inadequate Physician Coverage

"Inadequate physician coverage" means there are not enough physicians in an area to provide one another with after hours support, and local physicians must refer their patients to the hospital emergency department after their regular office hours. In some such counties, local physicians staff the emergency department part-time or they are on call for one another part-time. The fact remains, however, that in those areas, local physicians are not able to provide full-time coverage among themselves.

1. During regular office hours, hospital staff will encourage the recipient to see their PCP or the PCP's substitute for non-emergency medical care.

    a. If a non-emergent Medicaid recipient in a hospital emergency department refuses to contact their PCP regarding their current medical need, or insists they are unable to contact their PCP; emergency department personnel will call the PCP or the PCP's substitute, at the time of the patient's presentation, to request authorization for treatment.

    b. The PCP or their substitute is under no obligation to refer the recipient to the hospital's emergency department for non-emergency care. If the PCP or the PCP's substitute authorizes a non-emergency outpatient visit, hospital staff and the PCP must note the referral in their respective patient records.

        * The PCP's documentation must state the nature of the patient's complaint and the hospital medical staff's diagnosis and treatment, including pertinent comments and recommendations, such as suggestions that the patient follow up with a visit to their PCP.

        * Documentation by the PCP's office and the hospital must include the date and the time hospital staff contacts the PCP.

2. If a Medicaid recipient presents to the hospital emergency department at a time not during their PCP's regular office hours, hospital staff must request a referral from the PCP, the PCP's substitute or the physician on call for the PCP, if one of these is available. If none are available because only the emergency department physician is on call or on duty, hospital staff must contact the PCP on the next working day. Hospital staff and the PCP's office staff must meet the following documentation requirements:

    a. The PCP's documentation must state the nature of the patient's complaint and the hospital medical staff's diagnosis and treatment, including pertinent comments and recommendations, such as suggestions that the patient follow up with a visit to their PCP.

    b. Documentation by the PCP's office and the hospital must include the date hospital staff contacts the PCP.

185.23 Counties with Inadequate Physician Coverage (Continued)

c. In some areas, as noted above, local physicians who are also PCPs staff the emergency department at least some of the time. When that is the case, the physician on call for a recipient's PCP might also be the emergency department physician. Documentation requirements are as stated directly above. These documentation provisions take precedence over those in Sections 185.52 and 185.53 whenever there might be a perceived conflict between the similar instructions.

If a recipient has no PCP, hospital staff will offer to enroll them with a PCP. Medicaid will provide participating hospitals with current listings of local area PCPs. Hospital personnel will enter the recipient's selection via the Voice Response System, and the enrollment will be effective immediately.

185.30 PCP Services

A PCP agrees to provide primary care services and health education; and to refer patients to specialty physicians, hospital care, or other services when necessary. The PCP will assess the recipient's medical condition and initiate or recommend treatment or therapy as needed. The PCP must assist the recipient in locating needed medical services. The PCP will also coordinate and monitor, on behalf of the recipient, prescribed medical and rehabilitation services.

185.40 PCP Referrals

Recipients participating in the PCP Managed Care Program may receive services only from their PCP unless the PCP refers them to another provider, or unless they access a service not requiring a PCP referral. A PCP may refer a recipient to a specific, named provider only if they name more than one provider and allow the recipient to choose. If the recipient elects to see a provider without a referral, the recipient will be responsible for the charges incurred. With respect to the quality and appropriateness of services, PCPs must accept co-responsibility for the ongoing care of referred patients. Services requiring a PCP referral may not begin until the PCP makes the referral. The PCP must renew, at least every 6 months, any referral for ongoing care. Medicaid defers to the physician's professional judgment in this regard and does not require that the PCP see the patient before making or renewing a referral.

185.41 Referral Form (DMS-2610)

Medicaid provides an optional referral form, the DMS-2610, located on page I-88 that the PCP may use to facilitate referrals. A PCP may also make a referral orally or by note or letter. Medicaid requires documentation of the referral in the recipient's medical record, regardless of the means by which the PCP makes the referral. Medicaid requires the provider receiving the referral to document it also, and to correspond with the PCP regarding the case when appropriate and when the PCP so requests.

185.50 PCP Substitutes

185.51 PCP Substitutes; General Requirements

Medicaid permits physicians to substitute for PCPs in some situations. The 3 requirements immediately following apply to all PCP substitutions *by physicians*.

1. The PCP and the substitute physician must document the substitution in the patient's record(s) as a referral, and include the specific reason for the substitution.

2. The substitute physician must provide the PCP's name and provider number to any other service provider to whom they refer the patient.

3. The substitute physician need not be a PCP.

185.52 PCP Substitutes; Rural Health Clinics and Physician Group Practices

Physicians affiliated with a Rural Health Clinic or enrolled in a Medicaid-enrolled physician group may substitute for a recipient's PCP if the PCP is unavailable. Acceptable reasons for a PCP not to be available are: the PCP's schedule is full because of an unusual number of urgent or time-consuming cases; recipients require services outside the PCP's normal working hours; or the PCP is ill, on vacation or other leave of absence, or in surgery. Habitual overscheduling of patients is not an acceptable reason for a PCP's use of a substitute. PCPs and substitutes must fully document each substitution as a PCP referral.

185.53 PCP Substitutes; Individual Practitioners

Individual practitioners must designate a substitute physician to take telephone calls, see recipients and make appropriate referrals when the PCP is unavailable. Acceptable reasons for a PCP not to be available are: recipients require services outside the PCP's normal working hours; or the PCP is ill, on vacation or other leave of absence, or in surgery. Habitual overscheduling or having too great a caseload are not acceptable reasons for a PCP's use of a substitute. PCPs and substitutes must fully document each substitution as a PCP referral.

185.60 Nurse Practitioners and Physician Assistants in Rural Health Clinics

Licensed nurse practitioners or licensed physician assistants, employed by a Medicaid-enrolled Rural Health Clinic (RHC) provider, may not function as PCP substitutes. However, they may provide primary care for the PCP's recipients, with certain restrictions.

1. The PCP affiliated with the RHC must issue a standing referral for primary care services rendered by nurse practitioners and physician assistants in or on behalf of the RHC.

2. The nurse practitioner or physician assistant may not make any referrals for medical services except for pharmacy services per established protocol.

3. The PCP must maintain a supervisory relationship with the nurse practitioner or physician assistant.

186 Payment of Primary Care Physicians

PCPs will continue to bill Medicaid on a fee for service basis. Additionally, Medicaid will pay the PCP a monthly management fee. Medicaid will pay a set amount per month, for each recipient enrolled with the PCP on the last day of the month, regardless of the duration of the recipient's enrollment with the PCP. The PCP will receive the payments quarterly; in October, January, April and July. An accompanying Remittance Advice and Status Report (RA) will itemize the payments, by recipient and enrollment month. The RA will list each PCP's managed care patients alphabetically, and will include each recipient's Medicaid identification number and address.

187 Non-Primary Care Physician Provider Participation

The PCP only refers recipients for access to a specific type of medical service. The PCP may refer recipients to a specific, named provider as long as more than one choice is given to the recipient. However, if the recipient elects to go to a non-referred-to provider, the recipient will then be responsible for the charges incurred. The PCP does not authorize any Medicaid service provision. The PCP program does not modify any Medicaid provider policy. All providers still must follow all Medicaid policy regulating the specific Medicaid services they are providing, such as medical necessity requirements, prior authorization, care plan development, etc. It remains the responsibility of the referred-to/billing provider, who renders service, to document that all Medicaid program requirements are met.

Except for the excluded services listed in Section 184, provider claims for services not authorized by the PCP will be denied. Providers, who have received a referral from a PCP, must indicate authorization by the PCP on the Medicaid claim to assure the appropriateness of the referral. This authorization is the PCP's Medicaid physician provider number which will be indicated on the Referral Form or verbally given to the provider referred to by the PCP. The provider must have documentation of the referral in the recipient's medical record via the referral form or notation of verbal referral.

DIVISION OF MEDICAL SERVICES
ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM

REFERRAL FORM

_____
Medicaid Provider Receiving Referral

I have performed a clinical assessment of the patient named below, whom I am referring for:

_____

_____

_____

_____

_____

_____

_____

Please advise me, as appropriate, of your medical findings and diagnosis, treatment plan and/or services you provide subsequent to this referral. Please note that services beyond the scope of this referral require a new referral. Referrals for ongoing services require renewal at least every 6 months.

_____ _____
Medicaid Recipient Name | Medicaid Recipient I.D. Number

_____ _____
Primary Care Physician (PCP) Name
(Please print, stamp or type physician's name) | PCP Medicaid Provider Number

_____ _____
PCP Signature | PCP Phone Number

_____
Date

(Reserved)

(Reserved)

200 DEVELOPMENTAL REHABILITATION SERVICES GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Developmental Rehabilitation Services

Providers of Developmental Rehabilitation Services must meet the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. Must be certified as a First Connections Program participant by Arkansas' Division of Developmental Disabilities Services (DDS) to provide early intervention services.

B. Must complete a provider application (Form DMS-652) and a Medicaid contract (Form DMS-653) with the Arkansas Medicaid Program. (Refer to Section I of this manual.)

1. The provider application (Form DMS-652) and Medicaid contract (Form DMS-653) must be submitted with verification of current certification from DDS.

2. Subsequent certifications must be submitted to the Arkansas Medicaid program within thirty days of issuance.

C. The provider application and Medicaid contract must be approved by the Arkansas Medicaid Program.

201.100 Providers of Developmental Rehabilitation Services in Arkansas and Bordering States

Only providers of developmental rehabilitation services in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as **routine services providers** if they meet all Arkansas Medicaid participation requirements outlined above.

Routine service providers may furnish and claim reimbursement for developmental rehabilitation services covered by Arkansas Medicaid. Services are subject to benefit limitations and coverage restrictions set forth in this manual. Claims must be filed according to Section III of this manual.

202 Required Documentation

A. Providers of Developmental Rehabilitation Services must establish and maintain records for each client.

B. Client records must support the levels of service billed to Medicaid.

C. Upon request, providers must furnish records to authorized representatives of the Arkansas Division of Medical Services, Medicaid Fraud Unit, and representatives of the Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS).

1. Medicaid providers must make available all required records for audit and inspection by the Department of Health and Human Services, or their authorized representatives, during normal business hours.

2. All records must be kept for a period of five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish medical records upon request may result in sanctions being imposed. (See Section I of this manual.)

D. All documentation must be made available to representatives of the Division of Medical Services at the time of an audit conducted by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.

E. Providers of Developmental Rehabilitation Services are required to maintain copies of the following documentation in each child's file.

1. A written prescription and referral for First Connections early intervention services signed by the child's primary care physician (PCP).

2. Part C/DDS eligibility verification (page 2 of the Individual Family Service Plan).

3. Program Participation Authorization Form signed by the child's parent(s) or legal guardian(s).

4. A current (within a year) Individual Family Service Plan (IFSP) developed by an interdisciplinary team of professionals, the assigned service coordinator and the parent(s) or guardian(s).

5. The provider of a service must maintain documentation of the service provided. This includes the date, times, activities conducted, outcomes or objectives worked on, progress made and recommendations (if appropriate).

6. Evaluations that meet the requirements of DDS and the First Connections Program.

210 PROGRAM COVERAGE

211 Introduction

The Medical Assistance (Medicaid) Program is designed to assist eligible Medicaid recipients in obtaining medical care within the guidelines specified in Section I of this manual. All Medicaid benefits are based upon medical necessity. See the Glossary (Section IV) of this manual for "medical necessity" definition.

212 Scope

Part C of the Individuals with Disabilities Education Act (IDEA) requires each state to provide mandated early intervention services. The Arkansas Department of Human Services Division of Developmental Disabilities Services (DDS) is the lead agency for the Part C early intervention program in Arkansas. First Connections is the name of the early intervention program.

Arkansas Medicaid's Developmental Rehabilitation Services Program provides coverage for the following First Connections early intervention services that are medically necessary for Medicaid eligible recipients under three years of age:

A. Developmental testing.

B. Therapeutic activities.

213 Exclusions

The following services are excluded from coverage in this program.

A. Services that are not included in the Individualized Family Service Plan (IFSP).

B. Services furnished that are not within the scope of practice of the professional performing them or supervising the activity.

C. Services for individuals who are not Medicaid eligible.

D. Services provided through the Developmental Day Treatment Clinic Services (DDTCS) Medicaid Program.

E. Services provided through the Child Health Management Services (CHMS) Medicaid Program.

F. Services furnished that are not in compliance with the policies and procedures established by DDS and the First Connections Program.

214.000 Coverage

Coverage of Developmental Rehabilitation Services is limited to two basic services for Medicaid eligible recipients who meet the eligibility requirements. Refer to section 214.100 for recipient eligibility criteria and sections 214.200 through 214.220 for information on the services covered.

214.100 Recipient Eligibility

Recipients eligible for these services must meet the following criteria:

A. The recipient must be Medicaid eligible and be under three years of age.

B. The recipient must have an Individualized Family Service Plan (IFSP) developed by a multidisciplinary team, that meets the requirements of Part C of IDEA.

C. The recipient must have been diagnosed by a multidisciplinary team as having a delay of 25% or more in one or more areas of development (physical, cognitive, communication, social or emotional and adaptive).

OR

The recipient must have a diagnosed physical or mental condition that has a high probability of developmental delay. These diagnosed conditions may include but are not limited to:

1. Down's syndrome and other chromosomal abnormalities associated with mental retardation;
2. Congenital syndromes and conditions associated with delays in development such as fetal alcohol syndrome, intra-uterine drug exposure, prenatal rubella, severe macro and microcephaly;
3. Metabolic disorders;
4. Intra-cranial hemorrhage;
5. Malignancy or congenital anomaly of brain or spinal cord;
6. Spina bifida;
7. Seizure disorder, asphyxia, respiratory distress syndrome, neurological disorder, sensory impairments; and
8. Maternal Acquired Immune Deficiency Syndrome.

214.200 Developmental Rehabilitation Services

Developmental rehabilitation services are early intervention services. This program covers two basic services: developmental testing and therapeutic activities. The DDS certified provider must ensure that an individual providing developmental testing services and therapeutic activities services meets the qualifications as outlined in Part C of IDEA and the DDS First Connections services guidelines.

Developmental rehabilitation services may be provided in the recipient's home, in the community or in a clinical setting.

Refer to Section III of this manual for billing instructions and procedure codes for services covered in this program.

214.210 Developmental Testing

Developmental testing is a battery of diagnostic tests for the purpose of determining a child's developmental status and need for early intervention services. This may include, but is not limited to, psychological and behavioral developmental profiles. The profiles are required to determine a person's eligibility for services and the development of the Individualized Family Service Plan (IFSP).

Developmental testing includes two instruments and a narrative report with interpretation.

Developmental testing is not covered through Developmental Rehabilitation Services if developmental testing has been provided and covered through a DDTCS program or a CHMS program within the last six months.

214.220 Therapeutic Activities

Therapeutic activities are services that provide direct instruction to a child, or both the parent or caregiver and the child, to promote the child's acquisition of skills in a variety of developmental areas.

A. Therapeutic activities must be based on an identified need as documented in the IFSP and must be the direct result of the level of delay(s) determined by the inter-disciplinary assessment.

214.220 Therapeutic Activities (Continued)

B. Therapeutic activities **may not** be provided on the same day a Developmental Day Treatment Clinic Services (DDTCS) core service is provided, or on the same day that services are provided in a Child Health Management Services (CHMS) pediatric day program/intervention setting.

C. Therapeutic activities must include direct one on one instruction to the child, or to the child and parent or caregiver.

215.000 Benefit Limits

Benefit limits are the limits on the *quantity* of covered services Medicaid eligible recipients may receive.

A. Developmental testing is limited to a maximum of 4 one hour units of service per calendar year.

B. Therapeutic activities are limited to a maximum of ½ hour units of service per day two days per week.

215.100 Extension of Benefits

Providers may request benefit extensions for **medically necessary** services by submitting appropriate DDS First Connections forms for a benefit extension along with supporting documentation to:

First Connections Infant & Toddler Program
Developmental Disabilities Services
P. O. Box 1437, Slot N503
Little Rock, Arkansas 72203-1437

DDS First Connections Infant & Toddler Program staff is responsible for approval or denial of benefit extension requests. The requesting provider will be notified of approval or denial of the request. The approval notification will list the procedure codes approved for benefit extension, the approved dates or date-of-service range and the number of units of service authorized.

Providers are to file the claims electronically, entering the assigned control number in the Prior Authorization (PA) number field of the HCFA-1500 claim format. Subsequent benefit extension requests will be necessary only when the extension expires or when a recipient's need for services unexpectedly exceeds the amount or number of services granted under the benefit extension.

Providers may obtain the appropriate forms for requesting benefit extensions from the DDS First Connections Service Coordinator or from the First Connections Program in the DDS central office as listed above.

Please refer to Section III of this manual for a listing of the procedure codes.

240 PRIOR AUTHORIZATION

241.000 Prior Authorization (PA) Request Procedures

A. Developmental Rehabilitation Services procedures **require prior authorization**. The DHS Division of Developmental Disabilities Services (DDS) staff is responsible for the review of and approval or denial of all prior authorization requests.

B. The DDS certified initial or ongoing service coordinator must submit all requests for prior authorization of Developmental Rehabilitation Services to:

First Connections Infant & Toddler Program
Developmental Disabilities Services
P. O. Box 1437, Slot N503
Little Rock, AR 72203-1437

C. Each request for prior authorization must include the following documents:

1. Completed DDS First Connections Voucher/Authorization Request Form
2. The signature and evaluation pages of the Individualized Family Service Plan (IFSP)
3. Data Input Form (page 1 for evaluation/page 2 for services)
4. Parental Authorization for services.

Providers may obtain the Prior Authorization (PA) forms from the First Connections program staff.

D. For prior authorization approval, the documentation submitted must substantiate the following:

1. Medical necessity for the service requested.
2. Eligibility for the First Connections Program.
3. Needed service(s) determined by a multi-disciplinary team.
4. IFSP completed within the last year.

E. Requests for prior authorization must be submitted within 30 days of the date of the development of the IFSP. A PA request is processed by the First Connections program staff within 15 working days of the receipt of request.

F. PA requests are returned if required documentation is not included. Partial documentation will not be retained by First Connections. Therefore the requester is required to re-submit the complete packet.

241.000 Prior Authorization (PA) Request Procedures (Continued)

G. First Connections staff will verify information submitted. A prior authorization (PA) control number will be assigned and the PA number will be entered into the Medicaid system.

H. Notification of the prior authorization approval will be sent to the service provider with a copy to the service coordinator and the parent or legal guardian.

I. The PA control number must be entered on the HCFA-1500 claim format when filing claims for reimbursement. Refer to Section III of this manual for billing instructions and procedure codes.

J. If a PA request is denied, the recipient may request a fair hearing. (Refer to section 242.)

241.100 Quality Assurance

The First Connections Program staff will review PA requests for 10% of the total number of children on each service coordinator's caseload. The IFSP will be reviewed and the parent or legal guardian will be contacted to assess successful outcomes for the child and family.

242 Appeal Process

When coverage of services or a prior authorization request for services is denied, the recipient may request a fair hearing of the denial of services from the Department of Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services, within thirty (30) days of the date of the denial notification.

Submit appeal requests to:

Department of Human Services
Appeals and Hearings Section
P. O. Box 1437, Slot N401
Little Rock, Arkansas 72203-1437

250 REIMBURSEMENT

251 Method of Reimbursement

The reimbursement methodology for Developmental Rehabilitation Services is a "fee schedule" methodology. Under the fee schedule methodology, reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowed for each procedure. The maximum allowable fee for a procedure is the same for all Developmental Rehabilitation Services providers.

252 Rate Appeal Process

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision the provider will be afforded the opportunity for a conference, if he/she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services, is unsatisfactory, the provider may then appeal the question to the standing Rate Review Panel established by the Director of the Division of Medical Services. This panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services Management Staff who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

300 GENERAL INFORMATION

301.000 Introduction

The purpose of Section III of the Arkansas Medicaid Manual is to explain the procedures for billing in the Arkansas Medicaid Program.

Three major areas are covered in this section:

A. General Information: This section contains information about electronic options, timely filing of claims, claim inquiries and supply procedures.

B. Billing Procedures: This section contains information on completing claims via AEVCS, NECS or paper. This section also contains information on procedure codes and other program-specific data elements.

C. Financial Information: This section contains information on the Remittance and Status report (RA), adjustments, refunds, and additional payment sources.

301.100 Automated Eligibility Verification and Claims Submission (AEVCS) System

The Automated Eligibility Verification and Claims Submission (AEVCS) System is the method of submitting Medicaid claims electronically. Medicaid requires AEVCS submission of the following claim types: UB-92, HCFA-1500, Vision, Dental, EPSDT and Pharmacy.

Providers have several choices of AEVCS submission methods: personal computer (PC)-based software, point of sale (POS) devices, or adapting their current office management system to submit claims in the proper format to AEVCS.

301.200 Personal Computer (PC) Software

Provider Electronic Solution Application software is available for any provider who submits Medicaid claims. The software requires, at a minimum, 486/66 processor with 8 MB RAM, 25 MB free space, CD-ROM drive, and Windows 95. We strongly recommend running the software on a Pentium 100 (or greater) processor with 16 MB RAM, 25 MB free space, CD-ROM drive and Windows 95, Windows 98, or Windows NT 4.0 or higher. Claims can be transmitted for processing by almost any Hayes-compatible modem, with the exception of the US Robotics Voice Modem and Hewlett-Packard's HP "Pavillion". Eligibility verifications are part of the base software system. The software supports the following claim types: HCFA-1500, UB-92, Dental, EPSDT, Pharmacy and Vision.

301.300 Point of Sale (POS) Devices

A. Emerald - This is a stand-alone POS device with a keyboard, printer and card-swipe. The Emerald is designed for use in offices with no other computer-based communication. The Emerald can be used to verify a patient's eligibility for Medicaid on the date of service, to key a claim for processing on-line or to reverse a claim submitted in error. (Reversals can only be processed on the same day the claim was accepted.)

B. Omni 380 - This is a stand-alone POS device with a keypad, printer and card swipe that allows the providers to verify a recipient's eligibility. Omnis can only check eligibility. The Omni can be beneficial in Admissions, Emergency Rooms and busy reception/check-in areas.

EDS has a staff of representatives available during regular business hours from 8:00 a.m. to 4:30 p.m. (see Section 119 of this manual for EDS holiday closings) to assist with any needs concerning POS devices. Please call the AEVCS Help Desk at (501) 375-1025 (locally and out-of-state), or 1-800-457-4275 (within Arkansas) for help with questions regarding software or POS devices.

301.400 Other AEVCS Solutions

A. Vendor Systems - Providers who have an office management system can opt to have their vendors upgrade their system to support AEVCS on-line transactions. EDS provides vendor specifications to interested vendors. The cost of upgrading the provider's system to support AEVCS is the responsibility of the provider.

B. Batch Solution - Providers who want to transmit a large volume of claims using their existing office management system may request the vendor specifications, which contain the batch specifications, from EDS. The batch solution allows providers to call into a bulletin board system at EDS and upload a batch of claims (transactions). EDS processes the claims, then creates response files on the bulletin board for providers to download.

EDS maintains a Provider Assistance Center to assist Medicaid providers during regular business hours from 8:00 a.m. to 4:30 p.m. (CST). See Section 119 of this manual for EDS holiday closings. Should you have any questions concerning claims payment, please contact the Provider Assistance Center at 1-800-457-4454 (Toll Free) within Arkansas or locally and out-of-state at (501) 376-2211.

EDS has a full time staff of Provider Representatives available for consultation regarding billing problems that cannot be resolved through the Provider Assistance Center. Provider Representatives are available to visit your office to provide training on billing.

302.000 Timely Filing

The Code of Federal Regulations (42 CFR), at 447.45 (d) (1), states "The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service." The 12 month filing deadline applies to all claims, including:

A. Claims for services provided to recipients with joint Medicare/Medicaid eligibility.

B. Adjustment requests and resubmissions of claims previously considered.

C. Claims for services provided to individuals who acquire Medicaid eligibility retroactively.

There are no exceptions to the 12 month filing deadline policy. However, the definitions and additional federal regulations below will permit some flexibility for those who adhere closely to them.

302.100 Medicare/Medicaid Crossover Claims

Federal regulations dictate that providers must file the Medicaid portion of claims for dually eligible beneficiaries within 12 months of the beginning date of service. The Medicare claim will establish timely filing for Medicaid, if the provider files with Medicare during the 12 month Medicaid filing deadline. Medicaid may then consider payment of Medicare deductible and/or coinsurance, even if the Medicare intermediary or carrier crosses the claim to Medicaid after more than a year has passed since the date of service. Medicaid may also consider such a claim for payment if Medicare notifies only the provider and does not electronically forward the claim to Medicaid. Federal regulations permit Medicaid to pay its portion of the claim within 6 months after the Medicaid "agency or the provider receives notice of the disposition of the Medicare claim."

Providers may not electronically transmit to EDS any claims for dates of service over 12 months in the past. To submit a Medicare/Medicaid crossover claim meeting the timely filing conditions in the first paragraph above, please refer to *Patients with Joint Medicare/Medicaid Coverage*, Section 342.000, of this manual. In addition to following the billing procedures explained in Section 342.000, enclose a signed cover memo or Claim Inquiry Form requesting payment for the Medicaid portion of a Medicare claim which was filed to Medicare within 12 months of the date of service, and which Medicare adjudicated more than 12 months after the date of service.

302.200 Clean Claims and New Claims

The definitions of the terms, *clean claim* and *new claim*, help to determine which claims and adjustments Medicaid may consider for payment, when more than 12 months have passed since the beginning date of service.

42 CFR, at 447.45 (b), defines a clean claim as a claim that Medicaid can process "…without obtaining additional information from the provider of the service or from a third party." The definition "…includes a claim with errors originating in a State's claims system."

A claim that denies for omitted or incorrect data, or for missing attachments, is not a clean claim. A claim filed more than 12 months after the beginning date of service is not a clean claim, except under the special circumstances described below.

A new claim is a claim that is unique, differing from all other claims in at least one material fact. It is very important to note that identical claims, received by Medicaid on different days, differ in the material fact of their receipt date, and are both new claims, unless defined otherwise in the next paragraph.

302.300 Claims Paid or Denied Incorrectly

Sometimes a clean claim pays incorrectly or denies incorrectly. When a provider files an adjustment request for such a claim, or refiles the claim after 12 months have passed from the beginning date of service, the submission is not necessarily a new claim. The adjustment or claim may be within the filing deadline. For Medicaid to consider that the submission is not a new claim and, therefore, is within the filing deadline, the adjustment or claim must meet two requirements:

A. The only material fact that differs between the two filings is the claim receipt date, because the Medicaid agency or its fiscal agent processed the initial claim incorrectly; *and*

B. The provider includes documentation that the Medicaid agency or fiscal agent error prevented resubmittal within the 12-month filing deadline.

302.400 Claims With Retroactive Eligibility

Retroactive eligibility does not constitute an exception to the filing deadline policy. If an appeal or other administrative action delays an eligibility determination, the provider must submit the claim within the 12-month filing deadline. If the claim denies for recipient ineligibility, the provider may resubmit the claim when the patient becomes eligible for the retroactive date(s) of service. Medicaid may then consider the claim for payment because the provider submitted the initial claim within the 12-month filing deadline, and the denial was not the result of an error by the provider.

302.400 Claims With Retroactive Eligibility (Continued)

To submit a claim for services rendered to a patient who is not yet eligible for Medicaid, enter, on the claim form or on the electronic format, a pseudo Medicaid recipient identification number, 9999999999. Medicaid will deny the claim. Retain the denial or rejection for proof of timely filing, if eligibility determination occurs more than 12 months after the date of service.

Occasionally, the state Medicaid agency or a federal agency, such as the Social Security Administration, is unable to complete a Medicaid eligibility determination in time for service providers to file timely claims. Arkansas Medicaid's claims processing system is unable to accept a claim for services rendered to an ineligible individual, and to suspend that claim until the individual is retroactively eligible for the claim dates of service. To resolve this dilemma, Arkansas Medicaid considers the pseudo recipient identification number 9999999999 to represent, an "…error originating within (the) State's claims system." Therefore, a claim containing that number is a clean claim if it contains all other information necessary for correct processing. By defining the initial claim as a clean claim, denied by processing error, we may allow the provider to refile the claim when the government agency completes the eligibility determination. The provider must submit with the claim, proof of the initial filing and a letter or other documentation sufficient to explain that administrative processes (such as determination of SSI eligibility) prevented the resubmittal before the filing deadline.

302.500 Submitting Adjustments and Resubmitting Claims

When it is necessary to submit an adjustment or resubmit a claim to Medicaid, after 12 months have passed since the beginning date of service, the procedures below must be followed.

302.510 Adjustments

If the fiscal agent has incorrectly paid a clean claim, and the error has made it impossible to adjust the payment before 12 months have passed since the beginning date of service, a completed Adjustment Request Form (Form EDS-AR-004, page III-60 of this manual) must be submitted to the address specified on the form. Attach the documentation necessary to explain why the error has prevented refiling the claim until more than 12 months have passed after the beginning date of service.

302.520 Claims Denied Incorrectly

Submit a paper claim to the address below, attaching:

A. A copy of the Remittance and Status Report (RA) page that documents a denial within 12 months after the beginning date of service, *or*

B. A copy of the error response to an AEVCS transmission, **computer-dated** within twelve (12) months after the beginning date of service; and

C. Attach additional documentation to prove that the denial or rejection was due to the error of the Division of Medical Services or the fiscal agent. Explain why the error has prevented refiling the claim until more than 12 months have passed after the beginning date of service.

302.520 Claims Denied Incorrectly (Continued)

Send these materials to:

EDS
Provider Assistance Center
P.O. Box 8036
Little Rock, AR 72203-8036

302.530 Claims Involving Retroactive Eligibility

Submit a paper claim to the address below, attaching:

A. A copy of the Remittance and Status Report (RA) page documenting a denial of the claim with 9999999999 as the Medicaid recipient identification number, dated within 12 months after the beginning date of service, *or*

B. A copy of the error response to an AEVCS transmission of the claim with 9999999999 as the Medicaid recipient identification number; the error response **computer-dated** within 12 months after the beginning date of service, *and*

C. Any additional documentation necessary to explain why the error has prevented refiling the claim until more than a year has passed after the beginning date of service.

Send these materials to:

EDS
Provider Assistance Center
P.O. Box 8036
Little Rock, AR 72203-8036

302.600 ClaimCheck® Enhancement

To solve some of the billing problems associated with differing interpretations of procedure code descriptions, EDS implemented the ClaimCheck® enhancement to the Arkansas MMIS system in February 1997. This software analyzes procedure codes and compares them to nationally accepted published standards to recommend more accurate billing. Most ClaimCheck® edits are simply automated versions of Medicaid edits already in place, so claims are resolved much more quickly. In some cases of denied claims, ClaimCheck® can recommend the appropriate procedure code or combination of codes to ensure payment.

ClaimCheck® developers based the software's edits on the guidelines contained in the *Physicians' Current Procedural Terminology* (CPT) book, and Arkansas Medicaid customized it for local policy and procedure codes. ClaimCheck® bases its editing decisions on the individual payee's own established policy, and recommends appropriate actions to the payee's claims processing system.

Please note that ClaimCheck® implementation does not affect Medicaid policy. If there are questions regarding the function of ClaimCheck® edits, the Provider Assistance Center (PAC) may be called at (501) 376-2211 (local and out-of-state) or 1-800-457-4454 (in-state WATS).

303.000 Claim Inquiries

The Arkansas Medicaid Program distributes a weekly Remittance and Status Report (RA) to each provider with claims paid, denied or pending, as of the previous weekend processing cycle. (Sections 320 through 324.800 of this manual contain information for a complete explanation of the RA). Use the RA to verify claim receipt and to track claims through the system. Claims transmitted through the Automated Eligibility Verification and Claims Submission (AEVCS) system will appear on the RA within 2 weeks of transmission. Paper claims and adjustments may take as long as six weeks to appear on the RA.

If a claim does not appear on the RA within the amount of time appropriate for its method of submission, contact the EDS Provider Assistance Center. A Provider Assistance Center Representative can explain what system activity, if any, regarding the submission, has occurred since EDS printed and mailed the last RA. If the transaction on the RA cannot be understood, or is in error, the representative can explain its current status and suggest remedies when appropriate. If there is no record of the transaction, the representative will suggest that the claim be resubmitted.

303.100 Claim Inquiry Form

When a written response to a claim inquiry is preferred, EDS provides a Medicaid Claim Inquiry Form, EDS-CI-003. The form in this manual may be copied, or a supply may be requested from EDS. A separate form for each claim in question must be used. EDS is required to respond in writing only if they can determine the nature of the questions. The Medicaid Claim Inquiry Form is for use in locating a claim transaction and understanding its disposition. If help is needed with an incorrect claim payment, refer to Section 330 of this manual for the Adjustment Request Form and information regarding adjustments.

303.200 Completion of the Claim Inquiry Form

To inquire about a claim, the following items on the Medicaid Claim Inquiry Form must be completed. A copy of this form follows these instructions. In order to answer your inquiry as quickly and accurately as possible, please follow these instructions:

A. Submit one Claim Inquiry Form (EDS-CI-003) for each claim inquiry.

B. Include supporting documents for your inquiry. (Use claim copies, AEVCS transaction printouts, RA copies and/or medical documents as appropriate).

C. Provide as much information as possible in Field 9. This information makes it possible to identify the specific problem in question and to answer your inquiry.

	Field Name and Number	Instructions for Completion
1.	Provider Number	Enter the 9-digit Arkansas Medicaid provider number assigned. If requesting information regarding a clinic billing, indicate the clinic provider number.
2.	Provider Name and Address	Enter the name and address of the provider as shown on the claim in question.
3.	Recipient Name (First, Last)	Enter the patient's name as shown on the claim in question.
4.	Recipient ID	Enter the 10-digit Medicaid identification number assigned to the patient.
5.	Billed Amount	Enter the amount the Medicaid Program was billed for the service.
6.	Remittance Advice Date	Enter the date of the Medicaid RA on which the claim most recently appeared.
7.	Date(s) of Service	Enter the month, day and year of the earliest date of service on the claim in question.

303.200 Completion of the Claim Inquiry Form (Continued)

	Field Name and Number	Instructions for Completion
8.	ICN (Claim Number)	Enter the 13-digit claim control number assigned to the claim by Medicaid. If the claim being questioned is shown on a Medicaid RA, this number will appear under the heading "Claim Number."
9.	Provider Message/Reason for Inquiry	State the specific description of the problem and any remarks which may be helpful to the person answering the inquiry.
10.	Signature, Phone and Date	The provider of service or designated authorized individual inquiring must sign and date the form.

NOTE: The lower section of the form is reserved for the response to your inquiry.

MEDICAID CLAIM INQUIRY FORM

SUBMIT ONE CLAIM INQUIRY FORM PER CLAIM INQUIRY

EDS
P.O. Box 8036
Little Rock, Arkansas 72203

1. Provider Number _____

2. Provider Name and Address:

_____

_____

_____

3. Recipient Name (first, last) _____

4. Recipient ID _____

5. Billed Amount _____ 6. RA Date _____

7. Date(s) of Service _____

8. ICN (Claim Number) _____

THE ABOVE INFORMATION IS USED FOR MAILING PURPOSES, PLEASE COMPLETE

9. Provider Message/Reason for Inquiry: _____

_____

_____

_____

_____

_____

10. Provider Signature _____ Phone _____ Date _____

RESERVED FOR EDS RESPONSE

Dear Provider:

- O This claim has been resubmitted for possible payment.
- O EDS can find no record of receipt of this claim as indicated above. Please resubmit.
- O This claim paid on _____ in the amount of $ _____.
- O This claim was denied on _____ with EOB code .
- O This claim denied on _____ with EOB code 952, "Service requires primary care physician referral."
- O This claim denied on _____ with EOB code 900, "Pricing of this procedure includes related services."
- O This claim denied on _____ with EOB code 280, "Recipient has other medical coverage, bill other insurance first."
- O This claim was received for payment after the 12 month filing deadline.

OTHER: _____

_____

_____

_____

EDS REPRESENTATIVE SIGNATURE _____ DATE _____

304.000 Supply Procedures

304.100 Ordering Forms from EDS

To order EDS-supplied forms, please use the Medicaid Form Request, Form EDS-MFR-001. An example of the form appears on page III-14. EDS supplies the following forms:

Acknowledgement of Hysterectomy Information	(DMS-2606)
Adjustment Request Form - Medicaid XIX	(EDS-AR-004)
CHMS Benefit Extension for Occupational, Physical and Speech Therapy Services	(DMS-629)
Certification Statement for Abortion	(DMS-2698)
Consent for Release of Information	(DMS-619)
DDTCS Transportation Survey	(DMS-632)
EPSDT	(DMS-694)
Explanation of Check Refund	(EDS-CR-002)
Hospice/INH Claim Form	(DHS-754)
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	(DCO-645)
Medicaid Claim Inquiry Form	(EDS-CI-003)
Medicaid Form Request	(EDS-MFR-001)
Medicaid Prior Authorization and Extension of Benefits Request	(DMS-2694)
Medical Equipment Request for Prior Authorization & Prescription	(DMS-679)
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	(DMS-633)
Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral	(DMS-640)
Parent Agreement for Private Duty Nursing for Recipients Under 21	(DMS-610)
Personal Care Assessment and Service Plan	(DMS-618)
Primary Care Physician Selection and Change Form	(DMS-2609)
Prior Authorization and Prescription for Medical Equipment for Medicaid Recipients Under Age 21	(DMS-609)
Referral for Medical Assistance	(DMS-630)
Request for Extension of Benefits	(DMS-699)
Request for Extension of Benefits for Medical Supplies for Medicaid Recipients Under Age 21	(DMS-602)
Request for Prior Authorization and Prescription for Hyperalimentation	(DMS-2615)
Request for Private Duty Nursing Services Prior Authorization and Prescription - Initial Request or Recertification	(DMS-2692)
Request for Targeted Case Management Prior Authorization for Recipients Under Age 21	(DMS-601)
Sterilization Consent Form	(DMS-615)
Sterilization Consent Form - Information for Men	(PUB-020)
Sterilization Consent Form - Information for Women	(PUB-019)
Verification of Medical Services	(DMS-2618)
Visual Care	(DMS-26-V)

304.100 Ordering Forms from EDS (Continued)

Complete the Medicaid Form Request and indicate the quantity needed of each form.

Mail your request to:
EDS
Provider Assistance Center
P. O. Box 8036
Little Rock, AR 72203-8036

The Medicaid Program does not provide copies of the HCFA-1500 claim form. The provider may request a copy of this claim form from any available vendor. An available vendor is:

Superintendent of Documents
U.S. Government Printing Office
Public Documents Department
N.W. Washington, DC 20402

MEDICAID FORM REQUEST

Provider #: _____ Name: _____

Address: _____ City: _____ State/ZIP: _____

Please indicate the quantity of forms below:

_____ DCO-645 (Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage)

_____ DHS-754 (Hospice/INH Claim Form)

_____ DMS-26-V (Visual Care)

_____ DMS-601 (Request for Targeted Case Management Prior Authorization for Recipients Under Age 21)

_____ DMS-602 (Request for Extension of Benefits for Medical Supplies for Medicaid Recipients Under Age 21)

_____ DMS-609 (Prior Authorization and Prescription for Medical Equipment for Medicaid Recipients Under Age 21)

_____ DMS-610 (Parent Agreement for Private Duty Nursing for Recipients Under 21)

_____ DMS-615 (Sterilization Consent Form)

_____ DMS-618 (Personal Care Assessment and Service Plan)

_____ DMS-619 (Consent for Release of Information)

_____ DMS-629 (CHMS Benefit Extension for Occupational, Physical and Speech Therapy Services)

_____ DMS-630 (Referral for Medical Assistance)

_____ DMS-632 (DDTCS Transportation Survey)

_____ DMS-640 (Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral)

_____ DMS-679 (Medical Equipment Request for Prior Authorization & Prescription)

_____ DMS-694 (EPSDT)

_____ DMS-699 (Request for Extension of Benefits)

_____ DMS-2606 (Acknowledgement of Hysterectomy Information)

_____ DMS-2609 (Primary Care Physician Selection and Change Form)

_____ DMS-2615 (Request for Prior Authorization and Prescription for Hyperalimentation)

_____ DMS-2618 (Verification of Medical Services)

_____ DMS-2692 (Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification)

_____ DMS-2694 (Medicaid Prior Authorization & Extension of Benefits Request)

_____ DMS-2698 (Certification Statement for Abortion)

_____ EDS-AR-004 (Adjustment Request Form - Medicaid XIX)

_____ EDS-CI-003 (Medicaid Claim Inquiry Form)

_____ EDS-CR-002 (Explanation of Check Refund)

_____ EDS-MFR-001 (Medicaid Form Request)

_____ PUB-019 (Sterilization Consent Form Information for Women)

_____ PUB-020 (Sterilization Consent Form Information for Men)

Received	Mailed
Date _____	Date _____
By _____	Qty _____

EDS-MFR-001 (Rev. 11/01)

310 BILLING PROCEDURES

311.000 Introduction

Developmental Rehabilitation Services providers use the HCFA-1500 format to bill the Arkansas Medicaid Program for services provided to eligible Medicaid recipients. Each claim may contain charges for only one recipient.

Providers submitting claims electronically, must maintain a daily electronic claim transaction summary, signed by an authorized individual. Refer to the Provider Contract (Form DMS-653).

311.100 Billing Instructions - AEVCS

The Automated Eligibility Verification and Claims Submission (AEVCS) system is the electronic method for verifying a recipient's eligibility and filing claims for payment. A provider may file a claim immediately after providing a service. AEVCS will edit the claim for billing errors and advise of the claim's acceptance into the processing system for adjudication. If AEVCS rejects the claim, it will list up to 9 reasons for the rejection and permit the claim to be corrected and resubmitted.

EDS processes each week's accumulation of claims during the weekend cycle. The deadline for each weekend cycle is 12:00 midnight Friday.

Section 301.000 of this manual contains information on available AEVCS options.

The following table lists the values/comments for each of the fields associated with a HCFA-1500 claim transaction. The last column provides a cross-reference to Section 311.400 of this manual for specific field requirements and instructions.

311.110 AEVCS HCFA-1500 Field Descriptions

Field Name	Values/Comments	Refer to Section 311.400
Header 1 Information		
Provider ID	Billing provider's Medicaid ID number. 9 digit numeric.	Field 33
Recipient ID	Recipient's Medicaid ID number. 10 digit numeric.	Field 1A
First Name	First character only of the recipient's first name.	Field 2
Last Name	First two characters only of the recipients last name.	Field 2
Patient Account Number	Provider can assign an individual number to identify the patient. Default = spaces.	Field 26
Prior Authorization Number	Prior authorization number. 10 digit numeric. Default = spaces.	Field 23
Referring Physician ID	9 digit numeric Medicaid provider number of the referring provider. Default = spaces.	Field 17A
Header 2 Information		
Diagnosis 1	Primary diagnosis code. Do not type the decimal.	Field 21
Diagnosis 2	Secondary diagnosis code, if applicable. Do not type the decimal. Default = spaces.	Field 21
Diagnosis 3	Third diagnosis code, if applicable. Do not type the decimal. Default = spaces.	Field 21
Diagnosis 4	Fourth diagnosis code, if applicable. Do not type the decimal. Default = spaces.	Field 21
Employment Related?	Not applicable to Developmental Rehabilitation Services.	Field 10A
Incident Date	Not applicable to Developmental Rehabilitation Services.	Field 14

311.110 AEVCS HCFA-1500 Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
Header 2 Information (con't)		
Accident Related?	Indicates whether the condition is due to an accident. "Y" = Yes "N" = No.	Field 10B or 10C
Hospital Admit Date	Not applicable to Developmental Rehabilitation Services.	Field 18
Facility Name	Name of facility where services were rendered if other than home or office. Default = spaces.	Field 32
Facility Address	Address of facility where services were rendered. Default = spaces.	Field 32
Outside Lab Work?	Not applicable to Developmental Rehabilitation Services.	Field 20
Therapy Services Code	Not applicable to Developmental Rehabilitation Services.	Field 19
School District Code	Local Education Agency (LEA) code that identifies the school district in which therapy services are rendered.	Field 19
Other Insurance?	Indicates whether the recipient has insurance. "Y" = Yes "N" = No.	N/A
TPL Paid Amount	Amount paid on this claim by third party carrier. Default = zero.	Field 29
TPL Denial Date	Date the claim was denied by third party carrier. Format = CCYYMMDD. Default = zero.	N/A

311.110 AEVCS HCFA-1500 Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
Detail Information		
From DOS	"From" date of service. Format = CCYYMMDD. For spanning dates of service, do not include any date on which no service was rendered.	Field 24A
To DOS	"To" date of service. Format = CCYYMMDD. For spanning dates of service, do not include any date on which no service was rendered.	Field 24A
POS	Place of service code.	See Section 311.200
TOS	Type of service code.	See Section 311.200
Procedure	Procedure code. 5 digit alpha numeric CPT or HCPCS code.	Field 24D
Modifier	Not applicable to Developmental Rehabilitation Services. Default = zero.	Field 24D
Hours	Not applicable to Developmental Rehabilitation Services.	Field 24D
Minutes	Not applicable to Developmental Rehabilitation Services.	Field 24D
Extreme Age	Not applicable to Developmental Rehabilitation Services.	N/A
Surgical Avoid	Not applicable to Developmental Rehabilitation Services.	N/A
Hypothermia	Not applicable to Developmental Rehabilitation Services.	N/A

311.110 AEVCS HCFA-1500 Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
Detail Information (con't)		
Hypotension	Not applicable to Developmental Rehabilitation Services.	N/A
Pressure	Not applicable to Developmental Rehabilitation Services.	N/A
Circulation	Not applicable to Developmental Rehabilitation Services.	N/A
Units	Number of units billed on this claim detail. "0" not valid.	Field 24G
Diagnosis	Diagnosis code that pertains to this detail. Enter appropriate diagnosis code from Header 2.	Field 24E
Charges	Billed amount for this detail.	Field 24F
Fund Code	Not applicable to Developmental Rehabilitation Services.	N/A
EPSDT/Family Planning	Indicates the services were rendered as a result of EPSDT screening. Enter "E" if services are a result of EPSDT screening. "F" = Family Planning. Default = spaces.	Field 24H
Performing Provider ID	Performing provider's Medicaid ID number if different from billing provider. 9 digit numeric.	Field 24K

311.110 AEVCS HCFA-1500 Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
TPL Information		
Carrier Code	National code assigned to identify the specific third party carrier. Default = spaces.	N/A
Policy Number	Third party carrier insurance policy number. Default = spaces.	Field 11
Company Name	Name of the third party carrier. Default = spaces.	Field 11C
Address	Address of the third party carrier. Default = spaces.	N/A
Second TPL	Indicates whether the recipient has a second third party insurance. Response required if primary insurance is entered; "Y" = Yes "N" = No.	Field 11D
Carrier Code	National code assigned to identify the specific third party carrier. Default = spaces.	N/A
Policy Number	Secondary third party carrier policy number. Default = spaces.	Field 9A
Company Name	Name of the secondary third party carrier. Default = spaces.	Field 9D
Address	Address of the secondary third party carrier. Default = spaces.	N/A
Insured/Other than Recipient	Enter "Y" if the insured person is the Medicaid recipient. Enter "N" if insured person is not the Medicaid recipient.	N/A
First Name	First name of the insured person if different from recipient and recipient is covered under the policy. Default = spaces.	Field 4

311.110 AEVCS HCFA-1500 Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
TPL Information (con't)		
Last Name	Last name of the insured person if different from recipient and recipient is covered under the policy. Default = spaces.	Field 4
Address	If the insured person's name is entered, enter the insured person's address. Default = spaces.	Field 7
Employer/ School Name	Name of the insured person's employer or school. Default = spaces.	Field 9C

311.120 AEVCS HCFA-1500 Claim Captured Response

Field Name	Values/Comments	Refer to Section 311.400
POS-Return	If non-zero, system error has occurred.	N/A
Return Code	System-assigned code that identifies the status. "C" = Claim Captured	N/A
ICN	Internal Control Number assigned to the processed claim.	N/A
Full First Name	Recipient's full first name.	N/A
Full Last Name	Recipient's full last name.	N/A
Diag1 Description	Description of the primary diagnosis.	N/A
Diag2 Description	Description of the secondary diagnosis.	N/A
Diag3 Description	Description of the third diagnosis.	N/A
Diag4 Description	Description of the fourth diagnosis.	N/A
Detail Description Count	Number of response descriptions for this transaction.	N/A

311.120 AEVCS HCFA-1500 Claim Captured Response (Continued)

Field Name	Values/Comments	Refer to Section 311.400
Detail Description Segments	Occurs 1-6 times.	N/A
Diagnosis Description	Detail diagnosis description.	N/A
Procedure Description	Detail procedure description.	N/A

311.130 AEVCS HCFA-1500 Claim Rejected Response

Field Name	Values/Comments	Refer to Section 311.400
POS-Return	If non-zero, a system error has occurred.	N/A
Return Code	System-assigned code that identifies the status. "R" = Claim Not Captured (error(s) detected)	N/A
Filler	Not Used.	N/A
Filler	Not Used.	N/A
Error Count	Number of errors to follow.	N/A
Error Segments	Occurs 1-9 times.	N/A
Error Code	Code associated with the errors found on this transaction.	N/A
Detail Number	Location on the claim where the error has occurred. "00" = Header "01" = Detail 1 "02" = Detail 2 "03" = Detail 3 "04" = Detail 4 "05" = Detail 5 "06" = Detail 6	N/A

311.140 AEVCS HCFA-1500 Claim Reversal

Field Name	Values/Comments	Refer to Section 311.400
Transaction Code	Code associated with the type of transaction. "ARCR"	N/A
Software Version	"00"	N/A
Terminal ID	Number that identifies the user's terminal. EDS will assign this number at the time of testing and certification.	N/A
Provider ID	Provider's Medicaid ID number. 9 digit numeric, i.e., 100000001.	N/A
Recipient ID	Recipient's Medicaid ID number. 10 digit numeric, i.e., 0100000101.	N/A
ICN	Internal Control Number assigned to the processed claim.	N/A

311.150 AEVCS HCFA-1500 Claim Reversed Response

Field Name	Values/Comments	Refer to Section 311.400
POS-Return	If non-zero, a system error has occurred.	N/A
ICN	Internal Control Number assigned to the processed claim.	N/A
Return Code	System-assigned code that identifies the status. "A" = Claim Reversed.	N/A

311.160 AEVCS HCFA-1500 Claim Reversal Rejected Response

Field Name	Values/Comments	Refer to Section 311.400
POS-Return	If non-zero, a system error has occurred.	N/A
Return Code	System-assigned code that identifies the status. "R" = Claim Not Reversed.	N/A
Error Count	Number of errors to follow.	N/A
Error Segments	Occurs 1-9 times.	N/A
Error Code	Code associated with the errors found on this transaction.	N/A
Detail Number	Location on the claim where the error has occurred. "00" = Header.	N/A

311.200 Place of Service and Type of Service Codes

Place of Service

3 – Office
4 – Patient's Home
5 – DDTCS Clinic/Day Care Facility
0 – Other locations

Type of Service

Q – Developmental Rehabilitation Services

311.300 Billing Instructions - Paper Claims Only

EDS 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 Developmental Rehabilitation Services, use the HCFA-1500. The numbered items correspond to numbered fields on the claim form. (A sample HCFA-1500 follows these billing instructions.)

The following instructions must be read and carefully adhered to, so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to:

EDS
Claims
P.O. Box 8034
Little Rock, AR 72203

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.

311.400 Completion of HCFA-1500 Claim Form

	Field Name and Number	Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
	A. Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number as it appears on the AEVCS eligibility verification transaction response.
2.	Patient's Name	Enter the patient's last name and first name as it appears on the AEVCS eligibility verification transaction response.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Patient's Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number		Instructions for Completion
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name, (post office box or RFD), city name, state name and zip code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
9.	Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	A. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	B. Other Insured's Date of Birth	This field is not required for Medicaid.
	Other Insured's Sex	This field is not required for Medicaid.
	C. Employer's Name or School Name	Enter the employer's name or school name.
	D. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to	
	A. Employment	Not required for Developmental Rehabilitation Services.
	B. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter State postal abbreviation) where the accident took place. Check "NO" if not auto accident related.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number	Instructions for Completion
C. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
D. Reserved for Local Use	This field is not required for Medicaid.
11. Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
A. Insured's Date of Birth	This field is not required for Medicaid.
Insured's Sex	This field is not required for Medicaid.
B. Employer's Name or School Name	Enter the insured's employer's name or school name.
C. Insurance Plan Name or Program Name	Enter the name of the insurance company.
D. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12. Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13. Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14. Date of Incident/Accident	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15. If Patient Has Had Same or Similar Illness, Give First Date.	This field is not required for Medicaid.
16. Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17. Name of Referring Physician or Other Source	Required, if applicable. Enter the name of the referring physician. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number	Instructions for Completion
A. I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18. Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format. Not required for this program.
19. Therapy Code and/or LEA #	Enter the appropriate code for occupational, physical and speech therapy services. Not required for this program.
20. Outside Lab Work	Check "YES" if laboratory work was performed outside your office. Check "NO" if laboratory work was performed inside your office.
21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with HCFA diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22. Medicaid Resubmission Code	Reserved for future use.
Original Reference Number	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number, if applicable.
24. A. Date of Service	Enter the "from" and "to" dates of service for each service provided in MM/DD/YY format. A single date of service need not be entered twice on the same line. Each claim detail line may include dates from only <u>one</u> calendar month. For example, dates of service 06-15-99 through 07-14-99 must be billed on two lines: 06-15-99 to 06-30-99 and 07-01-99 to 07-14-99. For spanning dates of service, do not include any date on which no service was rendered.
B. Place of Service	Enter the appropriate place of service code. See Section 311.200 for codes.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number	Instructions for Completion
C. Type of Service	Enter the appropriate type of service code. See Section 311.200 for codes.
D. Procedures, Services or Supplies	Enter the procedure code that best describes the service. Enter applicable modifiers if available. A procedure code for a service performed more than once on the same date should be listed as one entry on the claim with multiple units listed in Field 24G.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD- 9-CM.
F. Charges	Enter the charge for the service. This charge should be the provider's customary fee to private-pay clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT Screening/Referral and/or Family Planning	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
I. Emergency	This field is not required for Medicaid.
J. Coordination of Benefit	This field is not required for Medicaid.
K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#."

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number		Instructions for Completion
		When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter this number in Field 33 after "GRP#."
25.	Federal Tax I.D. Number	This field is not required for Medicaid.
26.	Patient's Account Number	This is an optional entry that may be used for accounting purposes. Enter the patient's (recipient's) account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted. The number will appear on the RA and assist in identifying claims.
27.	Accept Assignment	This field is not required for Medicaid.
28.	Total Charge	Enter the total of Column 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. DO NOT enter any payment by the patient or any amount previously paid by Medicaid. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge.
		NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number		Instructions for Completion
31.	Physician's or Supplier's Signature	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and zip code of the facility where services were performed.
33.	Billing Provider	Enter the billing provider's name and complete address. Telephone number is requested but not required.
	Provider I.D. Number	Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE(State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☐	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes, return to and complete item 9 a-d.*
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATES OF SERVICE FROM MM DD YY	TO MM DD YY	B Place Of Service	C Type Of Service	D PROCEDURES. SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27.ACCEPT ASSIGNMENT (For govt. claims, see back) YES ☐ NO ☐
28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I Certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90) FORM AAD-1500
FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS. SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS, and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 US 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as other necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed. Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988" permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this

burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

312.000 SPECIAL BILLING PROCEDURES

312.100 Developmental Rehabilitation Services Procedure Codes

The following is a listing of Developmental Rehabilitation Services procedure codes. It is imperative that the Medicaid code listed for the services provided be used.

Procedure Code	Description	Benefit Limit
96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report, per hour.	Four (4) one hour units per calendar year
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Two 15 minute units per day, two days per week

RESERVED

320 REMITTANCE AND STATUS REPORT

321.000 Introduction of Remittance and Status Report

The Remittance and Status Report, or Remittance Advice (RA), is a computer generated document showing the status and payment breakdown of all claims submitted to Medicaid for processing. It is designed to simplify accounting by allowing accurate reconciliation of claim submissions.

An RA is mailed each week a provider has claims paid, denied or in process. Once a week, all claims completed in a daily cycle are processed through the financial cycle. The RA is produced at the time checks are issued. Checks are written to providers for payment of their claims. The accompanying RAs are produced explaining each provider's payment on a claim by claim basis. Only providers who have finalized claims or claims in process (claims that have been through at least one financial cycle) will receive an RA.

321.100 Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT) allows providers to have their Medicaid payments automatically deposited instead of receiving a check. See Section I of the provider manual for an enrollment form and additional information.

322 Purpose of the RA

The RA is the first source of reference if there are questions regarding a particular claim. If the RA does not resolve the question and it becomes necessary to contact the EDS Provider Assistance Center, reference the applicable claim number. This number will assist EDS staff in providing the answers to questions.

It is necessary for the provider to retain all copies of the RAs to assist in keeping claims and payment records current. Also, this is the provider's only record of paid and denied claims.

The RA is also a status report that inventories the current status of active claims. Should a submitted claim not appear on the RA within four to six weeks after submission, the EDS Provider Assistance Center may be contacted. If the result of this call is the claim, in fact, has not been processed or is not being processed, EDS will ask the provider to resubmit a legible copy of the claim form or to refile the claim electronically.

323 Segments of the RA

There are seven main segments of an RA:

Report Heading
Paid Claims
Denied Claims
Adjusted Claims
Claims In Process
Financial Items
Claims Payment Summary

Refer to the explanation and example of the RA on the following pages. The printed column headings at the top of each page and the numbered field headings are described to help in reading the RA.

324.000 Explanation of the Remittance and Status Report

324.100 Report Heading

	Report Heading	Description
1.	Provider Name and Address	The name and address of the Medicaid provider to whom the Medicaid payment will be made.
2.	RA Number	A unique identification number assigned to each RA.
3.	Provider Number	The unique 9-digit number to which this RA pertains. The payment associated with each RA is reported to the IRS on the federal tax ID linked to each provider number.
4.	Control Number	Internal page number for all RAs produced on each cycle date.
5.	Report Sequence	Assigned sequentially for the provider's convenience in identifying the RA. The first RA received from EDS for the calendar year is numbered "1," the second "2," etc. Filing your RAs in chronological order by this number ensures that none are missing.
6.	Date	The date the RA was produced. This is also the "checkwrite" date, or the date on the check associated with this RA.
7.	Page	The number assigned to each page comprising the RA. Numbering begins with "1" and

increases sequentially.

324.100 Report Heading (Continued)

	Report Heading	Description
8.	Name and Recipient ID	The recipient's last name, first name, middle initial and 10-digit Medicaid identification number. Claims are sorted alphabetically, by patient last name.
9.	Service Dates	Format MM/DD/YY (Month, Day, Year) in "From" and "To" dates of service. For each detail, "From" indicates the beginning date of service and "To" indicates the ending date of service.
10.	Days or Units	The number of times a particular service is billed within the given service dates.
11.	Procedure/Revenue/Drug Code and Description	Procedure code - CPT or HCPCS code corresponding to the service on the claim. The type of service code directly precedes the 5-digit procedure code.
12.	Total Billed	The amount the provider bills per detail.
13.	Non-Allowed	The amount of the billed charge that is non-allowed per detail.
14.	Total Allowed	The total amount Medicaid allows for that detail. (Total Allowed = Total Billed - Non-Allowed)
15.	Spend Down	The amount of money a patient must pay toward his medical expenses when his income exceeds the Medicaid financial guidelines.
16.	Patient Liability	Not applicable.
17.	Other Deducted Charges	The total amount paid by other resources (other insurance or co-pay if either exist).
18.	Paid Amount	The amount Medicaid pays (Paid Amount = Total Allowed - Other Deducted Charges).
19.	Explanation of Benefit Code(s)	A number corresponding to a message which explains the action taken on claims. The messages for each explanation code are listed on the final page of the RA.
20.	Cover Page Messages	Messages written for provider information.

324.200 Paid Claims

This section shows all claims that have been paid, or partially paid, since the previous checkwrite.

	Field Name	Description
1.	County Code	A unique 2-digit number assigned to each recipient's county of residence.
2.	RCC	Reimbursement Cost Containment - The reimbursement rate on file for a hospital. This item doesn't apply to claims filed on HCFA-1500.
3.	Coins, Deductible, PA/LEA, MCR Paid Amt., TPL	Coinsurance, deductible and the Medicare paid amount will be listed for crossover claims. Third Party Liability will show the amount paid by other insurance coverage. If applicable, the prior authorization number will be listed after "PA/LEA."
4.	Claim Control Number	A unique 13-digit control number assigned to each claim by EDS for internal control purposes. Please use this internal control number (ICN) when corresponding with EDS about a claim. Example: 0599033067530 (ICN) Format: RRYYDDDBBBSSS a. RR-05 - The first and second digits indicate the media the claim was submitted on to EDS (e.g., "05" - AEVCS, "10" - magnetic tape, "98" - paper, "50" - adjusted claims). b. YY-99 - The third and fourth digits indicate the year the claim was received.

324.200 Paid Claims (Continued)

Field Name		Description
		c. DDD-033 - The fifth, sixth and seventh digits indicate the day of the year, or Julian date, the claim was received (e.g., 033 = February 2). d. The remaining digits are used for internal record-keeping purposes.
5.	Medical Record Number	The "patient control number" entered in electronic claim format, or "patient account number" (field 26) entered on the HCFA-1500 paper claim.
6.	Diagnosis	The primary diagnosis code used on the claim.
7.	Servicing Physician	The servicing physician's (performing provider) provider number appears only on RAs for groups or clinics.
8.	Admit =	Date of admission to a facility.

324.300 Denied Claims

This section identifies denied claims and denied adjustments. Denial reasons may include: ineligible status, non-covered services and claims billed beyond the filing time limits. Claims in this section will be referenced alphabetically by the recipient's last name, thereby facilitating reconciliation with provider records. Up to three code numbers will appear in the column entitled EOB (Explanation of Benefit) codes. Definitions of EOB codes are on the last page of the RA. The EOB messages regarding denied claims specify the reason EDS is unable to process the claims further.

Denied claims are finalized, and no additional action will be taken on the claims unless the provider has additional information that would allow some payment and refiles the claim accordingly.

Denied claims are listed on the RA in the same format as paid claims.

324.400 Adjusted Claims

Payment errors - underpayments and overpayments as well as payments for the wrong procedure code, wrong dates of service, wrong place of service, etc - can be adjusted by canceling ("voiding") the incorrectly adjudicated claim and processing the claim as if it were a new claim. Most adjustment transactions appear in the *Adjusted Claims* section of the RA. Denied adjustments appear at the end of the *Denied Claims* section of the RA.

The simplest explanation of an adjustment transaction is:

A. EDS subtracts from today's check total the full amount paid on a claim that contained at least one payment error.

B. EDS reprocesses the claim - or processes the corrected claim - and pays the correct amount.

C. EDS adds the difference to the remittance (or subtracts the difference if it is a negative amount).

Adjustments sometimes appear complicated because the necessary accounting and documentation procedures add a number of elements to an otherwise routine transaction. Also, there are variations in the accounting and documentation procedures, because there is more than one way to submit an adjustment and there is more than one way to adjudicate and record adjustments. There are positive (additional payment is paid to the provider) and negative (the provider owes EDS additional funds) adjustments, adjustments involving withholding of previously paid amounts, adjustments submitted with check payments and denied adjustments. The following subsections thoroughly explain adjustments, how they appear on the RA, and the meaning, from a bookkeeping perspective, of each significant element.

324.410 The Adjustment Transaction

The *Adjusted Claims* section has two parts. Each part is divided into two segments. The first part is the adjustment transaction. The adjustment transaction is divided into a "Credit To" segment and a "Debit To" segment.

324.411 The "Credit To" Segment

The first segment of the adjustment transaction is the "Credit To" segment. In this section, EDS identifies the adjustment transaction, the adjusted claim, and the previously paid amount EDS will withhold from today's check as a result of this adjustment. The adjustment transaction is identified by an internal control number (ICN) that follows the field heading, "Claim Number." Adjustment ICNs are formatted in the same way as claim numbers; the first two digits of an adjustment ICN are "50." Immediately to the right of the adjustment ICN are the words "Credit To," followed by the claim number and paid date of the original claim that paid in error.

324.411 The "Credit To" Segment (Continued)

Underneath the "Credit To" line are displayed the recipient's Medicaid ID number, the claim beginning and ending dates of service and the provider's medical record number (or the patient account number) from the original claim, followed by the original billed amount. Keep in mind that EDS adjusts the entire claim, even if only one detail paid in error, so the total billed amount shown here is the total billed amount of the entire claim being adjusted. At the right end of this line, in the "Paid Amount" column, is the amount originally paid on the claim, which is the amount EDS will withhold from today's remittance.

The actual withholding of the original paid amount does not occur in the *Adjusted Claims* section; it occurs in the *Financial Items* section of the RA. Adjustments are listed in *Financial Items*, with the appropriate amounts displayed under the field headings "Original Amount," "Beginning Balance," "Applied Amount" and "New Balance." (Please see the discussion of *Financial Items* in Section 324.600.) Finally, the total of all amounts withheld from the remittance is displayed under "Withheld Amount," in the *Claims Payment Summary* section of the RA.

324.412 The "Debit To" Segment

A. The second segment of the adjustment transaction is the "Debit To" segment. In this segment, EDS displays the adjudication of the reprocessed claim and, for informational purposes, the net adjustment amount. The net adjustment amount is the additional amount to be paid in this remittance as a result of the adjustment, **or** it is the amount by which the remittance will be less than the total of all paid claims minus AEVCS fees and other withheld amounts.

B. The "Net Adjustment" amount - the amount due to EDS when adjusting an overpayment, or the amount due to the provider when adjusting an underpayment - is on the second line of the "Debit To" segment.

1. In the case of an adjustment of an underpayment, the "Net Adjustment" amount will be added to the total paid claims amount on today's remittance.

2. If EDS is due the amount shown as the net adjustment, the letters "CR" will immediately follow the amount. "CR" means that the claim's original paid amount is greater than the new paid amount (as when the original payment is an overpayment), and the amount denoted by "CR" must be deducted from the total paid claims amount on today's remittance.

C. Adjudication:

Immediately following the "Net Adjustment" line is the complete adjudication of the reprocessed claim, cross-referenced to the original claim number. The last line displays the new paid amount. The difference between the paid amount in the "Credit To" segment and the paid amount in the "Debit To" segment is the amount shown in "Net Adjustment." (See subpart B, above.)

324.420 Adjusted Claims Totals

At the end of the adjustment transactions is the total number of adjusted claims in today's RA, the total of all billed amounts, the total non-allowed amounts and the total of all paid amounts, the last being the total "Debit To" amount, as well.

For information purposes, the last segment is the total of all "Net Adjustment" amounts in today's RA. Net adjustment amounts displayed with "CR" are treated as negative numbers in the calculation of the net adjustment total.

324.430 Adjustment Submitted with Check Payment

Some providers prefer to send a check for the overpayment amount with their adjustment request. In such a case, the original paid amount displayed in the "Credit To" segment is listed in the *Financial Items* section of the RA with an EOB code indicating that EDS has received a check for that amount. Also, since EDS does not withhold that amount from the remittance, it appears in the *Claims Payment Summary* section under "Credit Amount" (instead of appearing under "Withheld Amount"). If EDS acknowledges more than one payment by check in *Financial Items*, the total of those check payments appears under "Credit Amount" in the *Claims Payment Summary* section. Amounts shown under "Credit Amount" are never deducted from the remittance because they are already paid.

324.440 Denied Adjustments

Occasionally an adjusted claim is denied. Adjustments can be denied for any of the reasons for which any other claim can be denied. Denied adjustments do not appear in the *Adjusted Claims* section. Denied adjustments do not have "Credit To" segments. Denied adjustments do not reflect a cross-reference to the original claim. Denied adjustments appear at the end of the *Denied Claims* section. Their adjudication is displayed by detail, in the same manner as an adjustment "Debit To" segment. The original paid amount of the claim intended to be adjusted is withheld from the remittance and it is so indicated in the *Financial Items* section, listed under the adjustment ICN.

324.500 Claims In Process

This section lists those claims that have been entered into the system but have not reached final disposition. Please do not rebill a claim shown in this section, as it is already in our system and will result in a rejection as a duplicate claim. These claims will appear on subsequent RAs in this section until they are paid, denied or returned.

Summary totals follow this section.

	Field Name	Description
1.	Recipient ID	The recipient's 10-digit Medicaid identification number.
2.	Patient Name	The recipient's last name, first name and middle initial.
3.	Service Dates: From	The beginning date of service for this claim.
4.	Service Dates: To	The ending date of service for this claim.
5.	Claim Number	The unique 13-digit number assigned to each claim for control purposes.
6.	Total Billed	The total amount billed by the provider. (The sum of the detail lines.)
7.	Medical Record	The "patient control number" entered in electronic claim format, or "patient account number" (field 26) entered on the HCFA-1500 paper claim.
8.	Explanation of Benefit Code(s)	Numeric representation of messages which explain what research is being done to the claim before payment can occur. Detailed descriptions of these messages will be listed on the last page of the RA.

324.600 Financial Items

This section contains a listing of the payments refunded by the provider, amounts recouped since the previous checkwrite, payouts and other transactions. It also includes any other recoupment activities being applied that will reflect negatively to the provider's total earnings for the year. The Explanation of Benefit codes beside each item indicate the action taken.

The "Credit To" entries from the *Adjusted Claims* section that are being recouped are listed in the *Financial Items* section. The "Credit To" portion of all adjusted claims appears in the *Adjusted Claims* section as information only and is actually applied in the *Financial Items* section.

	Field Name	Description
1.	Recipient ID	The recipient's 10-digit Medicaid identification number.
2.	From DOS	The from date of service.
3.	Transaction Dates	The date on which this transaction was entered into the system.
4.	Claim Control Number	The unique number assigned to this transaction by EDS.
5.	Reference	Information that may be of help in identifying the transaction (example, recipient's name).
6.	Original Amount	The original amount of the transaction. This amount will be the same on each RA for a particular transaction until it has been completed.
7.	Beginning Balance	The amount remaining for this transaction prior to this RA. (For example, if a recoupment had been initiated for $1,000.00, but only $200.90 was deducted, then the next RA would show a beginning balance of $799.10 to be recouped.)

324.600 Financial Items (Continued)

	Field Name	Description
8.	Applied Amount	The amount applied on this RA to the beginning balance. (If the provider sent a refund check for two different recipients or if the monies were recouped from two different recipients, then the amounts applicable to each recipient would be displayed in the applied amount column individually.)
9.	New Balance	The amount left for this transaction after this RA.
10.	Explanation of Benefit Code(s)	The last page of the RA will give detailed descriptions.

324.700 AEVCS Transactions

This section contains a listing of all AEVCS transactions by the transaction category and transaction type submitted by the provider. It also contains separate totals for claim transactions, reversal transactions and total transactions for this provider.

	Field Name	Description
1.	Transaction Category	This field indicates the type of transaction submitted by the provider.
2.	Transaction Types	The type of claim transmitted by the provider.
3.	Transaction Count	The total number of transactions for the transaction type.
4.	Transaction Amount	The total charges for transactions transmitted for the transaction type.
5.	Total Claim Transaction	The total number of claims transmitted and the total charges for the transaction category.
6.	Total Reversal Transaction	The total number of reversals submitted by the provider. This is informational only as there are no transaction fees for reversals.
7.	Total Transactions For This Provider	The total number of AEVCS transactions, including claims transmitted, reversals, eligibility verifications and total charges.

324.800 Claims Payment Summary

This section summarizes all Medicaid payments and credits made to each provider for the specific RA pay period entitled "Current Processed" as well as for the year entitled "Year to Date Total."

	Field Name	Description
1.	Days or Units	The total days or units paid, denied and adjusted.
2.	Claims Paid	Total number of claims paid, denied and adjusted by the Medicaid Program.
3.	Claims Amount	Total paid amount from *Paid Claims* section plus any supplemental payouts (e.g., resulting from a "Debit To" adjustment listed in the *Adjusted Claims* section).
4.	Withheld Amount	Total amount withheld from RA (e.g., resulting from "Credit To" Adjustments). This amount is the sum of the "Applied Amount" fields of the *Financial Items* section.
5.	Net Pay Amount	Claims amount less withheld amount(s). This is the amount of the provider's check.
6.	Credit Amount	Total amount refunded to the Medicaid Program by the provider. EDS posts check refunds here. See Section 330
7.	Net 1099 Amount	The provider's income reported to Federal and State governments for tax purposes. This amount is derived from the Net Pay Amount less the Credit Amount.
8.	Tax Amount	The amount of tax withheld on this RA. Not currently used.
9.	Quarterly Tax Amount	The cumulative amount of tax withheld for this financial quarter. Not currently used.
10.	AEVCS Transaction Fees	Total amount of AEVCS transaction fees charged to the provider.
11.	AEVCS Transaction Recoupment Amount	Total amount of AEVCS transaction fees withheld from the RA. This amount is obtained from the "Total Transactions For This Provider" field of the AEVCS transaction section.

324.800 Claims Payment Summary (Continued)

	Field Name	Description
12.	Deferred Compensation Recoup Amount	Amount withheld from the RA and deposited in the provider's designated account for deferred compensation.
13.	ARKids 1st/CHIP/Medicaid Summary	A summary count and total amount paid for ARKids First, CHIP and Medicaid claims.
14.	Explanation of Benefit Code(s)	The descriptions of all explanation of benefit codes used in the RA.
15.	Federal Tax ID	The provider's social security number or federal Employer Identification Number (EIN). All monies paid to the provider will be reported to the IRS under this number. If the number listed is incorrect, contact the provider enrollment unit to update the file.

Developmental Rehabilitation Services sample RA

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

1 PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

2 R/A NUMBER 12345

3 **STATE OF ARKANSAS**

PROVIDER NUMBER 123456105

4 CNTRL NUM 1

5 REPORT SEQ NUMBER 3

6 DATE 12/01/01 PAGE 1 7

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
8	9						10	11	12	13	14	15	16	17	18	19

20 TO ALL PROVIDERS

THE PURPOSE OF THE “RA MESSAE” IS TO KEEP YOU INFORMED. PLEASE READ EACH ONE AND CONTACT EDS IF YOU HAVE ANY QUESTIONS CONCERNING THE RA MESSAGE.

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

REMITTANCE ADVICES CANNOT BE FORWARDED. THEREFORE, THE ARKANSAS MEDICAID PROGRAM MUST BE NOTIFIED OF AN ADDRESS CHANGE WITH THE PROVIDER’S ORIGINAL SIGNATURE (NO FACSIMILE). PLEASE INDICATE ALL PROVIDER NUMBERS AFFECTED BY THE CHANGE.

Developmental Rehabilitation Services sample RA

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456178 CNTRL NUM 2 REPORT SEQ NUMBER 3 DATE 11/01/01 PAGE 2

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM YY	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
PAID CLAIMS MEDICAL	1			2				4	5	6		7		8		
DUNN, JOHN	CO = 60			RCC =				CLAIM NUMBER = 9801294123456	MRN =		DIAG =		SERV PHYS = 123456178		ADMIT =	
0123456789	10	21	01	10	21	01	2 Q	96111 00 DEVELOPMENTAL TESTING	110 00	7 22	102	78 00		00	102 78	61
	COST SHARE = 00						PA/LEA =	TPL = 00	110 00	7 22	102	78 00		00	102 78	TAX = 00
SMITH, BOB	CO = 26			RCC =				CLAIM NUMBER = 9801297123456	MRN =		DIAG =		SERV PHYS = 123456178		ADMIT =	
0123654789	10	24	01	10	24	01	1 Q	97530 00 THERAPEUTIC ACTIVITIES	20 00	2 00	18	00 00		00	18 00	61
	COST SHARE = 00						PA/LEA =	TPL = 00	20 00	2 00	18	00 00		00	18 00	TAX = 00
2 CLAIMS							2 MEDICAL	**********	130 00	9 22	120	78 00		00	120 78 TAX=00	
********* TOTAL PAID CLAIMS							2 CLAIMS		130 00	9 22	120	78 00		00	120 78 TAX=00	

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456178 CNTRL NUM 3 REPORT SEQ NUMBER 3 DATE 11/01/01 PAGE 3

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
DENIED CLAIMS MEDICAL																
SMITH, MARY	CO = 37			RCC =				CLAIM NUMBER = 9801292123456	MRN =		DIAG =			SERV PHYS = 123456178	ADMIT =	
0112233456	10	19	01	10	19	01	1 Q	96111 00 DEVELOPMENTAL TESTING	55 00		55 00	00	00	00	00	470
	COST SHARE = 00						PA/LEA =	TPL = 00	55 00		55 00	00	00	00	00	TAX = 00
1 CLAIMS							1 MEDICAL	**********	55 00		55 00	00	00	00	00 TAX=00	
******* TOTAL DENIED CLAIMS							1 CLAIMS		55 00		55 00	00	00	00	00 TAX=00	

Developmental Rehabilitation Services sample RA

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456178 CNTRL NUM 4 REPORT SEQ NUMBER 3 DATE 11/01/01 PAGE 4

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
ADJUSTED CLAIMS PROFESSIONAL ADJUSTMENT																
SMITH, MARY	CO = 37			CLAIM NUMBER = 5101289123456					** ADJUSTMENT		** CREDIT TO 9801289123456		PAID DATE 102801			
0112233456	10	16	01	10	16	01	1 Q	MED REC =	55 00						55 00	
SMITH, MARY	CO = 37			CLAIM NUMBER = 5101289123456					** ADJUSTMENT		** DEBIT TO 9801289123456		PAID DATE 102801	SERV PHYS = 123456178		
											NET ADJUSTMENT			TAX= 00	3 61CR	
0112233456	10	16	01	10	16	01	1 Q	96111 00 DEVELOPMENTAL TESTING	55 00	3 61	51 39		00	00	51 39 TAX=00	61
	COST SHARE = 00						PA/LEA =	TPL = 00								
1 CLAIMS							1 PROFESSIONAL ADJUSTMENT *****									
*** TOTAL ADJUSTED CLAIMS							1 CLAIMS									
TOTAL NET ADJUSTMENT									55 00	3 61	51 39		00	00	51 39	TAX=00
										TOTAL NET TAX = 00					3 61CR	

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456178 CNTRL NUM 5 REPORT SEQ NUMBER 3 DATE 11/01/01 PAGE 5

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
CLAIMS IN PROCESS PROFESSIONAL				THESE CLAIMS ARE BEING PROCESSED AS LISTED												
2																
SMITH, FRANKLIN	10	12	01	10	12	01		ICN 9801285123456	18 00		MEDICAL RECORD=430001001					14
1 5544332211		3			4			5	6		7					8
1 CLAIMS								PROFESSIONAL	********	18 00						
** TOTAL PENDING CLAIMS								1 CLAIMS		18 00						

Date: 2-1-02

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456178 CNTRL NUM 6 REPORT SEQ NUMBER 3 DATE 11/01/01 PAGE 6

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
FINANCIAL ITEMS																
[2] FROM DOS / [3] TXN DATES / [4] CONTROL NUMBER / [5] REFERENCE / [6] ORIGINAL AMOUNT / [7] BEGINNING BALANCE / [8] APPLIED AMOUNT / [9] NEW BALANCE / [10] EOB																
RECIP ID																
5544332211	10	11	01	10	11	01	9801285123564	SMITH, FRANKLIN			18 00	18 00	18 00		0 00	
								TOTAL FINANCIAL ITEMS 1								

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456178 CNTRL NUM 7 REPORT SEQ NUMBER 3 DATE 11/01/01 PAGE 7

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
AEVCS TRANSACTIONS																
[1] TRANSACTION CATEGORY							[2]	[3] TRANSACTION COUNT			[4]	TRANSACTION AMOUNT				
CLAIM								HCFA		1			17			
							[5]	TOTAL CLAIM TRASACTIONS					17			
REVERSAL							[6]	TOTAL REVERSAL TRASACTIONS		0						
ELIGIBILITY VERIFICATION										10			1 00			
							[7]	TOTAL TRANSACTIONS FOR THIS PROVIDER		11			1 17			

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456105 CNTRL NUM 8 REPORT SEQ NUMBER 3 DATE 12/01/01 PAGE 8

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	TO DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
CLAIMS PAYMENT SUMMARY							1	2 / 3	4	5	6	7	8	9		
							DAYS OR UNITS	CLAIMS PAID / CLAIMS AMOUNT	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT	TAX AMOUNT	QTR TAX AMOUNT		
CURRENT PROCESSED							2	2 / 130.00	18 00	112 00	00	112 00	00	00		
YEAR-TO-DATE TOTAL							10	10 / 1300.00	180 00	1120 00	00	1120 00	00	00		
							10	11 /								
							AEVCS TXN FEES	AEVCS TXN RECOUP AMT / DEF COMP RECOUP AMT								
CURRENT PROCESSED							1.17	1.17 / .00								
YEAR-TO-DATE TOTAL							11.70	11.70 / .00								

13 ARKIDS 1ST/CHIP/MEDICAID SUMMARY

	ARKIDS 1ST CLAIMS	ARKIDS 1ST TOTAL PAID	CHIP CLAIMS	CHIP TOTAL PAID	MEDICAID CLAIMS	MEDICAID TOTAL PAID
DRUG	0	0.00	0	0.00	0	0.00
DRUG ADJUSTMENT	0	0.00	0	0.00	0	0.00
MEDICAL	0	0.00	0	0.00	2	112.00
DENTAL	0	0.00	0	0.00	0	0.00
SCREEN	0	0.00	0	0.00	0	0.00
PROFESSIONAL CROSSOVER	0	0.00	0	0.00	0	0.00
VISION	0	0.00	0	0.00	0	0.00
PROFESSIONAL ADJUSTMENT	0	0.00	0	0.00	1	3.61
INPATIENT HOSPITAL	0	0.00	0	0.00	0	0.00
INPATIENT NURSING HOME	0	0.00	0	0.00	0	0.00
INPATIENT CROSSOVER	0	0.00	0	0.00	0	0.00
NURSING HOME CROSSOVER	0	0.00	0	0.00	0	0.00
NURSING HOME ADJUSTMENT	0	0.00	0	0.00	0	0.00
INPATIENT ADJUSTMENT	0	0.00	0	0.00	0	0.00
OUTPATIENT	0	0.00	0	0.00	0	0.00
OUTPATIENT CROSSOVER	0	0.00	0	0.00	0	0.00
OUTPATIENT ADJUSTMENT	0	0.00	0	0.00	0	0.00

14 IF AN * APPEARS TO THE LEFT OF A DETAIL, PAID DETAIL HAS BEEN ADDED SYSTEMATICALLY.
IF ** APPEARS TO THE LEFT OF A DETAIL, A DENIED DETAIL WAS ADDED SYSTEMATICALLY. RECOMMENDED BILLING INDICATED ON DETAIL.

THE FOLLOWING IS A DESCRIPTION OF THE EOB CODES UTILIZED THROUGHOUT THE REPORT. 15

470 DUPLICATE OF CLAIM PAID.
14 CLAIM IN PROCESS. PLEASE DO NOT REBILL.
61 PAID IN FULL BY MEDICAID.

**** FEDERAL TAX ID EIN 222334455

330 ADJUSTMENT REQUEST FORM

The Adjustment Request Form is to be submitted for the reconsideration of a previously **paid** claim (even if the paid amount is $0.00) due to incomplete or inaccurate claim information, processing errors or pricing file errors. All of the necessary information for processing the adjustment must be included on the request form. A copy of the corrected claim or transaction and a copy of the page of the RA it was paid on may be attached to offer further clarification. However, on joint Medicare/Medicaid claims, the Explanation of Medicare Benefits (EOMB) must be attached. If a provider submits an Adjustment Request Form that is not valid, the EDS Adjustment Unit will notify the provider.

Adjustment Request Forms should be filed as soon as the incorrect payment has been identified. Requests for correction or review must be submitted to EDS within the 12-month timely filing deadline. Adjustment requests cannot be processed if more than 12 months have passed since the "from date of service".

The following instructions explain how to complete the form. A copy of the form is included following these instructions. Read the instructions carefully and be sure to complete all Adjustment Request Forms thoroughly and accurately so that they may be handled efficiently.

331 Instructions for Completing the Adjustment Request Form

	Field Name and Number	Instructions for Completion
1.	Provider Number	Enter the 9-digit Arkansas Medicaid provider number under which payment is to be made.
2.	Provider Name and Address	Complete this field with the same information with which you bill Medicaid.
3.	Overpayment (Credit)	Should apparent duplicate payments, incorrect payments or overpayments be received, please submit an adjustment request and check the box labeled overpayment. EDS will withhold (recoup) the overpayment amount from future claims payments.
4.	Underpayment (Debit)	Should a claim be underpaid, check the box labeled underpayment to have the correct amount added to future claims payments.

331 Instructions for Completing the Adjustment Request Form (Continued)

	Field Name and Number	Instructions for Completion
5.	Informational Corrections	Check this box if the claim paid the correct amount using incorrect information such as wrong dates of service. This box should be checked only if it will not affect the amount paid.
6.	Claim Number (ICN - Internal Control Number)	Enter the 13-digit claim number exactly as it is printed on your RA.
7.	Patient Name	Enter the patient's last name, first name and middle initial.
8.	Recipient ID Number	Enter the entire 10-digit Medicaid identification number assigned to the recipient as it appears on the RA.
9.	Remittance Advice Date	Enter the date of the RA, which is found at the top right corner of the RA.
10.	Date(s) of Service	Enter the beginning and ending month, day and year of services rendered.
11.	Billed Amount	Enter the amount the Medicaid Program was actually billed for the service(s).
12.	Paid Amount	Enter the amount actually paid by Medicaid for the service(s) in question.
13.	Description of the Problem	Indicate a specific reason for the adjustment request and the nature of the incorrect payment.
14.	Signature and Date	Enter the signature of the requester and the date the adjustment request was prepared.

ADJUSTMENT REQUEST FORM - MEDICAID XIX

MAIL TO: EDS; Adjustments; P.O. Box 8036; Little Rock, Arkansas 72203
IMPORTANT: If all required information is not complete, the form will be returned to provider.

Provider Number: _____

Provider Name: _____

Address: _____

_____

☐ OverPayment: Please process to correct the overpayment.

☐ UnderPayment: Please process to correct the underpayment.

☐ Informational Corrections: Please process to reflect the correct information.

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

Claim Number: _____ Patient Name: _____

Recipient I.D. Number: _____ Remittance Advice Date: _____

Date(s) of Service: _____

Billed Amount: _____ Paid Amount: _____

Description of the Problem:

_____

_____

_____

_____

Signature: _____ Date: _____

EDS USE ONLY

_____ Date of Adjustment Reviewer: _____

Adjustment Action:

_____ Pay

_____ Deny

_____ Recoup

EDS-AR-004
Revised 10/99

332 Explanation of Check Refund Form

The Arkansas Medicaid Program provides RAs each week to providers who have claims paid, denied or in process. If an overpayment or a payment error has occurred, providers are responsible for refunding the Medicaid Program.

Refunds to the Medicaid Program may be accomplished by sending a check in the amount of the overpayment made payable to the Arkansas Medicaid Program or by returning the original check issued by EDS. The Arkansas Medicaid Explanation of Check Refund Form must be completed and submitted with the refund.

In instances of underpayment, some providers prefer returning a check in the amount of the underpayment or the original check instead of requesting an adjustment. When EDS posts the refund, the amount of the refund will appear in the *Claims Payment Summary* section of the RA. The provider may then resubmit the original or corrected claim for correct adjudication and payment.

Provide the following information in the appropriate fields on an Arkansas Medicaid Explanation of Check Refund Form for each refund you send to EDS:

1. Provider Name and Medicaid Provider Number
2. Refund Check Number, Check Date and Check Amount
3. 13 digit Claim Number (from RA)
4. Recipient ID Number and Name
5. Dates of Service
6. Date of Medicaid Payment
7. Date of Service Being Refunded
8. Services Being Refunded
9. Amount of Refund
10. Amount of Insurance Received
11. Insurance Name, Address and Policy Number
12. Reason for Return (from codes listed on form)
13. Signature, Date and Telephone

This information will allow the refund to be processed accurately and efficiently.

Explanation of Check Refund

Mail To: Arkansas Medicaid
Refunds
PO Box 8104
Little Rock, AR 72203

Provider Name _____ Medicaid Provider Number _____

Refund Check Number _____ Refund Check Date _____ Refund Check Amount _____

Information needed on each claim being refunded		**Claim 2**	
13 digit Claim Number (from RA)			
Recipient's ID Number (from RA)			
Recipient's Name (Last, First)			
Date(s) of service on claim			
Date of Medicaid payment			
Date(s) of service being refunded			
Services being refunded			
Amount of refund			
Amount of insurance received, if applicable			
Insurance Co. name, address, and policy number, if applicable			
Reason for return (see codes listed below)			

1. BILL: An incorrect billing or keying error was made.
2. DUP: A payment was made by Arkansas Medicaid more than once for the same service(s).
3. INS: A payment was received by a third party source other than Medicare.
4. MC ADJ: An over application of deductible or coinsurance by Medicare has occurred.
5. PNO: A payment was made on a recipient who is not a client in your office.
6. OTHER: (Please explain)

_____

_____

Signature _____ Date _____ Telephone _____

340 ADDITIONAL PAYMENT SOURCES

341 Introduction

The Medicaid Program is required by federal regulations to utilize all third party sources and to seek reimbursement for services that have also been paid by Medicaid. "Third party" means an individual, institution, corporation or public or private agency that is liable to pay all or part of the medical cost of injury, disease or disability of a Medicaid recipient. Examples of third party resources are:

A. Medicare (Title XVIII)

B. Railroad Retirement Act

C. Insurance Policies
   1. private health
   2. group health
   3. liability
   4. automobile/medical insurance
   5. family health insurance carried by an absent parent

D. Worker's Compensation

E. Veteran's Administration

F. CHAMPUS

The Medicaid policies concerning the handling of cases involving Medicare/Medicaid coverage differ from the policies concerning other third party coverage.

Arkansas Rehabilitation Services (ARS) is not a third party source. If ARS and Medicaid pay for the same service, refund ARS.

342.000 Patients With Joint Medicare/Medicaid Coverage

342.100 Claim Filing Procedures

If medical services are provided in Arkansas to a patient who is entitled to Medicare under the Social Security Act and also to Medicaid benefits, it is necessary to file a claim only with Medicare. If the Medicare fiscal intermediary is Arkansas Blue Cross/Blue Shield or Mississippi Blue Cross/Blue Shield (Medicare intermediary for Louisiana, Missouri and Mississippi), the claim should be filed according to Medicare's instructions and sent to the Medicare intermediary. The claim will automatically cross to Medicaid. Mississippi Blue Cross/Blue Shield will cross over only Medicare Part A claims.

342.100 Claim Filing Procedures (Continued)

According to the terms of the Medicaid provider contract, a provider must "accept Medicare assignment under Title XVIII in order to receive payment under Title XIX for any appropriate deductible or coinsurance which may be due and payable under Title XIX."

When the Medicare intermediary or carrier completes the processing of the claim, they will forward it to EDS on computer tape. EDS will process it in the next weekend cycle for payment of coinsurance and deductible. The transaction will usually appear on the Medicaid RA within 3 weeks of payment by Medicare. If it does not appear within that time, you should request payment according to the instructions below.

When a provider learns of a patient's Medicaid eligibility only after filing a claim to Medicare, the instructions below should be followed after Medicare pays the claim.

Some Medicare carriers and intermediaries do not cross claims to Arkansas Medicaid. Claims for Medicare beneficiaries entitled under the Railroad Retirement Act never cross to Medicaid.

EDS provides software with which to electronically bill Medicaid for Professional Crossover claims that do not cross to Medicaid. Institutional providers and those without electronic billing capability must mail a copy of the claim payment information from the Medicare Payment Report to:

EDS
Provider Assistance Center
P.O. Box 8036
Little Rock, AR 72203-8036

On the Medicare Payment Report:

A. Circle the provider name.
Write or type, within the circle, the Medicaid pay-to provider number to which Medicaid will write the check.

B. Circle the single claim you are submitting for payment.

1. Within the circle, write or type the recipient's Medicaid identification number effective for the claim dates of service.

2. When requesting payment for two or more claims appearing on the same page, send a separate copy for each claim, with only one claim circled on each copy and all other requested information present.

EDS staff must be able to locate and read the Medicare payment date and the Medicare claim's internal control number. Please ensure those items are present and readable.

342.200 Denial of Claim by Medicare

Any charges denied by Medicare will not be automatically forwarded to Medicaid for reimbursement. In cases where the patient does not have Medicare coverage, but is eligible for Medicaid, it will be necessary for the provider to file a claim with Medicaid.

342.300 Adjustments by Medicare

Any adjustment made by Medicare will not be automatically forwarded to Medicaid. If Medicare makes an adjustment that results in an overpayment or underpayment by Medicaid, submit an Adjustment Request Form with a copy of the Medicare EOMB reflecting Medicare's adjustment. Enter the Medicaid provider number and the patient's Medicaid identification number on the face of the Medicare EOMB.

350 OTHER PAYMENT SOURCES

351 General Information

Many persons eligible for Arkansas Medicaid are covered by private insurance or may sustain injuries for which a third party could be liable. The following is an explanation of the patient's and the provider's role in the detection of third party sources and in the reimbursement of the third party payment to the Medicaid Program for services that have been paid by Medicaid.

EDS has a full time staff of trained professionals to assist with any questions or problems regarding third party liability, including, but not limited to, payment of claims with third party liability and requests for insurance information. Should a provider have any questions concerning third party liability, the EDS Provider Assistance Center may be contacted at 1-800-457-4454 (Toll Free) within Arkansas or locally and out-of-state at (501) 376-2211.

352 Patient's Responsibility

It is the responsibility of the recipient to report the name and policy number of any other payment source to the provider of medical services at the time services are provided. The recipient must also authorize the insurance payment to be made directly to the provider.

353 Provider's Responsibility

It is the provider's responsibility to be alert to the possibility of third party sources and to make every effort to obtain third party insurance information. The provider should also inquire about liability coverage in accident cases and pursue this or notify Medicaid. It is the responsibility of the provider to file a claim with the third party source and to report the third party payment to the Medicaid Program. If a provider is aware that a Medicaid recipient has other insurance that is not reflected when billing through AEVCS, the insurance information should be faxed to the DMS Third-Party Liability unit at (501) 682-1644.

All Medicaid claims, including claims which involve third party liability, are filed on an assignment basis. In no case may the recipient be billed for charges above the Medicaid allowable on paid claims. A claim is considered paid, even though the actual Medicaid payment has been reduced to zero by the amount of third party liability. This applies whether the third party payment was reported on the original claim or whether it was refunded by way of an adjustment or by personal check. All services billed which are limited by the Medicaid Program count toward the patient's benefit limits even in cases where the amount of Medicaid payment is reduced to zero by the amount of third party liability, except for Medicare crossover claims with no secondary payer other than Medicaid.

The AEVCS system provides fields to capture any Third Party Liability (TPL) information the provider may obtain. The provider is required to record TPL for each claim submitted.

When an AEVCS user enters a claim for services to a recipient who has other insurance coverage for the service and enters a TPL paid amount of $0.00, the point of sale (POS) device prompts the user to enter the date of the denial EOB or the date of the EOB showing that the allowed amount was applied to the insurance deductible.

360 REFERENCE BOOKS

361 Diagnosis Code Reference

The Arkansas Medicaid Program uses the *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM) as a reference for coding primary and secondary diagnoses for all providers that are required to file claims with diagnosis codes completed.

To order the ICD-9-CM, please call 1-800-678-TEXT.

MEDICODE
5225 Wiley Post Way
Suite 500
Salt Lake City, UT 84116
FAX: 1-801-323-3183

362 HCPCS Procedure Code Reference

The State of Arkansas uses the HCFA Common Procedure Coding System (HCPCS). HCPCS is composed of unique state assigned codes and CPT codes. If applicable, the state-assigned codes are listed in the Billing Procedures Section of this manual. *The Physician's Current Procedural Terminology* (CPT) is the basic component of the HCFA Common Procedure Coding System (HCPCS).

To order the CPT, please call 1-800-678-TEXT.

MEDICODE
5225 Wiley Post Way
Suite 500
Salt Lake City, UT 84116
FAX: 1-801-323-3183

CPT is a systematic listing of medical terms and identifying codes for reporting medical services provided by physicians. Each procedure or service is identified with a 5-digit code. The use of CPT codes simplifies the reporting of services.

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	Effective Date: 2-1-02
Subject: UPDATE CONTROL LOG	Revised Date:

Update No.	Release Date	Update No.	Release Date	Update No.	Release Date	Update No.	Release Date
1.		21.		41.		61.	
2.		22.		42.		62.	
3.		23.		43.		63.	
4.		24.		44.		64.	
5.		25.		45.		65.	
6.		26.		46.		66.	
7.		27.		47.		67.	
8.		28.		48.		68.	
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10.		30.		50.		70.	
11.		31.		51.		71.	
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