SECTION I - GENERAL POLICY

CONTENTS

100.000 GENERAL INFORMATION

100.100 Introduction
101.000 Provider Manuals
101.100 Provider Manual Organization
101.200 Updates
101.300 Obtaining Provider Manuals
102.000 Legal Basis of the Medicaid Program
103.000 Scope of Program
103.100 Federally Mandated Services
103.200 Optional Services
104.000 Services Available through the Child Health Services (EPSDT) Program
105.000 Services Available through Demonstration Projects and Waivers
105.100 ARChoices
105.110 ARKids First-B
105.120 Autism Waiver
105.130 ConnectCare: Primary Care Case Management (PCCM)
105.140 DDS Community and Employment Support (CES)
105.160 Living Choices Assisted Living
105.170 Non-Emergency Transportation Services (NET)
105.180 TEFRA
105.190 Telemedicine
105.200 Patient-Centered Medical Home (PCMH)

110.000 SOURCES OF INFORMATION

110.100 Provider Enrollment Contractor
110.200 Provider Relations and Claims Processing Contractor
110.300 Utilization Review Section
110.400 Reserved
110.450 Reserved
110.500 Customer Assistance
110.600 Americans with Disabilities Act
110.700 Medicaid Fraud Detection and Investigation Program
110.800 Dental Care Unit
110.900 Visual Care Unit
111.000 DMS and Fiscal Agent Office Hours

120.000 BENEFICIARY ELIGIBILITY

121.000 Introduction
122.000 Agencies Responsible for Determining Eligibility
122.100 Department of Human Services County Offices
122.200 District Social Security Offices
123.000 Medicaid Eligibility Information
123.100 Date Specific Medicaid Eligibility
123.200 Retroactive Medicaid Eligibility
123.400 Beneficiary Lock-In
124.000 Beneficiary Aid Categories
124.100 Client Aid Categories with Limited Benefits
124.110 ARKids First-B
124.120 Medically Needy
124.130 Pregnant Women, Infants & Children
124.140 Reserved
124.150 Qualified Medicare Beneficiaries (QMB)
124.160 Qualifying Individuals-1 (QI-1)
124.170 Specified Low-Income Medicare Beneficiaries (SMB)

124.180 Reserved
124.190 Reserved
124.200 Client Aid Categories with Additional Cost Sharing
124.210 ARKids First-B
124.220 TEFRA
124.230 Workers with Disabilities
124.240 Transitional Medicaid Adult
124.250 Arkansas Health and Opportunity for Me (ARHOME)
125.000 Medicaid Identification Card
125.100 Explanation of Medicaid Identification Card
125.200 Non-Receipt or Loss of Card by Beneficiary
125.300 Reporting Suspected Misuse of I.D. Card

130.000 BENEFICIARY RESPONSIBILITIES

131.000 Charges that Are Not the Responsibility of the Beneficiary
132.000 Charges that Are the Responsibility of the Beneficiary
133.200 Inpatient Hospital Coinsurance Charge to ARKids First-B Beneficiaries
134.000 Exclusions from Cost Sharing Policy
135.000 Collection of Coinsurance/Co-payment
136.000 Patient Self Determination Act

140.000 PROVIDER PARTICIPATION

141.000 Provider Enrollment
141.100 Revalidation of Enrollment
141.101 Application Fees
141.102 Hardship Exceptions
141.103 Provider Screening
142.000 Conditions of Participation
142.100 General Conditions
142.200 Conditions Related to Billing for Medicaid Services
142.300 Conditions Related to Record Keeping
142.400 Conditions Related to Disclosure
142.410 Disclosures of Ownership and Control
142.420 Disclosures of Information Regarding Personnel Convicted of Crime
142.430 Disclosures of Business Transactions
142.500 Conditions Related to Fraud and Abuse
142.600 Conditions Related to Provider Refunds to DMS
142.610 Overpayments Owed by Medicaid Providers Out of Business or Discharged in Bankruptcy Proceedings
142.700 Medicare Mandatory Assignment of Claims for “Physician” Service 1216s and Medicaid’s Mandatory Assignment of Claims for Provider Services
142.800 Condition of Participation – Education
142.900 Principal Accountable Providers (PAPs)
143.000 Recovery Audit Contractors (RACs)
144.000 Tax Compliance
145.000 Electronic Visit Verification (EVV) for In-Home Personal Care, Attendant Care, Respite-Services, and Home Health Services
145.100 Legal Basis and Scope of EVV Requirement
145.200 EVV Participation Requirements
145.300 EVV Claims Requirements
145.400 Third Party EVV System Requirements

150.000 ADMINISTRATIVE REMEDIES AND SANCTIONS

151.000 Grounds for Sanctioning Providers
152.000 Sanctions
153.000 Rules Governing the Imposition and Extent of Sanctions
154.000 Notice of Violation
155.000 Notice of Provider Sanction

156.000 Withholding of Medicaid Payments

160.000 ADMINISTRATIVE RECONSIDERATION AND APPEALS

161.200 Administrative Reconsideration
161.300 Administrative Appeals of Adverse Actions that are not Sanctions
161.400 Sanction Appeals
161.500 Continued Services During the Appeal Process
162.000 Notice of the Appeal Hearing
162.100 Conduct of Hearing
162.200 Representation of Provider at a Hearing
162.300 Right to Counsel
162.400 Appearance in Representative Capacity
163.000 Form of Papers
163.100 Notice, Service and Proof of Service
164.000 Witnesses
165.000 Amendments
166.000 Continuances or Additional Hearings
167.000 Failure to Appear
168.000 Record of Hearing
169.000 Decision
169.100 Recovery of the Costs of Services Continued During the Appeal Process

170.000 THE ARKANSAS MEDICAID PRIMARY CARE CASE MANAGEMENT PROGRAM

170.100 Introduction
171.000 Primary Care Physician Participation
171.100 PCP-Qualified Physicians and Advanced Practice Nurse Practitioners
171.110 Exclusions
171.120 Hospital Admitting Privileges Requirement
171.130 EPSDT Agreement Requirement
171.140 Primary Care Case Manager Agreement
171.160 PCP Instate and Trade-Area Restriction
171.170 PCP for Out-of-State Services
171.200 PCCM Enrollee/Caseload Management
171.210 ConnectCare Caseload Maximum and PCP Caseload Limits
171.220 Illegal Discrimination
171.230 Primary Care Case Management Fee
171.300 Required Case Management Activities and Services
171.310 Investigating Abuse and Neglect
171.320 Child Health Services (EPSDT) Requirements
171.321 Childhood Immunizations
171.400 PCP Referrals
171.410 PCCM Referrals and Documentation
171.500 Primary Care Case Management Activities and Services
171.510 Access Requirements for PCPs
171.600 PCP Substitutes
171.601 PCP Substitutes; General Requirements
171.610 PCP Substitutes; Rural Health Clinics and Physician Group Practices
171.620 PCP Substitutes; Individual Practitioners
171.630 Advanced Practice Registered Nurses and Physician Assistants in Rural Health Clinics (RHCs)
172.000 Exemptions and Special Instructions
172.100 Services not Requiring a PCP Referral
172.110 PCP Enrollment/Referral Guidelines for Medicaid Waiver Program Participants
172.200 Medicaid-Eligible Individuals Who May not Enroll with a PCP
172.300 Automated PCP Enrollment Verification
173.000 PCCM Selection, Enrollment and Transfer
173.100 PCP Selection and Enrollment at Local County DHS Offices
173.200 PCP Selection and Enrollment at PCP Offices and Clinics

173.300 PCP Selection and Enrollment Through the ConnectCare HelpLine
173.400 PCP Selection and Enrollment at Participating Hospitals
173.500 PCP Selection for Supplemental Security Income (SSI) Beneficiaries
173.600 Transferring PCP Enrollment
173.610 PCP Transfers by Enrollee Request
173.620 PCP Transfers by PCP Request
173.630 PCP Enrollment Transfers Initiated by the State

180.000 EPISODES OF CARE
181.000 Incentives to Improve Care Quality, Efficiency and Economy

190.000 PROVIDER DUE PROCESS
190.001 The Medicaid Fairness Act
190.002 Definitions
190.003 Administrative Appeals
190.004 Records
190.005 Technical Deficiencies
190.006 Explanations of Adverse Decisions Required
190.007 Rebilling at an Alternate Level Instead of Complete Denial
190.008 Prior Authorizations – Retrospective Reviews
190.009 Medical Necessity
190.010 Promulgation Before Enforcement
190.011 Copies
190.012 Notices
190.013 Deadlines
190.014 Federal Law

191.000 BENEFICIARY DUE PROCESS
191.001 Definitions
191.002 Notice
191.003 Determination of Medical Necessity – Content of Notice
191.004 Administrative Appeals
191.005 Conducting the Hearing
191.006 Records

100.000 GENERAL INFORMATION

100.100 Introduction 9-15-09

Section I imparts general program information about the Arkansas Medicaid Program. It includes information about beneficiary eligibility and explains the provider's role and responsibilities. The intent is to provide users with an understanding of Medicaid Program objectives and regulations. Additionally, it contains details providers may need to answer questions often asked about the Medicaid Program. Seven major areas are covered in Section I.

A. General information about the program - Contains information regarding the background, history and scope of the Medicaid Program, including information about Medicaid waivers and/or programs administered by the Division of Medical Services.

B. Beneficiary eligibility - Contains information about Medicaid beneficiary aid categories, beneficiaries' eligibility for benefits and an explanation of the Medicaid identification card, the beneficiaries' responsibilities and additional beneficiary information.

C. Provider participation - Specifies the provider enrollment procedures, the general conditions that must be met by providers to begin and to maintain program participation and remedies and sanctions that the Division of Medical Services may employ in the administration and regulation of the Arkansas Medicaid Program.

D. Administrative remedies and sanctions - Describes the rules for imposing sanctions.

E. Provider due process - Describes how a provider may request an administrative reconsideration of an adverse decision/action within 30 calendar days after the notice of the decision/action.

F. Beneficiary due process - Describes how a beneficiary may request an administrative reconsideration of an adverse decision/action within 30 calendar days after the notice of the decision/action.

G. Primary Care Case Management Program (PCCM) - Defines the scope of the Primary Care Case Management Program (PCCM) and regulations regarding provider and enrollee participation. It lists the categories of eligibility that are exempt from primary care physician (PCP) referral requirements and it itemizes the services that do not require PCP referral. PCP enrollment and enrollment transfer procedures are explained, as are PCP referral requirements and procedures.

101.000 Provider Manuals 1-1-16

Provider manuals contain the policies and procedures of the Arkansas Medicaid Program. These policies and procedures are generally based on federal and state laws and federal regulations. Medicaid provider manual policy and procedures, and changes thereto, are promulgated as required by the state's Administrative Procedure Act.

When fully utilized, each program manual is an effective tool for the provider. It provides information about the Medicaid Program, covered and non-covered services, billing procedures and detailed instructions for completing paper claims.

Obtain provider manuals from the Arkansas Medicaid website (**https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx**).

101.100 Provider Manual Organization 1-1-16

The manuals are organized as follows:

A. Section I – general information

B. Section II – program policy and program-specific billing information, including special billing

C. Section III – generic billing information

D. Section IV – glossary

E. Section V – forms and contact information

F. Notices of Rule Making

G. Official Notices

H. Remittance Advice messages (RAs)

Sections I, III, IV and V are the same in each manual; only Section II is program- and provider-specific.

The manuals are divided into numbered sections with a heading and a revision date, such as "101.000 Provider Manuals 4-1-06". Text that appears underlined and blue indicates a hyperlink to the information being referenced, and it may be viewed or printed. The paper version contains the same underlined text, though not in blue, so paper users must locate the "linked" information.

101.200 Updates 8-1-12

Provider manuals are amended ("updated") in accordance with new, repealed or revised federal and state legislative and legal clarifications. Changes and clarifications in DMS medical policy, new administrative or billing procedures and numerous other requirements are issued and implemented when warranted. These changes and clarifications are released to the provider in the form of a manual update, a notice of rule making, an official notice or a remittance advice (RA) message.

Provider manuals are updated automatically on the Arkansas Medicaid website. Providers are notified via e-mail when an applicable manual update transmittal is issued. Providers must give Provider Enrollment a valid, current e-mail address to receive such e-mail notification. Only revised sections are issued in manual updates along with an update transmittal memorandum to detail changes. All policy changes including manual updates, notices of rule making, official notices and RA messages are posted weekly on What's new for Arkansas Medicaid providers at **https://medicaid.mmis.arkansas.gov/Provider/newprov.aspx**. Bookmark this page and review often for the latest provider information.

Policy and procedure changes are highlighted in the electronic media to help providers quickly review changes. Provider manual update transmittals are assigned sequential identification numbers, e.g., Update Transmittal MANUAL-1-11. The transmittal memo identifies any new sections being added and the sections being replaced, deleted or amended. It provides brief explanations of the revisions. Provider manual update transmittal memos are recorded on the update log following each section of the manual.

For persons maintaining a printed provider manual, the updated manual sections should be manually filed in the provider manual, and the outdated sections should be crossed out or removed, as appropriate. The transmittal memo effective date should be entered on the update log opposite the appropriate update transmittal number. Transmittal memos should be filed immediately following the update log in descending numerical order by transmittal number. Immediately following the transmittal memos should be the notices of rule making, then official notices, both of which are numbered sequentially and should be filed with the most recent first. The RAs will follow the notices of rule making and official notices, with the most recent filed first.

101.300 Obtaining Provider Manuals 8-1-21

All provider manuals, manual updates, notices of rule making, official notices and RAs are available for downloading, without charge, from the **Arkansas Medicaid website**.

Enrolled providers may purchase extra paper copies of a manual through the fiscal agent. See information below regarding purchasing copies. Persons, entities and organizations that are not enrolled providers may purchase a paper copy of a provider manual through the fiscal agent.

The cost for a printed copy of an Arkansas Medicaid provider manual is $125.00.

Send orders for printed manuals to the Arkansas Medicaid Fiscal Agent, Information Library Unit. Include with your order a check made to the Fiscal Agent for the appropriate amount. **View or print the manual order contact information.**

102.000 Legal Basis of the Medicaid Program 9-15-09

Title XIX of the Social Security Act created a joint federal-state medical assistance program commonly referred to as Medicaid. Ark Code Ann § 20-77-107 authorizes the Department of Human Services to establish a Medicaid Program in Arkansas. The Medicaid Program provides necessary medical services to eligible persons who would not be able to pay for such services.

Title XIX of the Social Security Act provides for federal grants to states for medical assistance programs. The stated purpose of Title XIX is to enable the states to furnish the following assistance:

A. Medical assistance to families with dependent children, the aged, the blind, the 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

In Arkansas, the Division of Medical Services (DMS) administers the Medicaid Program. Within the Division, the Office of Long Term Care (OLTC) is responsible for nursing home policy and procedures.

103.000 Scope of Program 4-1-06

The Arkansas Medicaid Program provides, with limitations, the services listed in Sections 103.100 and 103.200.

103.100 Federally Mandated Services 1-1-16

Program	Coverage
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Child Health Services)	Under Age 21
Family Planning	All Ages
Federally Qualified Health Center (FQHC)	All Ages
Home Health	All Ages
Inpatient Hospital	All Ages
Laboratory and X-Ray	All Ages
Certified Nurse-Midwife	All Ages
Medical and Surgical Services of a Dentist	All Ages
Nurse Practitioner (Pediatric, Family, Obstetric-Gynecologic and Gerontological)	All Ages
Nursing Facility	Age 21 or Older
Outpatient Hospital	All Ages
Physician	All Ages
Rural Health Clinic	All Ages
Transportation Services (Emergency)	All Ages
Transportation Services (Non-Emergency)*	All Ages
*Excluding nursing facilities, ICF/IID, Retroactive Eligibility, QMBs, SMBs and ARKids-B	

103.200 Optional Services 12-1-19

Program	Coverage
Adult Behavioral Health Services for Community Independence	18 or older

Program	Coverage
Adult Developmental Day Treatment (ADDT)	Pre-School and Age 18 or Older
Ambulatory Surgical Center	All Ages
Audiological	Under Age 21
Certified Registered Nurse Anesthetist (CRNA)	All Ages
Chiropractic Services	All Ages
Dental Services	Under Age 21
Developmental Rehabilitation Services	Under Age 3
Durable Medical Equipment	All Ages
Early Intervention Day Treatment (EIDT)	Under Age 21
End-Stage Renal Disease (ESRD) Facility Services	All Ages
Hearing Aid Services	Under Age 21
Hospice	All Ages
Hyperalimentation	All Ages
IndependentChoices (Self-Directed Personal Assistance)	Age 18 or Older
Inpatient Psychiatric Services	Under Age 21
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	All Ages
Medical Supplies	All Ages
Nursing Facility	Under Age 21
Occupational, Physical and Speech-Language Therapy	Under Age 21
Orthotic Appliances	All Ages
Outpatient Behavioral Health Services	All Ages
PACE (Program of All-Inclusive Care for the Elderly) (*Participants must meet additional medical and non-medical criteria in addition to age eligibility.)	Age 55 or older*
Personal Care	All Ages
Podiatrist	All Ages
Portable X-Ray	All Ages
Prescription Drugs	All Ages
Private Duty Nursing Services (High Technology, Non-Ventilator Dependent, EPSDT Program)	Under Age 21
Private Duty Nursing Services (Non-Ventilator Dependent Beneficiaries Age 21 or Older)	Age 21 or Older
Private Duty Nursing Services (Ventilator-Dependent)	All Ages
Prosthetic Devices	All Ages
Rehabilitative Hospital and Extended Rehabilitative Hospital Services	All Ages

Program	Coverage
Rehabilitative Services for Persons with Physical Disabilities (RSPD)	Under Age 21
Rehabilitative Services for Youth and Children	Under Age 21
Respiratory Care	Under Age 21
School-Based Mental Health Services	Under Age 21
Targeted Case Management for Beneficiaries of DDS Children's Services (Title V Agency)	Under Age 21
Targeted Case Management for DDS Children's Services (Title V Agency) who are SSI Beneficiaries and TEFRA Waiver Participants	Under Age 16
Targeted Case Management for Beneficiaries Age 21 or Under with a Developmental Disability	Age 21 or Under
Targeted Case Management for Beneficiaries Age 22 or Older with a Developmental Disability	Age 22 or Older
Targeted Case Management for Beneficiaries in the Child Health Services (EPSDT) Program	Under Age 21
Targeted Case Management for Beneficiaries in the Division of Children and Family Services	Under Age 21
Targeted Case Management for Beneficiaries in the Division of Youth Services	Under Age 21
Targeted Case Management for Beneficiaries Age 60 or Older	Age 60 or Older
Targeted Case Management for Pregnant Women	Pregnant Women - All Ages
Ventilator Equipment	All Ages
Visual Care	All Ages

104.000 Services Available through the Child Health Services (EPSDT) Program 10-13-03

Medicaid covers certain services only through the Child Health Services (EPSDT) Program for individuals under age 21. See the Child Health Services (EPSDT) manual and the appropriate provider program manual for more information.

105.000 Services Available through Demonstration Projects and Waivers 4-1-06

The services detailed in Sections 105.100 through 105.190 are available for eligible beneficiaries through waivers of federal regulations.

105.100 ARChoices 1-1-16

ARChoices is designed for beneficiaries ages 21 and older who, without the waiver's services, would require an intermediate level of care in a nursing home. Individuals ages 21 through 64 must have a physical disability as determined through Social Security Railroad Retirement or DHS's Medical Review Team. The services listed below are designed to maintain beneficiaries at home and preclude or postpone institutionalization.

A. Adult family home

B. Attendant care services

C. Home delivered meals

D. Personal emergency response system

E. Adult day services

F. Adult day health services

G. Respite care

H. Environmental accessibility/adaptations/adaptive equipment

ARChoices eligibility requires a determination of categorical eligibility, a determination of level of care, the development of a plan of care and a cost comparison to determine the cost-effectiveness of the plan of care. ARChoices requires notifying the beneficiary that he or she may freely choose between waiver services and institutional services.

Refer to the ARChoices provider manual for more detailed information.

105.110 ARKids First-B 9-1-15

ARKids First-B incorporates uninsured children age 18 and under into the health care system. ARKids First-B benefits are comparable to those of the state employees and teachers insurance programs. Most services require cost sharing.

The following is a summary of the eligibility criteria for ARKids First-B:

A. Family income must be above the 142% Federal Poverty Level (FPL) up to and including 211% FPL.

B. Applicants must be age 18 and under.

C. Applicants must have had no health insurance that covers comprehensive medical services, other than Medicaid, within the preceding 90 days (unless insurance coverage was lost through no fault of the applicant).

1. Applicants whose health insurance is inaccessible are deemed uninsured.
2. Children who do not have primary comprehensive health insurance, whose insurance is inaccessible or have non-employer sponsored insurance are considered uninsured. Primary comprehensive health insurance is defined as insurance that covers both physician and hospital charges.

For more information, refer to the ARKids First-B provider manual and to the Arkansas Medicaid website at https://medicaid.mmis.arkansas.gov/.

105.120 Autism Waiver 10-15-12

The purpose of the Autism waiver is to provide one-on-one, intensive early intervention treatment for young children ages eighteen (18) months through six (6) years with a diagnosis of autism. The waiver participants must meet the intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care and have a diagnosis of autism.

The community-based services offered through the Autism waiver are as follows:

1. Individual Assessment, Program Development and Training
2. Provision of Therapeutic Aides
3. Plan Implementation and Monitoring of Intervention Effectiveness

4. Lead Therapy Intervention
5. Line Therapy Intervention
6. Consultative Clinical and Therapeutic Services

The waiver program is operated by the Partners for Inclusive Communities (Partners) under the administrative authority of the Division of Medical Services.

105.130 ConnectCare: Primary Care Case Management (PCCM) 10-1-12

ConnectCare is the Arkansas Medicaid Primary Care Case Management (PCCM) system. In ConnectCare, a Medicaid beneficiary selects and enrolls with a primary care physician (PCP) that has contracted with DMS to be responsible for managing the health care of a limited number (specified by the PCP) of Medicaid enrollees.

A PCP contracts with DMS to provide primary care, health education and case management for his or her enrollees. DMS pays the PCP a monthly per-enrollee case management fee in addition to the regular Medicaid fee-for-service reimbursement.

The PCP is responsible for referring enrollees to specialists and other providers; therefore, he or she is responsible for deciding whether a particular referral is medically necessary. A PCP may make such decisions in consultation with physicians or other professionals as needed and in accordance with his or her medical training and experience; however, a PCP is not required to make any referral simply because it is requested.

A PCP coordinates his or her enrollees' medical and rehabilitative services with the providers of those services. Medical and rehabilitative professionals to whom a PCP refers a patient are required to report to or consult with the PCP so that the PCP can coordinate care and monitor an enrollee's status, progress and outcomes.

Most Medicaid beneficiaries, and children participating in ARKids First-B, must enroll with a PCP to receive covered services. Some individuals are not required to enroll with a PCP. Few services are covered without PCP referral. See Sections 170.000 through 173.000 for details regarding ConnectCare.

105.140 DDS Community and Employment Support (CES) 7-1-20

The Developmental Disability Services Community and Employment Support (DDS CES) waiver program is for beneficiaries who, without the waiver's services, would require institutionalization. Participants must not be residents of a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

DDS CES eligibility requires a determination of categorical eligibility, a determination of level of care, the development of a plan of care, and a cost comparison to determine the cost-effectiveness of the plan of care. The DDS CES program further requires advising the beneficiary that he or she may freely choose between waiver and institutional services.

Services supplied through this program are:

A. Supportive living

B. Respite care

C. Supplemental support services

D. Supported employment services

E. Environmental modifications

F. Adaptive equipment

G. Specialized medical supplies

H. Community transition services

I. Consultation services

J. Crisis intervention services

105.160 Living Choices Assisted Living 7-15-12

Living Choices Assisted Living is a home- and community-based services waiver that is administered jointly by the Division of Aging and Adult Services (DAAS) and the Division of Medical Services (DMS). Qualifying individuals are Medicaid-eligible persons aged 21 and older who have been determined by Medicaid to be eligible for an intermediate level of care in a nursing facility. The individual must be a person with a physical disability, blind or elderly.

Participants in Living Choices must reside in Level II assisted living facilities (ALFs), in apartment-style living units. The assisted living environment encourages and protects individuality, privacy, dignity and independence. Each Living Choices participant receives personal, health and social services in accordance with an individualized plan of care developed and maintained in cooperation with a DAAS-employed registered nurse. A participant's individualized plan of care is designed to promote and nurture his or her optimal health and well being.

Living Choices providers furnish "bundled services" in the amount, frequency and duration required by the Living Choices plans of care. They facilitate participants' access to medically necessary services that are not components of Living Choices bundled services, but which are ordered by participants' plans of care. Living Choices providers receive per diem Medicaid reimbursement for each day a participant is in residence and receives services. The per diem amount is based on a participant's "tier of need," which DAAS-employed RNs determine and periodically re-determine by means of comprehensive assessments performed in accordance with established medical criteria. There are four tiers of need.

Living Choices participants are eligible to receive up to nine Medicaid-covered prescriptions per month. More detailed information may be found in the Living Choices Assisted Living provider manual.

105.170 Non-Emergency Transportation Services (NET) 7-1-20

Medicaid non-emergency transportation (NET) services for Medicaid beneficiaries are furnished by regional brokers under the authority of a capitated selective contract waiver. Medicaid beneficiaries contact their local transportation broker for non-emergency transportation to appointments with Medicaid providers.

Adult Developmental Day Treatment (ADDT) providers transporting Medicaid beneficiaries to ADDT Clinic Service providers for ADDT services have been allowed to remain enrolled as fee-for-service providers for that purpose only, if they so choose. All other Medicaid non-emergency transportation for ADDT clients must be obtained through the regional broker.

The Arkansas Medicaid non-emergency transportation waiver program does not include transportation services for:

A. Nursing facility residents;

B. Residents of intermediate care facilities for individuals with intellectual disabilities (ICF/IID);

C. Qualified Medicare Beneficiaries (QMB) when Medicaid pays only the Medicare premium, deductible, and co-pay;

D. Special Low-Income Qualified Medicare Beneficiaries (SMB);

E. Qualifying Individual -1 (QI-1);

F. ARKids First-B beneficiaries; or

G. Periods of retroactive eligibility.

Detailed information may be found in the Transportation provider manual and on the **Arkansas Medicaid website**.

105.180 TEFRA 9-1-15

The Arkansas Department of Human Services implemented the TEFRA waiver effective January 1, 2003. The TEFRA waiver covers beneficiaries under age 19 who are eligible for Medicaid services as authorized by Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and amended by the Omnibus Budget Reduction Act of 2005. TEFRA children, aid category 49, receive the full range of Medicaid services. However, a premium may be required, based on parental income. See Section 124.220 for the premium chart. TEFRA waiver coverage is for non-institutionalized children only.

105.190 Telemedicine 1-1-22

Telemedicine is defined as the use of electronic information and communication technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a client. Telemedicine includes store-and-forward technology and remote client monitoring.

Store-and-forward technology is the transmission of a client's medical information from a healthcare provider at an originating site to a healthcare provider at a distant site. An originating site includes the home of a client. Remote client monitoring means the use of electronic information and communication technology to collect personal health information and medical data from a client at an originating site that is transmitted to a healthcare provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring.

Arkansas Medicaid shall provide payment to a licensed or certified healthcare professional or a licensed or certified entity for services provided through telemedicine if the service provided through telemedicine is comparable to the same service provided in person. Payment will include a reasonable facility fee to the originating site operated by a licensed or certified healthcare professional or licensed or certified healthcare entity if the professional or entity is authorized to bill Arkansas Medicaid directly for healthcare services. There is no facility fee for the distant site. The professional or entity at the distant site must be an enrolled Arkansas Medicaid Provider. Any other originating sites are not eligible to bill a facility fee.

Coverage and reimbursement for services provided through telemedicine will be on the same basis as for services provided in person. While a distant site facility fee is not authorized under the Telemedicine Act, if reimbursement includes payment to an originating site (as outlined in the above paragraph), the combined amount of reimbursement to the originating and distant sites may not be less than the total amount allowed for healthcare services provided in person.

Professional Relationship

The distant site healthcare provider will not utilize telemedicine services with a client unless a professional relationship exists between the provider and the client. A professional relationship exists when, at a minimum:

1. The healthcare provider has previously conducted an in-person examination of the client and is available to provide appropriate follow-up care;
2. The healthcare provider personally knows the client and the client's health status through an ongoing relationship and is available to provide follow-up care;

3. The treatment is provided by a healthcare provider in consultation with, or upon referral by, another healthcare provider who has an ongoing professional relationship with the client and who has agreed to supervise the client's treatment including follow-up care;
4. An on-call or cross-coverage arrangement exists with the client's regular treating healthcare provider or another healthcare provider who has established a professional relationship with the client;
5. A relationship exists in other circumstances as defined by the Arkansas State Medical Board (ASMB) or a licensing or certification board for other healthcare providers under the jurisdiction of the appropriate board if the rules are no less restrictive than the rules of the ASMB.
    a. A professional relationship is established if the provider performs a face to face examination using real time audio and visual telemedicine technology that provides information at least equal to such information as would have been obtained by an in-person examination. (See ASMB Regulation 2.8);
    b. If the establishment of a professional relationship is permitted via telemedicine under the guidelines outlined in ASMB regulations, telemedicine may be used to establish the professional relationship only for situations in which the standard of care does not require an in-person encounter and only under the safeguards established by the healthcare professional's licensing board (See ASMB Regulation 38 for these safeguards including the standards of care); or
6. The healthcare professional who is licensed in Arkansas has access to a client's personal health record maintained by a healthcare professional and uses any technology deemed appropriate by the healthcare professional, including the telephone, with a client located in Arkansas to diagnose, treat, and if clinically appropriate, prescribe a noncontrolled drug to the client.

A health record is created with the use of telemedicine, consists of relevant clinical information required to treat a client, and is reviewed by the healthcare professional who meets the same standard of care for a telemedicine visit as an in-person visit.

A professional relationship does not include a relationship between a healthcare provider and a client established only by the following:

1. An internet questionnaire;
2. An email message;
3. A client-generated medical history;
4. Text messaging;
5. A facsimile machine (Fax) and EFax;
6. Any combination of the above; or
7. Any future technology that does not meet the criteria outlined in this section.

The existence of a professional relationship is not required when:

1. An emergency situation exists; or
2. The transaction involves providing information of a generic nature not meant to be specific to an individual client.

Once a professional relationship is established, the healthcare provider may provide healthcare services through telemedicine, including interactive audio, if the healthcare services are within the scope of practice for which the healthcare provider is licensed or certified and in accordance with the safeguards established by the healthcare professionals licensing board.

Telemedicine with a Minor Client

Regardless of whether the provider is compensated for healthcare services, if a healthcare provider seeks to provide telemedicine services to a minor in a school setting and the minor client is enrolled in Arkansas Medicaid, the healthcare provider shall:

1. Be the designated Primary Care Provider (PCP) for the minor client;
2. Have a cross-coverage arrangement with the designated PCP of the minor client; or
3. Have a referral from the designated PCP of the minor client.

If the minor client does not have a designated PCP, this section does not apply. Only the parent or legal guardian of the minor client may designate a PCP for a minor client.

Telemedicine Standard of Care

Healthcare services provided by telemedicine, including without limitation a prescription through telemedicine, shall be held to the same standard of care as healthcare services provided in person. A healthcare provider providing telemedicine services within Arkansas shall follow applicable state and federal laws, rules and regulations regarding:

1. Informed consent;
2. Privacy of individually identifiable health information;
3. Medical record keeping and confidentiality, and
4. Fraud and abuse.

A healthcare provider treating clients in Arkansas through telemedicine shall be fully licensed or certified to practice in Arkansas and is subject to the rules of the appropriate state licensing or certification board. This requirement does not apply to the acts of a healthcare provider located in another jurisdiction who provides only episodic consultation services.

Telemedicine Exclusions

Telemedicine does not include the use of:

1. Audio-only communication unless the audio-only communication is in real-time, is interactive, and substantially meets the requirements for a health care service that would otherwise be covered by the health benefit plan:
   a. Documentation of the engagement between patient and provider via audio-only communication shall be placed in the medical record addressing the problem, content of the conversation, medical decision-making, and plan of care after the contact;
   b. Medical documentation is subject to the same audit and review process required by payers and governmental agencies when requesting documentation of other care delivery such as in-office or face-to-face visits;
2. A facsimile machine;
3. Text messaging; or
4. Email.

105.200 Patient-Centered Medical Home (PCMH) 1-1-14

DMS established the Patient-Centered Medical Home (PCMH) program to improve the health of the population, enhance the patient experience, and control the growth in healthcare costs. To achieve these goals, the PCMH program includes practice support and incentives to provide care coordination; promote practice transformation; increase performance transparency; and reward providers for delivery of economic, efficient, and quality care. Please refer to Section II of the Patient-Centered Medical Home Manual for information about eligibility, enrollment, and payment.

110.000 SOURCES OF INFORMATION

110.100 Provider Enrollment Contractor 9-15-09

The provider enrollment functions for the Medicaid program are performed by an independent contractor. Any questions regarding provider enrollment, participation requirements or contracts should be directed to the Medicaid Provider Enrollment Contractor. **View or print the Provider Enrollment contact information.**

110.200 Provider Relations and Claims Processing Contractor 8-1-21

Provider assistance and education and the processing of claims for the Medicaid program are performed by an independent contractor.

The Arkansas Medicaid Fiscal Agent has a staff of **claims representatives** available to assist with any needs concerning claims.

The Arkansas Medicaid Fiscal Agent maintains a **Provider Assistance Center (PAC)** to assist Arkansas Medicaid providers.

The Arkansas Medicaid fiscal agent has a full-time staff of Provider Representatives available for consultation regarding billing problems and technical assistance that cannot be resolved through the Provider Assistance Center. Provider Representatives are available to visit providers' offices to provide training on billing and on-site technical assistance. To find your Provider Representative to schedule a visit, view the DHS or designated vendor's **Outreach Specialists** page.

110.300 Utilization Review Section 7-1-20

The Utilization Review (UR) Section of the Arkansas Medicaid Program performs professional medical utilization review(s) for a wide variety of services in a timely and cost-effective manner. Medicaid's UR participates in the development of clinically based standard(s) of care coverage determinations and serves as a resource to Arkansas Medicaid providers. UR has a responsibility for assuring quality medical care to Arkansas Medicaid beneficiaries through detection and reporting quality of care concerns to appropriate bodies, in addition to protecting the integrity of state and federal funds supporting the Medicaid Program.

Utilization Review provides professional review(s) for:

A. Pre- and post-payment of medical services;

B. Prior authorization for private duty nursing, hearing aids and hearing aid repair, extension of benefits for home health beneficiaries age twenty-one (21) and older, extension of benefits for personal care for beneficiaries age twenty-one (21) and older, medical supplies, and incontinence products;

C. Monitoring contractors performing prior authorizations and extension of benefits for the following programs: in-patient psychiatric services, in-patient and out-patient hospitalization, emergency room utilization, personal care for beneficiaries under the age of twenty-one (21), Early Intervention Day Treatment, therapy, OBHS. ABHSCI, transplants, durable medical equipment, and hyperalimentation services; and

D. Authorization and arrangement of out-of-state transportation for beneficiaries for medically necessary services/treatments not available in-state.

View or print the Utilization Review contact information.

110.400 Reserved 5-1-11

110.450 Reserved 5-1-11

110.500 Customer Assistance 9-15-09

Customer Assistance, of the Division of County Operations, addresses beneficiary inquiries regarding Medicaid eligibility, the Medicaid identification card and Medicaid coverage and benefits. **View or print the Division of County Operations Customer Assistance Section contact information.**

110.600 Americans with Disabilities Act 10-13-03

Any materials needed in an alternate format, such as large print, can be obtained by contacting the Americans with Disabilities Act Coordinator. **View or print the Americans with Disabilities Act Coordinator contact information.**

110.700 Medicaid Fraud Detection and Investigation Program 1-1-16

Federal Regulations require the implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess reimbursements by the Medicaid program. The purpose of the Office of the Medicaid Inspector General (OMIG) is to investigate fraud allegations and ensure Arkansas' Medicaid compliance. **[Title XIX of the Social Security Act, Arkansas Code Annotated, 42 C.F.R. §455 and the Arkansas State Plan].**

The goal of the unit is to verify the nature and extent of services reimbursed by the Medicaid program, while ensuring reimbursements made are consistent with the quality of care being provided and protecting the integrity of both state and federal funds.

Responsibilities of the unit include the following:

A. Verifying medical services meet an accepted standard of care and are rendered as billed

B. Verifying services are provided by qualified providers to eligible beneficiaries

C. Verifying reimbursement for services is correct and that all funds identified for collection prior to Medicaid reimbursement are pursued

The OMIG Section is responsible for conducting on-site medical reviews for the purpose of verifying the above tasks as well as record keeping and other specified information. Providers selected for an on-site review will not be notified in advance. Review analysts may request additional information regarding the provider's medical practice. **View or print Office of Medicaid Inspector General contact information.**

Additionally, the OMIG Section is responsible for the identification and recoupment of questioned costs claimed for reimbursement from Medicaid funds when warranted. Situations resulting in recoupment include, but are not limited to, the following:

A. When duplicate payments are made

B. When the Quality Improvement Organization (QIO) 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 a provider has been assessed a monetary penalty for failure to follow a corrective action plan which was developed to correct a pattern of non-compliance as provided in Sections 151.000 and 190.005

When a review is completed, Office of Medicaid Inspector General will forward a findings report to the provider. If questioned costs are identified through the review, a "Notice of Decision/Action" will be forwarded to the provider. This notice must comply with Section 190.006 of this manual and must include the name(s) of the patient(s), date(s) of service, date(s) of payment and the reason(s) for the recoupment decision.

Upon receipt of this notice, the provider has thirty-five (35) calendar days in which to pursue one of the following actions:

A. Forward a check for the indicated recoupment amount

B. Request administrative reconsideration

C. Appeal

See Sections 160.000 through 169.000 for rules and procedures related to administrative reconsideration and appeals.

110.800 Dental Care Unit 10-13-03

The dental coordinator assists providers with questions regarding dental services. **View or print the Dental Coordinator contact information.**

110.900 Visual Care Unit 10-13-03

The visual care coordinator assists providers with questions regarding visual care services. **View or print the Visual Care Coordinator contact information.**

111.000 DMS and Fiscal Agent Office Hours 9-15-09

A Provider Assistance Center is available for provider billing and reimbursement questions 8:00 a.m. until 5:00 p.m., Monday through Friday, with the exception of state and official holidays. **View or print the Provider Assistance Center contact information.**

The Division of Medical Services is available to answer provider questions regarding service coverage not directly addressed within this provider manual 8:00 a.m. until 4:30 p.m., Monday through Friday, with the exception of state and official holidays. **View or print the Division of Medical Services contact information.**

120.000 BENEFICIARY ELIGIBILITY

121.000 Introduction 6-1-08

Medicaid eligibility determinants are such things as income (individual or household), resources, and medical needs with charges exceeding one's ability to pay, age or disability, current residency in Arkansas and other factors. The full range of criteria is beyond the scope of this provider manual. Eligibility inquiries should be made to the local DHS County office in the individual's county of residence.

122.000 Agencies Responsible for Determining Eligibility 1-1-23

The Department of Human Services (DHS) local county offices or district Social Security offices determine beneficiary eligibility for most Medicaid beneficiaries.

District Social Security offices determine Supplemental Security Income (SSI) eligibility, which automatically confers Medicaid eligibility for SSI beneficiaries.

122.100 Department of Human Services County Offices 6-1-08

Family Support Specialists in the DHS county offices are responsible for evaluating the circumstances of an individual or family to determine eligibility, and if eligible, the proper aid category through which Medicaid should be received.

After evaluation and determination, the DHS county office establishes Medicaid eligibility dates in accordance with state and federal policy and regulations. See Sections 123.000 and 124.000 of this manual for further explanation.

122.200 District Social Security Offices 7-15-12

Social Security representatives are responsible for evaluating an individual's circumstances to determine eligibility for the Supplemental Security Income (SSI) program administered by the Social Security Administration. SSI includes aged, blind and permanently and totally disabled categories. The SSI aid categories are listed in Section 124.000.

To be eligible for SSI, an individual must be aged, blind or be an individual with a permanent and total disability. All income, resource and other eligibility criteria must be met.

Individuals entitled to SSI automatically receive Medicaid.

123.000 Medicaid Eligibility Information 7-1-20

Under contract with the Division of Medical Services, the fiscal agent provides Medicaid eligibility verification through the provider portal via the web or through the Voice Response System (VRS). To access the VRS, providers can call the Provider Assistance Center automated help line. **View or print the Provider Assistance Center contact information.**

Eligibility requests can be submitted interactively through the provider portal via the web. Instructions for verifying eligibility through the provider portal are available using the site's online Help feature.

Medicaid providers are able to verify a beneficiary'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 electronic solutions.** Providers must print and retain eligibility documentation in the beneficiary's record each time services are provided or to document retroactive eligibility.

The Provider Assistance Center and 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 for dates of service that are more than a year prior to the eligibility authorization date.

Electronic Benefit Eligibility information only indicates information on claims that have been processed. It does not reflect any claims that may still be pending.

123.100 Date Specific Medicaid Eligibility 7-1-20

Beneficiary eligibility in the Arkansas Medicaid Program is date specific. Medicaid eligibility may begin or end on any day of a month. An electronic response through the provider portal or Voice Response System (VRS) provides the current eligibility period through the date of the inquiry. An electronic eligibility verification inquiry and positive response through the provider portal or VRS (i.e. the beneficiary is eligible on the date of service) guarantees that a claim for service on that date will not deny for ineligibility.

123.200 Retroactive Medicaid Eligibility 6-1-08

Medicaid beneficiaries may be found eligible for Medicaid benefits for the three-month period before the application date, if eligibility requirements for the three-month period are met. The DHS county offices establish retroactive eligibility. Initial SSI eligibility is usually retroactive.

123.400 Beneficiary Lock-In 4-1-06

The beneficiary lock-in rule enables physicians and pharmacists to provide quality care and assures that the Medicaid Program does not unintentionally facilitate drug abuse or injury from overmedication or drug interaction.

If a beneficiary has utilized pharmacy services at a frequency or amount that is not medically necessary, as determined by a computerized algorithm and clinical review process, DMS can "lock-in" the beneficiary by requiring him or her to choose a single provider of pharmacy services. After lock-in, DMS will deny claims for pharmacy services submitted by any provider other than the selected provider. The selected provider will be notified prior to lock-in, so that adequate time is allowed for selection of another pharmacy if the selected provider cannot provide the needed services.

If a beneficiary fails or refuses to choose one provider, a list of providers used by the beneficiary will be reviewed and a provider will be chosen at random. DMS will ensure that the beneficiary has reasonable access, taking into account geographic location and reasonable travel time, to pharmacy services of adequate quality.

Before imposing lock-in, DMS or its agent will mail a notice to the beneficiary in accordance with the beneficiary due process rules found in Section 191.000 of this manual. The notice will also inform the beneficiary of his or her right to request administrative reconsideration and outline that process. If the beneficiary does not appeal or request reconsideration, he must choose a pharmacy using the selection form enclosed with the notice.

When a beneficiary has been locked-in, eligibility verification transactions will reflect "lock-in to other provider." The restriction will be removed after demonstration by the beneficiary that the abusive situation has been corrected. Application of this rule will not result in the denial, suspension, termination, reduction or delay of medical assistance to any beneficiary.

Any provider who believes that a particular beneficiary should be considered for beneficiary lock-in should notify the Division of Medical Services, Pharmacy Unit/Utilization Review Section. **View or print the Division of Medical Services, Pharmacy Unit/Utilization Review Section contact information.**

124.000 Beneficiary Aid Categories 1-1-23

A full list of client aid categories is available online. **View or print the Client Aid Category list**.

124.100 Client Aid Categories with Limited Benefits 1-1-23

Most Medicaid categories provide the full range of Medicaid services as specified in the Arkansas Medicaid State Plan. However, certain categories offer a limited benefit package. These categories are discussed below. **View or print the Client Aid Category list**.

124.110 ARKids First-B 1-1-16

Act 407 of 1997 established the ARKids First Program. The ARKids First-B Program incorporates uninsured children into the health care system. ARKids First-B benefits are comparable to the Arkansas state employees and teachers insurance program.

Refer to the ARKids First-B provider manual for the scope of each service covered under the ARKids First-B Program.

124.120 Medically Needy 1-1-16

The medically needy categories help provide medical care for those individuals who are medically eligible for benefits, but while their income and/or resources exceed the Medicaid limits for other types of assistance, the income is insufficient to pay for all or part of necessary medical care.

Medically needy beneficiaries are covered for the full range of Medicaid benefits with the exception of long term care services (which includes ICF/IID) and personal care services.

For more information regarding the medically needy program, providers may access the Medicaid website at **https://medicaid.mmis.arkansas.gov/**.

124.130 Pregnant Women, Infants & Children 1-1-23

The infants and children in the SOBRA (Sixth Omnibus Budget Reconciliation Act of 1986) aid category receive the full range of Medicaid benefits.

Pregnant Women (PW)-eligibility ends on the last day of the month in which the 60th postpartum day occurs.

PW-Unborn Child group (covered through the State Child Health Insurance program, which is authorized by Section 4901 of the Balanced Budget Act of 1997) does not cover sterilization or any other family planning services. Therefore, providers must verify eligibility to determine if the pregnant women is PW-or PW "Unborn Child" (when providers check eligibility, the system will reflect: "PW Unborn CH-no Ster cov" for the Unborn Child group).

Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are:

A. Prenatal services

B. Delivery

C. Postpartum services for 60 days (plus the days remaining in the month in which the 60-day period ends)

D. Services for conditions that may complicate the pregnancy

System eligibility verification will specify "PW unborn ch-no ster cov/FP."

124.140 Reserved 9-1-15

124.150 Qualified Medicare Beneficiaries (QMB) 1-1-16

The Qualified Medicare Beneficiary (QMB) group was created by the Medicare Catastrophic Coverage Act and uses Medicaid funds to assist low-income Medicare beneficiaries. QMBs do not receive the full range of Medicaid benefits. For example, QMBs do not receive prescription drug benefits from Medicaid or drugs not covered under Medicare Part D. If a person is eligible for QMB, Medicaid pays the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance, less any Medicaid cost sharing, for Medicare covered medical services. Medicaid also pays the Medicare Part A hospital deductible and the Medicare Part A coinsurance, less any Medicaid cost sharing. Medicaid pays the Medicare Part A premium for QMBs whose employment history is insufficient for Title XVIII to pay it. Certain QMBs may be eligible for other limited Medicaid services. Only individuals considered to be Medicare/Medicaid dually eligible qualify for coverage of Medicaid services that Medicare does not cover.

To be eligible for QMB, individuals must be age 65 or older, blind or an individual with a disability and enrolled in Medicare Part A or conditionally eligible for Medicare Part A. Their countable income may equal but may not exceed 100% of the Federal Poverty Level (FPL). Countable resources may be equal to but not exceed twice the current Supplemental Security Income (SSI) resource limitations.

Generally, individuals may not be certified in a QMB category and in another Medicaid category simultaneously. However, some QMBs may simultaneously receive assistance in the medically needy categories, SOBRA pregnant women (61 and 62). QMB generally do not have Medicaid coverage for any service that is not covered under Medicare; with the exception of the above listed categories and individuals dually eligible.

Individuals eligible for QMB receive a plastic Medicaid ID card. Providers must view the electronic eligibility display to verify the QMB category of service. The category of service for a QMB will reflect QMB-AA, QMB-AB or QMB-AD. The system will display the current eligibility.

Most providers are not federally mandated to accept Medicare assignment (See Section 142.700). However, if a physician (by Medicare's definition) or non-physician provider desires Medicaid reimbursement for coinsurance or deductible on a Medicare claim, he or she must accept Medicare assignment on that claim (see Section 142.200 D) and enter the information required by Medicare on assigned claims. When a provider accepts Medicare according to Section 142.200 D, the beneficiary is not responsible for the difference between the billed charges and the Medicare allowed amount. Medicaid will pay a QMB's or Medicare/Medicaid dual eligible's Medicare cost sharing (less any applicable Medicaid cost sharing) for Medicare covered services.

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

124.160 Qualifying Individuals-1 (QI-1) 7-15-12

The Balanced Budget Act of 1997, Section 4732, (Public law 105-33) created the Qualifying Individuals-1 (QI-1) aid category. 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 do not receive a Medicaid card. Additionally, unlike QMBs and SMBs, they may not be certified in another Medicaid category for simultaneous periods. Individuals who meet the eligibly requirements for both QI-1 and medically needy spend down must choose which coverage they want 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 an individual with a disability and entitled to receive Medicare payment 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 not exceed twice the current SSI resource limitations.

124.170 Specified Low-Income Medicare Beneficiaries (SMB) 7-15-12

The Specified Low-Income Medicare Beneficiaries Program (SMB) was mandated by Section 4501 of the Omnibus Budget Reconciliation Act of 1990.

Individuals eligible as specified low-income Medicare beneficiaries (SMB) are not eligible for the full range of Medicaid benefits. They are eligible only for Medicaid 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 those for QMB program. The individuals must be aged 65 or older, blind or an individual with disabilities and entitled to receive Medicare Part A hospital insurance and Medicare Part B 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.

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

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

124.180 Reserved 9-1-15

124.190 Reserved 9-1-15

124.200 Client Aid Categories with Additional Cost Sharing 1-1-23

Certain programs require additional cost sharing for Medicaid services. **View or print the Client Aid Category list.**

The forms of cost sharing in the Medicaid Program are co-payment and premiums. These programs are discussed in Sections 124.210 through 124.250.

Copayments may not exceed the amounts listed in the cost sharing schedules, as updated each January 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

A family's total annual out-of-pocket cost sharing cannot exceed five percent (5%) of the family's gross income.

124.210 ARKids First-B 6-1-08

Covered services provided to ARKids First-B participants are (with only a few exceptions) within the same scope of services provided to other Arkansas Medicaid beneficiaries, but may be subject to cost sharing requirements. See Section II of the ARKids First-B provider manual for a list of services that require cost sharing and the amount of participant liability for each service.

124.220 TEFRA 1-1-23

Eligibility category 49 covers children under age 19 who are eligible for Medicaid services as authorized by Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and amended by the Omnibus Budget Reduction Act. Children in category 49 receive the full range of Medicaid services. However, there are cost sharing requirements. Families will be charged a sliding scale monthly premium based on the income of the custodial parents. Custodial parents with incomes above 150 percent of the federal poverty level (FPL) and in excess of $25,000 annually will be subject to a sliding scale monthly premium. The monthly premium, described in the following chart, can only be assessed if the family income is in excess of one-hundred and fifty percent (150%) of the federal poverty level.

The premiums listed in the TEFRA Cost Share Schedule below represent family responsibility. They will not increase if a family has more than one TEFRA-eligible child. Co-payments are not charged for services to TEFRA children, and a family's total annual out-of-pocket cost sharing cannot exceed five percent (5%) of the family's gross income.

TEFRA Cost Share Schedule
Effective July 1, 2022

Family Income		Monthly Premiums		
From	To	%	From	To
$0	$25,000	0%	$0	$0
$25,001	$50,000	1.00%	$20	$41
$50,001	$75,000	1.25%	$52	$78
$75,001	$100,000	1.50%	$93	$125
$100,001	$125,000	1.75%	$145	$182
$125,001	$150,000	2.00%	$208	$250
$150,001	$175,000	2.25%	$281	$328
$175,001	$200,000	2.50%	$364	$416
$200,001	No limit	2.75%	$458	$458

The maximum premium is $5,500 per year ($458 per month) for income levels of $200,001 and above.

124.230 Workers with Disabilities 1-1-23

The Workers with Disabilities (WD) category is an employment initiative designed to enable people with disabilities to gain employment without losing medical benefits. Individuals who are ages sixteen (16) through sixty-four (64), with a disability as defined by Supplemental Security Income (SSI) criteria and who meet the income and resource criteria may be eligible in this category.

Co-payments are required for the following services:

Adult Medicaid Cost Share Schedule	
Service	**Copay**
Office Visits and Outpatient Services	
Physician visit (including PCP/specialist/audiologist/podiatrist visit, excluding preventive services and X-ray)	$4.70
Preventative Care/Screening/Immunizations/EPSDT	$0.00
Other Practitioner Office Visit (Nurse, Physician Assistant)	$4.70
Federally Qualified Health Center (FQHC)	$4.70
Rural Health Clinic	$4.70
Ambulatory Surgical Center	$4.70
Family planning services and supplies (including contraceptives)	$0.00
Chiropractor	$4.70
Acupuncture	Not covered
Pharmacy	
Generics	$4.70
Preferred Brand Drugs	$4.70
Non-Preferred Brand Drugs	$9.40

Specialty Drugs (i.e., High-Cost)	$9.40
Testing and Imaging	
X-rays and Diagnostic Imaging	$4.70
Imaging (CT/Pet Scans, MRIs)	$4.70
Laboratory Outpatient and Professional Services	$4.70
Allergy Testing	$4.70
Inpatient Services	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Emergency and Urgent Care	
Emergency Room Services	$0.00
Non-Emergency Use of the Emergency Department	$9.40
Emergency Transportation/Ambulance	$0.00
Urgent Care Centers or Facilities	$4.70
Durable Medical Equipment	
Durable Medical Equipment	$4.70
Prosthetic Devices	$4.70
Orthotic Appliances	$4.70
Mental and Behavioral Health and Substance Abuse	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Mental/Behavioral Health and SUD Outpatient Services	$4.70
Rehabilitation and Habilitation	
Rehabilitative Occupational Therapy	$4.70
Rehabilitative Speech Therapy	$4.70
Rehabilitative Physical Therapy	$4.70
Outpatient Rehabilitation Services	$4.70
Habilitation Services	$4.70
Surgery	
Inpatient Physician and Surgical Services	$0.00
Outpatient Surgery Physician/Surgical Services	$4.70
Treatments and Therapies	
Chemotherapy	$4.70
Radiation	$4.70
Infertility Treatment	Not covered
Infusion Therapy	$4.70
Vision	
Dental	
Accidental Dental	$4.70

Women's Services	
Delivery and all Inpatient services for maternity care	$0.00
Prenatal and postnatal care	$0.00
Other	
Home health Care Services	$4.70
Hospice Services	$0.00
End Stage Renal Disease Services (Dialysis)	$0.00
Personal Care	Not covered

*** Exception:** Cost sharing for nursing facility services is in the form of "patient liability" which generally requires that patients contribute most of their monthly income toward their nursing facility care. Therefore, WD clients (Aid Category 10) and Transitional Medicaid clients (Aid Category 25) who temporarily enter a nursing home and continue to meet WD or TM eligibility criteria will be exempt from the co-payments listed above.

124.240 Transitional Medicaid Adult 1-1-23

The Transitional Medicaid program extends Medicaid coverage to families up to 185% of FPL that, due to earned income, lost eligibility for the Parents/Caretaker-Relative (PCR) Aid Category. The Transitional Medicaid program provides up to twelve (12) months of extended coverage after losing PCR eligibility.

Pertinent co-payment amounts for clients covered by Adult Transitional Medicaid are the same as those listed in Section 124.230.

124.250 Arkansas Health and Opportunity for Me (ARHOME) 1-1-23

The ARHOME program operates as a demonstration waiver under Section 1115 of the Social Security Act. It provides premium assistance to allow clients eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act to enroll in qualified health plans. The ARHOME aid category covers adults ages 19-64 who earn up to 138% of the federal poverty level and are not eligible for Medicare. Under ARHOME, clients receive services either through a qualified health plan (QHP) or through three other benefit plans delivered through fee for service. Cost sharing applies only to ARHOME clients who are enrolled in a QHP or who are awaiting enrollment in a QHP (IABP benefit plan). ARHOME clients in a benefit plan based on their status as medically frail (FRAIL) or alternative benefit plan (ABP) will not be subject to any cost sharing.

ARHOME QHP Cost Share amounts for clients enrolled in a QHP are as follows:

ARHOME QHP Cost Share Schedule	
Service	**Copay**
Office Visits and Outpatient Services	
Physician visit (including PCP/specialist/audiologist/podiatrist visit, excluding preventive services and X-ray)	$4.70
Preventative Care/Screening/Immunizations/EPSDT	$0.00
Other Practitioner Office Visit (Nurse, Physician Assistant)	$4.70
Federally Qualified Health Center (FQHC)	$4.70
Rural Health Clinic	$4.70

Ambulatory Surgical Center	$4.70
Family planning services and supplies (including contraceptives)	$0.00
Chiropractor	$4.70
Acupuncture	Not covered
Nutritional Counseling	$4.70
Pharmacy	
Generics	$4.70
Preferred Brand Drugs	$4.70
Non-Preferred Brand Drugs	$9.40
Specialty Drugs (i.e., High-Cost)	$9.40
Testing and Imaging	
X-rays and Diagnostic Imaging	$4.70
Imaging (CT/Pet Scans, MRIs)	$4.70
Laboratory Outpatient and Professional Services	$4.70
Allergy Testing	$4.70
Inpatient Services	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Emergency and Urgent Care	
Emergency Room Services	$0.00
Non-Emergency Use of the Emergency Department	$9.40
Emergency Transportation/Ambulance	$0.00
Urgent Care Centers or Facilities	$4.70
Durable Medical Equipment	
Durable Medical Equipment	$4.70
Prosthetic Devices	$4.70
Orthotic Appliances	$4.70
Mental and Behavioral Health and Substance Abuse	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Mental/Behavioral Health and SUD Outpatient Services	$4.70
Rehabilitation and Habilitation	
Rehabilitative Occupational Therapy	$4.70
Rehabilitative Speech Therapy	$4.70
Rehabilitative Physical Therapy	$4.70
Outpatient Rehabilitation Services	$4.70
Habilitation Services	$4.70
Surgery	
Inpatient Physician and Surgical Services	$0.00

Outpatient Surgery Physician/Surgical Services	$4.70
Treatments and Therapies	
Chemotherapy	$4.70
Radiation	$4.70
Infertility Treatment	Not covered
Infusion Therapy	$4.70
Vision	
Routine Eye Exam	Not covered
Dental	
Basic Dental Services	Not covered
Accidental Dental	$4.70
Orthodontia	Not covered
Women's Services	
Delivery and all Inpatient services for maternity care	$0.00
Prenatal and postnatal care	$0.00
Other	
Eyeglasses for Adults	Not covered
Diabetes Education	$0.00
Home Health Care Services	$4.70
Private-Duty Nursing	Not covered
Hospice Services	$0.00
End Stage Renal Disease Services (Dialysis)	$0.00
Personal Care	Not covered

125.000 Medicaid Identification Card

125.100 Explanation of Medicaid Identification Card 1-1-16

Medicaid beneficiaries are issued a magnetic identification card similar to a credit card. Each identification card displays a hologram, and for many Medicaid categories, a picture of the beneficiary. Children under the age of five, ARKids First-B participants, nursing home patients and home- and community-based waiver beneficiaries are not pictured. New participants in ARKids First-A are not pictured unless their current certification is under an existing case number and they have a previously issued photo ID card. The DHS Division of County Operations issues the Medicaid identification card to Medicaid beneficiaries.

THE MEDICAID IDENTIFICATION CARD DOES NOT GUARANTEE ELIGIBILITY FOR A BENEFICIARY. Payment is subject to verification of beneficiary eligibility at the time services are provided. See Section 123.000 for verification of beneficiary eligibility procedures, and Section III for electronic eligibility verification information.

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

A. Identification Number - A unique ten-digit number assigned to each individual Medicaid beneficiary by the Arkansas Division of County Operations.

B. Name of Beneficiary - Identifies the name of the beneficiary who is eligible to receive Medicaid benefits. The card reflects the beneficiary's name at time of issuance.

C. Birth date - Month/Day/Year - This date represents the month, day and year of birth of the beneficiary listed.

D. Date of Issuance - This date represents the month, day and year the card was issued to the beneficiary.

E. Signature - This is the signature of the beneficiary named on the ID card.

View or print an example of the Medicaid ID card.

NOTE: ARKids First-B identification cards look different from a Medicaid identification card. See the ARKids First-B provider manual for more information.

125.200 Non-Receipt or Loss of Card by Beneficiary 6-1-08

When beneficiaries report non-receipt or loss of a Medicaid card, refer them to the local DHS County Office or the Division of County Operations, Customer Assistance. **View or print the Division of County Operations, Customer Assistance contact information.**

125.300 Reporting Suspected Misuse of I.D. Card 1-1-16

When a provider suspects misuse of a Medicaid identification card, the provider should contact the Office of Medicaid Inspector General. An investigation will then be made. **View or print the Office of Medicaid Inspector General contact information.**

130.000 BENEFICIARY RESPONSIBILITIES

131.000 Charges that Are Not the Responsibility of the Beneficiary 12-1-20

Except for cost sharing responsibilities outlined in Sections 133.000 – 135.000, a beneficiary is not liable for the following charges:

A. A claim or portion of a claim denied for lack of medical necessity.

B. Charges in excess of the Medicaid maximum allowable rate.

C. A claim or portion of a claim denied due to provider error.

D. A claim or portion of a claim denied because of errors made by DMS or the Arkansas Medicaid fiscal agent.

E. A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed.

F. A claim or portion of a claim denied because a provider failed to obtain prior, concurrent, or retroactive authorization for a service.

G. A claim or portion of a claim denied because the claim did not meet Electronic Visit Verification (EVV) requirements (see 145.000).

H. The difference between the beneficiary Medicaid cost sharing responsibility, if any, and the Medicare or Medicare Advantage co-payments.

I. Medicaid pays the difference, if any, between the Medicaid maximum allowable fee and the total of all payments previously received by the provider for the same service. Medicaid beneficiaries are not responsible for deductibles, co-payments, or coinsurance amounts to the extent that such payments, when added to the amounts paid by third

parties, equal or exceed the Medicaid maximum for that service, even if the Medicaid payment is zero. The beneficiary is responsible for paying applicable Medicaid cost share amounts.

J. The beneficiary is not responsible for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

If an individual who makes payment at the time of service is later found to be Medicaid eligible and Medicaid is billed, the individual must be refunded the full amount of his or her payment for the covered service(s). If it is agreeable with the individual, these funds may be credited against unpaid non-covered services and Medicaid cost-sharing amounts that are the responsibility of the beneficiary.

The beneficiary may not be billed for the completion and submission of a Medicaid claim form.

Exception: Medicaid does not cover the deductible, co-payments, or other cost share amounts levied to Medicare Part D drugs.

132.000 Charges that Are the Responsibility of the Beneficiary 9-1-08

A beneficiary is responsible for:

A. Charges incurred during a time of ineligibility

B. Charges for non-covered services, including services received in excess of Medicaid benefit limitations, if the beneficiary has chosen to receive and agreed to pay for those non-covered services

C. Charges for services which the beneficiary has chosen to receive and agreed to pay for as a private pay patient

D. Spend down liability on the first day of spend down eligibility

E. The beneficiary is also responsible for any applicable cost-sharing amounts such as premiums, deductibles, coinsurance, or co-payments imposed by the Medicaid Program pursuant to 42 C.F.R. §§ 447.50 – 447.60 (2004). These cost-sharing responsibilities are outlined in Sections 124.210 -124.230 and 133.000 - 135.000 of this manual.

The beneficiary is not responsible for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

133.200 Inpatient Hospital Coinsurance Charge to ARKids First-B Beneficiaries 7-1-11

For inpatient admissions, the coinsurance charge per admission for ARKids First-B participants is 10**%** of the hospital's Medicaid per diem, applied on the first covered day.

Example:

An ARKids First-B beneficiary is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1950.00 and the beneficiary 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).

134.000 Exclusions from Cost Sharing Policy 1-1-23

The following populations are excluded from the client cost sharing requirement:

A. Individuals under twenty-one (21) years of age, except:

1. ARKids First-B clients (see the ARKids First-B manual for cost share and more information about this program).

B. Pregnant women.

C. Individuals who are American Indian or Native Alaskan

D. Individuals who are inpatients in a long-term care facility (nursing facility (NF) and intermediate care for individuals with intellectual disabilities (ICF/IID) facility) when, as a condition for receiving the institutional services, the individual is required to spend all but a minimal amount (for personal needs) of his or her income for medical care costs.

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

E. Individuals who are enrolled in a Provider-led Arkansas Shared Savings Entity (PASSE).

F. Individuals receiving hospice care.

G. Individuals who are at or below 20% of the federal poverty level.

The following services are excluded from the client cost sharing requirement:

A. 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, or
3. Serious dysfunction of any bodily organ or part.

B. Pregnancy-related services

C. Preventive services

D. Services for provider-preventable conditions

E. Family planning services and supplies.

The provider must maintain sufficient documentation in the client’s medical record to substantiate any exemption from the client cost sharing requirement.

135.000 Collection of Coinsurance/Co-payment 1-1-23

The method of collecting the coinsurance/co-payment amount from the client is the provider's responsibility. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing (coinsurance or co-payment) from the client remains the provider's responsibility.

The provider may not deny services to a Medicaid client because of the individual's inability to pay the coinsurance or co-payment. However, the individual's inability to pay does not eliminate his or her liability for the coinsurance or co-payment charge.

The client's inability to pay the coinsurance or co-payment does not alter the Medicaid reimbursement for the claim. Unless the client or the service is exempt from cost sharing requirements as listed in Section 134.000, Medicaid reimbursement is made in accordance with the current reimbursement methodology and when applicable cost sharing amounts are deducted from the maximum allowable fee before payment.

Hospitals are required to comply with certain federal rules before assessing non-emergency copays. Hospitals are expected to comply with emergency room screening requirements, help locate alternate providers when screening determines the patient's need to be non-emergent, and inform clients of treatment options that have a lesser co-pay before the hospital and the state can charge the non-emergency use of the emergency room co-pay.

Hospitals must develop written policies and tracking mechanisms to identify how they comply with the requirement and produce data on member choice and expenditures. Policies and data must be available upon request of DHS and its designees.

The Medicaid cost-sharing amount for clients who use hospital emergency department services for non-emergency reasons can be found in the ARHOME QHP Cost Share Schedule for clients enrolled in a QHP **or** the Adult Medicaid Cost Share Schedule. (See Sections 124.230 and 124.250)

This cost-sharing amount will only apply to Medicaid clients who are subject to a copay. There will not be any cost-sharing required from clients who need emergency services or treatment.

The first step in the process will be for hospital emergency departments to conduct an appropriate medical screening to determine whether the client needs emergency services.

If the screening determines that emergency services are needed, hospitals should tell the client what the cost-sharing amount will be for the emergency services provided in the emergency department ($0.00). Hospitals should then provide needed emergency services per their established protocols.

If the screening determines that emergency services are not needed, hospitals may provide non-emergency services in the emergency department. Before providing non-emergency services and imposing client cost sharing for such services, however, the hospital must:

- Tell the client what the cost-sharing amount will be for the non-emergency services provided in the emergency department,
- Give the client the option of paying for and receiving services in the emergency department, or
- Give the client the name and location of an alternate non-emergency services provider that can provide the needed services in a timely manner and at a lower cost than the hospital emergency department, and
- Refer the client to the alternate provider, who will then coordinate scheduling for treatment.

136.000 Patient Self Determination Act 6-1-08

The Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L.101-508 requires that Medicaid-certified hospitals and other health care providers and organizations, 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 Centers for Medicare & Medicaid Services (CMS). The federal requirements mandate conformity to current state law. Accordingly, providers must employ the following procedures:

A. Provide all adult (aged 18 and older) patients (not just Medicaid beneficiaries) 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 furnished to Medicaid beneficiaries by the following provider types and in accordance with the listed procedures.

   1. Hospitals at the time of the individual's admission as an inpatient.
   2. Nursing facilities when the individual is admitted as a resident.
   3. Providers of home health or personal care services in advance of the individual receiving care.
   4. Hospices at the time of a beneficiary's initial election of hospice care.

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

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

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

E. Not discriminate against a beneficiary 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.

F. Educate staff and the community on advance directives.

G. 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.

H. 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.

A description of advance directive must be distributed to each patient. **View or print a sample form describing advance directives and a sample declaration form that meets the requirements of law.**

140.000 PROVIDER PARTICIPATION

141.000 Provider Enrollment 11-1-17

Any provider of health care services must be enrolled in the Arkansas Medicaid Program before Medicaid will cover any services provided by the provider to Arkansas Medicaid beneficiaries. Enrollment as a Medicaid provider is contingent upon the provider satisfying all rules and requirements for provider participation as specified in the applicable provider manual, state and federal law. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

All providers must sign all applicable forms that require a signature and the Arkansas Medicaid Provider Contract. The signature must be an original signature or an approved electronic signature of the individual provider. The provider's authorized representative may sign the contract for a group practice, hospital, agency or other institution.

In addition to the information in Section 140.000, Section II of each program's provider manual may contain supplemental provider type specific participation requirements. The provider enrollment functions for the Arkansas Medicaid Program are performed by an independent contractor. The contractor is responsible for provider enrollment services for new providers and changes to current provider enrollment files. Potential providers must complete all appropriate portions of a provider enrollment Application Packet to execute the provider contract. They must also submit a copy of all certifications and licenses verifying compliance with enrollment criteria for the applicable provider type or discipline to be practiced and pay the application fee (if applicable). See Section 141.101 for Application Fees.

Potential providers may enroll on the Arkansas Medicaid website at **https://medicaid.mmis.arkansas.gov/.** Potential providers that are not required to pay application fees may also send the printed form to the Medicaid Provider Enrollment Unit. **View or print the Provider Enrollment contact information.**

All subsequent state license and certification renewals must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and FINAL 30 days to comply. Failure to timely submit verification of license or certification renewals will result in cancellation of enrollment in the Arkansas Medicaid Program. **View or print the provider enrollment and contract package (Application Packet).**

In addition to the submission of the Application Packet, the following forms are required and must be submitted to complete the enrollment process:

A. W-9 Tax form (DMS-652)

B. Medicaid Provider Contract (DMS-652)

C. PCP Agreement, if applicable (DMS-2608. See Section 171.000 for PCP requirements.)

D. EPSDT Agreement, if applicable (DMS-831. See Section 201.000 of the EPSDT provider manual for the EPSDT Agreement.)

E. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.

F. Authorization for Electronic Funds Transfer (Automatic Deposit)

Each provider must notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract status, such as:

A. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.

B. Change in Federal Employer Identification Number (FEIN) may require the completion of a new enrollment application

C. Authorization for Electronic Funds Transfer (Automatic Deposit)

D. Change in practice or specialty

E. Retirement or death of provider

F. Name Change Form

G. Change of Ownership Form (DMS-0688) (**View or print form DMS-0688 – Provider Change of Ownership Information Form.**)

H. Address/Email Change Form (DMS-673) (**View or print form DMS-673 – Address/Email Change Form.**) **NOTE:** An active email address is required.

I. Change in Ownership Control (5% or more) or Conviction of Crime (**View or print form DMS-675 – Ownership and Conviction Disclosure.**)

J. Disclosure of Significant Business Transactions (**View or print form DMS-689 – Disclosure of Significant Business Transactions.**)

When the provider has successfully met all requirements, the Medicaid Provider Enrollment Unit will assign a unique Medicaid number to the provider. The assigned provider number is linked to the provider's tax identification number (either a Social Security Number or a Federal Employer Identification Number) and to the provider's National Provider Identifier (NPI) unless the provider is an atypical provider not required to have an NPI.

141.100 Revalidation of Enrollment 7-1-13

Federal regulation 42 CFR 455.414 requires Arkansas Medicaid to revalidate the enrollment of all providers regardless of provider type, at least every 5 years. Revalidation of an enrollment includes:

A. Submission of a new application,

B. Payment of application fee, if applicable (See Section 141.102 for Application Fees requirements.), and

C. Satisfactory completion of screening activities.

The revalidation notice will be sent to the provider 90 days before their revalidation deadline using the "Mail To" address on file. It is important that providers keep their address information up to date to ensure that they receive this notice. Failure to submit the required documentation prior to the deadline will interrupt the ability to have claims paid.

Providers enrolling on or after July 1, 2013 will have a future revalidation date set at the time of their enrollment. All providers that were enrolled before July 1, 2013 will be required to revalidate their enrollments upon receipt of notice from Medicaid Provider Enrollment. This initial revalidation will determine the revalidation cycle for providers.

141.101 Application Fees 7-1-13

Federal regulation 42 CFR 455.460 requires that Arkansas Medicaid collect applicable application fees from prospective or re-enrolling providers prior to the execution of the Medicaid Provider Contract and issuance of a Medicaid Provider ID number.

The following providers are not required to pay the application fee to Arkansas Medicaid:

A. Individual physicians or non-physician practitioners.

B. Physician or non-physician practitioner group practices.

C. Providers who are enrolled in either of the following:

1. Medicare
2. Another state's Medicaid or Children's Health Insurance Program.

D. Providers that have paid the applicable application fee to:

1. A Medicare contractor; or
2. Another state.

The application fee will be subject to change each year in accordance with the federally published application fee.

All providers that are required to pay an application fee must enroll online. Application fees must be paid by credit card, debit card or electronic funds transfer and submitted with the online application.

Applications submitted without payment, proof of payment or exception letter will not be accepted. (See Section 141.102 for Hardship Exceptions requirements.) Providers must maintain their supporting documentation on file.

141.102 Hardship Exceptions 7-1-13

Section 1866(j)(2)(C)(iii) of the Act permits the Secretary of the federal Department of Health and Human Services to grant, on a case-by-case basis, exceptions to the application fee for institutional providers and suppliers enrolled in the Medicare and Medicaid programs and CHIP, if the Secretary determines that imposition of the fee would result in a hardship. Such requests will be considered on a case-by-case basis, as required by the statute.

141.103 Provider Screening 7-1-13

Federal regulation 42 CFR 455.450 requires that Arkansas Medicaid screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment based on a categorical risk assessment; and conduct on-site visits in accordance with 42 CFR 455.432, which includes pre-enrollment and post enrollment site visits as well as unannounced on-site inspections of any provider location.

A. Conduct a criminal background check on the provider and anyone with five percent (5%) or higher direct or indirect ownership interest in the provider, and

B. Require submission of a set of fingerprints from the provider and anyone with five percent (5%) or higher direct or indirect ownership interest in the provider.

142.000 Conditions of Participation 8-1-14

Providers enrolled in the Arkansas Medicaid Program must agree to and meet the conditions of participation contained in sections within 140.000.

A. Failure to comply with the requirements contained within Section 140.000 may result in termination from the Medicaid Program and/or recovery of money paid for services by the Division of Medical Services.

B. Nothing in the conditions of participation is a limitation on the ability of DMS to take any action that is authorized by federal or state laws, regulations or rules or to refrain from taking any action that is not mandated by federal or state laws, regulations or rules.

C. Arkansas Code Annotated 12-12-925 prohibits the provision of goods and services under the Arkansas Medicaid program by persons that are required to register as a sex offender, listed in the Federal Bureau of Investigation's National Sex Offender Registry or listed in the United States Department of Justice Dru Sjodin National Sex Offender Public Website. Persons to which this law is applicable will be denied enrollment as a Medicaid provider or terminated if a current Medicaid provider. As this law applies regardless of enrollment as a Medicaid provider, please see also Section 142.500 E for additional information.

142.100 General Conditions 10-8-10

A. Each provider must be licensed, certified or both, as required by law, to furnish all goods or services that may be reimbursed by the Arkansas Medicaid Program.

B. Providers must adhere to all applicable standards for professional conduct and quality care.

C. It is the responsibility of each provider to read the complete Arkansas Medicaid provider manual provided by DMS and to abide by the rules and regulations specified in the manual.

D. All services provided must be medically necessary. The beneficiary is not liable for a claim or portion of a claim when the Medicaid Program, either directly or through a designee, determines that the services were not medically necessary.

E. Services will be provided to qualified beneficiaries without regard to race, color, national origin or disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

F. Each provider must notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract, such as:

1. Change of address (**View or print form DMS-673 – Address Change Form.**)
2. Change in members of group, professional association or affiliations*
3. Change in practice or specialty*
4. Change in Federal Employer Identification Number (FEIN)*
5. Retirement or death of provider*
6. Complete change of ownership (**View or print form DMS-0688 – Provider Change of Ownership Information Form.**)
7. Change in Ownership Control (5% or more) or Conviction of Crime (**View or print form DMS-675 – Ownership and Conviction Disclosure.**)
8. Disclosure of Significant Business Transactions (**View or print form DMS-689 – Disclosure of Significant Business Transactions**.)

Changes in items two (2) through five (5) above may be properly addressed through a letter of explanation with the provider's original signature or an approved electronic signature and the appropriately corrected pages of the provider application document (**View or print form DMS-652 – Provider Application Form**).

G. Except for Medicaid-covered services and other professional services furnished in exchange for the provider's usual and customary charges, a Medicaid provider may not knowingly give, offer, furnish, provide or transfer money, services or any thing of value for less than fair market value to any Medicaid beneficiary, to anyone related to any Medicaid beneficiary within the third degree or any person residing in the household of a beneficiary.

This rule does not apply to:

1. Pharmaceutical samples provided to a physician at no cost or to other comparable circumstances where the provider obtains the sample at no cost and distributes the samples without regard to Medicaid eligibility.
2. Provider actions taken under the express authority of state or federal Medicaid laws or rules or the provider's agreement to participate in the Medicaid Program.

142.200 Conditions Related to Billing for Medicaid Services 4-1-23

A. Any covered service performed by a provider must be billed only after the service has been provided. No service or procedure may be pre-billed.

B. Endorsement of the provider check issued by the Medicaid fiscal agent certifies that the services were rendered by or under the direct supervision of the provider as billed.

C. It is the responsibility of each provider to be alert to the possibility of third-party sources of payment and to report receipt of funds from these sources to DMS.

D. Each provider must accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any Medicare deductible or coinsurance due and payable under Title XIX (Medicaid). See Section 142.700 for more information and details.

E. Each provider must accept payment from Medicaid as payment in full for covered services, make no additional charges, and accept no additional payment from the beneficiary for these services.

F. Medicaid providers may not charge beneficiaries for the completion and submission of a Medicaid claim form. If the provider agrees to accept the patient as a Medicaid beneficiary and agrees to bill Medicaid for the services rendered, the beneficiary may not be charged for this billing procedure.

G. Claims for services provided to eligible Medicaid beneficiaries must be submitted to the Medicaid fiscal agent within twelve (12) months from the date of service.

H. Federal Public Health Service's 340B Drug Pricing Program: All covered entities (except Federally Qualified Health Centers) that participate in the Federal Public Health Service's 340B Drug Pricing Program (340B) that carve Arkansas Medicaid into the 340B program are required to bill Arkansas Medicaid using their 340B actual invoice price for covered outpatient drugs. Reimbursement shall be no more than the 340B ceiling price. The 340B actual invoice price for each drug reimbursement covered under this program must be submitted to the Department prior to any claims being processed. A covered outpatient drug includes outpatient drugs and drugs used in connection with an inpatient or outpatient service provided by a hospital. Covered entities (except Federally Qualified Health Centers) must also identify all 340B drug claims using the medical modifiers JG or TB. Medical drug claims from covered 340B entities without the modifiers JG or TB will be considered non-340B drug claims and will be subject to rebate invoicing.

I. 340B drug claims will be subject to post payment review. Providers are responsible for maintaining documentation to support billed amounts.

142.300 Conditions Related to Record Keeping 9-15-09

A. Each provider must prepare and keep complete and accurate original records that fully disclose the nature and extent of goods, services or both provided to and for eligible beneficiaries. The provider must contemporaneously establish and maintain beneficiary records that completely and accurately explain all evaluation, care diagnoses and any other activities of the provider in connection with the Medicaid beneficiary. The delivery of all goods and services billed to Medicaid must be documented in the beneficiary's medical record. Beneficiary records must support the levels of service billed to Medicaid. Providers furnishing any Medicaid covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the aforementioned prescription, care plan or order within five (5) business days of the date it is written. When verbal orders are properly received, a written prescription must be obtained within fourteen (14) business days of the date the prescription is written or received through verbal order. The provider must maintain a copy of each subsequent, relevant prescription and follow all prescriptions and care plans.

B. If a provider maintains more than one office in the state, the provider must designate one such office as a home office. Original records must be maintained at the provider's home office. A copy of the records must be maintained at the provider's service delivery site. If the provider changes ownership or ceases doing business in the state, all required original records must be maintained at a site in the state that is readily accessible by DMS and its agents and designees.

C. Each provider must retain all records for five (5) years from the date of service or until all audit questions or review issues, appeal hearings, investigations or administrative or judicial litigation to which the records may relate are finally concluded, whichever period is later. Failure to furnish medical records upon request may result in sanctions being imposed. Federal legislation further requires that any accounting of private healthcare information (PHI) or Health Insurance Portability and Accountability Act of 1996 (HIPAA) polices or complaints must be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.

D. Upon request, each provider must furnish all original records in its possession regarding the furnishing or billing of Medicaid goods or services, upon request, to authorized representatives of the Division of Medical Services or their designated representatives, state Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services, or their designated agents. The request may be made in writing or in person. No advance notice is required for an in-person request. When records are stored off-premise or are 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 made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel. If an audit of records determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation supporting the services will be accepted from the provider for consideration. Additional documentation will not be accepted at a later date.

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

142.400 Conditions Related to Disclosure

142.410 Disclosures of Ownership and Control 9-1-08

A. The Division of Medical Services (DMS) requires that providers disclose the following information regarding direct or indirect ownership and control interest as a condition of participation in the Medicaid Program. (**View or print form DMS-675 – Ownership and Conviction Disclosure.**)

1. The name and address of each person with a direct or indirect ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.
2. In compliance with information shown above, the provider must also disclose if any person named above is related to another as a spouse, parent, child or sibling.
3. The name of any other disclosing entity in which a person with a direct or indirect ownership or control interest in the disclosing entity also has a direct or indirect ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:
   a. Keep copies of all these requests and the responses to them,
   b. Make them available to representatives of the Secretary of Health and Human Services or to the Division of Medical Services upon request, and
   c. Advise DMS when there is no response to a request.

B. Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified above to representatives of an Arkansas survey agency at the time of a survey. The survey agency must promptly furnish the information to the Secretary of Health and Human Services and to the Division of Medical Services.

C. Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified above to the Secretary of Health and Human Services within the prior twelve-month period, must submit the information to the Division of Medical Services before entering into a contract or agreement to participate in the program.

142.420 Disclosures of Information Regarding Personnel Convicted of Crime 9-1-08

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

A. Has direct or indirect ownership or control interest in the provider, or is an agent or managing employee of the provider, and

B. Has ever been convicted of a criminal offense. (**View or print form DMS-675 – Ownership and Conviction Disclosure.**)

142.430 Disclosures of Business Transactions 9-1-08

A provider must submit full, accurate and complete information regarding:

A. The ownership of any subcontractor with whom the provider has business transactions totaling more than $25,000 or five percent (5%) of the provider's total operating expenses during the 12-month period immediately prior to the date of application or application renewal, and

B. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the application or application renewal.

C. Beginning on the effective date of enrollment in the Arkansas Medicaid Program, ongoing full and complete disclosure must be submitted concerning any significant business transactions (see definition on instruction page of DMS-689) that occur between the named entity and subcontractor or wholly owned supplier. This information must be submitted to Arkansas Medicaid, Provider Enrollment, within 35 days of the date the transaction takes place (**View or print form DMS-689 – Disclosure of Significant Business Transactions**.)

142.500 Conditions Related to Fraud and Abuse 8-1-14

A. 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.

B. Any provider who engages in abuse or over-utilization of services provided to Medicaid beneficiaries, when such abuse or over-utilization has been determined by DMS professional staff, medical consultants, contractors or designees, may be terminated from participation in the Medicaid Program, required to repay monies paid by the Medicaid Program for such services or have other appropriate action taken upon recommendation of the above-referenced parties.

C. 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, the following:

1. Instruction on admissions and authorization for payments
2. Instruction on the use and format of required program forms
3. Instruction on key provisions of the Medicaid Program
4. Instruction on reimbursement rates
5. Instruction on how to inquire about program requirements, payment or billing problems and the overall operation of the program

D. Providers are obligated to screen all employees and contractors to determine if any of them are excluded from participation in Federal health care programs.

1. Providers can search the LEIE website maintained by the United States Health and Human Services Office of Inspector General which contains the names of any excluded individual or entity. (**http://www.oig.hhs.gov/fraud/exclusions.asp**). The United States General Services Administration maintains a list of excluded providers at **https://www.epls.gov/.** Providers should search the website monthly to capture exclusions and reinstatements that have occurred since the last search.
2. Providers can find a Department of Human Services excluded list on the Arkansas Department of Human Services website at: **https://ardhs.sharepointsite.net/ExcludedProvidersList/Excluded%20Provider%20List.html.** This list contains the names of any excluded individuals or entities. The Arkansas Department of Finance and Administration, Office of State Procurement, maintains a list of suspended or debarred vendors at: **http://www.dfa.arkansas.gov/offices/procurement/guidelines/Pages/suspendedDebarredVendors.aspx**

3. If providers discover any exclusion information other than what is provided on the websites, providers should report that information to Provider Enrollment.

4. Providers should check the websites monthly to capture exclusions and reinstatements which may have occurred since the last search.

E. No Medicaid payments can be made for any times or services directed or prescribed by an excluded or prohibited provider; or any other authorized person, when the individual entity furnishing the services knew or should have known of the exclusion or prohibition. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded or prohibited. (See 42 CFR Section 1001.1901(b)).

F. Civil monetary penalties may be imposed against Medicaid providers who employ or enter into contracts with excluded individuals or entities to provider items or services to Medicaid beneficiaries. (See 1128A(a)(6) of the Act and 42 CFR Section 1003.102(a)(2).)

142.600 Conditions Related to Provider Refunds to DMS 4-1-24

Within thirty (30) days, a provider must refund any money the state is obligated to repay the federal government as a result of disallowance, recoupment or other adverse action in connection with Medicaid payments to the provider.

Any outstanding balances over thirty (30) days will be recouped against future payments. Providers unable to refund their outstanding balance within thirty (30) days must contact Gainwell Technologies Provider Assistance Center (PAC) to discuss repayment options. Note: All outstanding balances must be paid back within one (1) year. **View or print the Provider Assistance Center contact information.**

142.610 Overpayments Owed by Medicaid Providers Out of Business or Discharged in Bankruptcy Proceedings 7-16-18

For the purpose of determining whether all or part of an overpayment must be refunded to the federal government, the Director or the Director's designee of the Division of Medical Services (DMS) of the Department of Human Services is authorized to determine and certify that a Medicaid Provider is either out of business or has had all or part of the overpayment discharged in a bankruptcy proceeding and that an overpayment owed by the provider cannot be collected under state law and procedures. The DMS Director may make this determination based on any facts and circumstances deemed relevant and material.

The DMS Director may presume a provider is out of business as of:

A. The date of suspension, expiration, surrender, or revocation of a license or certification required for the provider to operate; or

B. For an entity, the date of:

1. Dissolution of the entity

2. Occurrence of an event which would trigger dissolution; or

3. Forfeiture or revocation of the entity's charter or authority to do business by the Secretary of State or other State authority.

A determination of certification made by the DMS Director under this section:

A. Does not abrogate, limit, or modify a provider's debt or obligation to repay;

B. Is not a defense to recoupment of Medicaid payments from a provider;

C. May not serve as an adverse action against a provider.

The DMS Director may determine:

A. That a provider has had all or part the debt discharged in a bankruptcy proceeding;

B. That the overpayment cannot be collected under state law;

The Director shall make such a determination when provided with a copy of the order.

142.700 Medicare Mandatory Assignment of Claims for "Physician" Service 1216s and Medicaid's Mandatory Assignment of Claims for Provider Services 6-1-08

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 (QMBs). 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, reimbursement for "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. Not all providers are federally mandated to accept Medicare assignment (see Section 142.200). However, if a physician or Medicaid enrolled non-physician desires Medicaid reimbursement for the insured's cost share on a Medicare claim, he or she must accept assignment on that claim (see Section 142.200 D) and enter the information required by Medicare on assigned claims. The beneficiary is not responsible for the difference between the billed charges and the Medicare allowed amount.

Item 1-C of the contract to participate in the Arkansas Medical Assistance Program (**View or print Form DMS-653 Section V of the Provider Manual**) requires enrollment and acceptance of assignment under Title XIX (Medicaid) for any applicable deductible or coinsurance that may be due and payable under Medicaid.

When a beneficiary is dually eligible for Medicare and Medicaid, including those eligible as Qualified Medicare Beneficiaries (QMBs,) and is provided services that are covered by Medicare, Medicaid will not reimburse for applicable deductible or coinsurance that may be due and payable under Medicare if Medicare has not been billed and made payment prior to billing Medicaid. The beneficiary cannot be billed the difference in Medicare and Medicaid payment or billed charges on assigned claims.

Claims properly filed directly to the original Medicare plan intermediary by Arkansas Medicaid enrolled providers should automatically cross to Medicare's Coordination of Benefits Assignment (COBA) process; then to Arkansas Medicaid, once Medicare processing and payment has been completed. The crossover claim should process in the next weekend cycle for Medicaid payment of applicable coinsurance and deductibles (usually within four to six weeks of Medicare payment). However, claims for Medicare beneficiaries entitled under the Railroad Retirement Act or Medicare Advantage will not automatically cross to Arkansas Medicaid for payment and must be filed directly with Arkansas Medicaid after Medicare payment has been received by the provider. See Section 330.000 of this provider manual for further information.

NOTE: A Provider enrolled to participate in the Title XVIII Medicare Program must notify the Provider Enrollment Unit of their National Provider Identifier (NPI). View or print form DMS-683, NPI Reporting Form. View or print Medicaid Provider Enrollment Unit contact information.

142.800 Condition of Participation – Education 9-15-09

A. Definitions:

1. Provider: any entity, including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists, whether for-profit

or not-for-profit, which receives or makes payments, under a State Plan approved under Title XIX or under any waiver of such plan, totaling at least $5,000,000 annually, regardless of whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of Section 1902(a) (68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

2. Employee: any officer or employee of the entity.

3. Contractor or agent: any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

4. Written policy: a written plan for a course of action. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. Each entity must establish and disseminate written policies which must also be adopted by its contractors or agents. The entity need not create an employee handbook if none already exists.

B. Requirements

1. The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

2. An entity shall establish written policies for all employees (including management), and for any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in Section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

142.900 Principal Accountable Providers (PAPs) 7-1-16

An Arkansas Medicaid enrolled and qualified provider who is licensed to diagnose and treat a beneficiary may be designated as a Principal Accountable Provider (PAP) within the Episodes of Care payment improvement initiative. Individual providers may be designated as a PAP only by a promulgated episode.

143.000 Recovery Audit Contractors (RACs) 1-1-13

Pursuant to 42 C.F.R. §§455.502 - .516, each state Medicaid program must contract with recovery audit contractors (RACs). Pursuant to these federal regulations, the Arkansas Medicaid program will coordinate the following activities:

A. RAC review of claims submitted by providers to identify overpayments or underpayments;

B. Coordination between Arkansas Medicaid and the RAC for recoupment of overpayments;

C. Coordination of recovery audit efforts of RAC and other auditing entities;

E. Referral of suspected fraud and/or abuse to the Medicaid Fraud Control Unit (MFCU) or other appropriate law enforcement agency; and

F. Limitation of the number and frequency of medical records to be reviewed by the RAC

G. Coordination of the administrative reconsideration and appeal process as set forth in Section 160.000 of this manual.

144.000 Tax Compliance 8-1-14

Under Ark. Code Ann. § 20-77-130, compliance with Arkansas tax laws is a condition of the continued Medicaid enrollment of Affected Medicaid Providers. The law requires that the Arkansas Medicaid Program disenroll noncompliant providers unless the provider can show good cause to remain in the Medicaid program. Good cause includes, without limitation, proof that Medicaid eligible beneficiaries will be unable to access medically necessary care if the Affected Provider is no longer enrolled in the Medicaid Program.

If the Department of Finance and Administration notifies the Medicaid Program that an Affected Provider is noncompliant, the Medicaid Program will notify the Affected Provider that the Affected Provider's Medicaid Provider Agreement will be terminated effective sixty (60) calendar days from the date of the notice unless:

A. The Department of Finance and Administration notifies the Department of Human Services that:

1. The Affected Medicaid Provider's tax obligation has been satisfied, otherwise resolved, or is the subject of a pending appeal; or

2. The Medicaid Provider is not an Affected Provider.

B. The Department of Human Services determines the Medicaid Provider is not an Affected Provider or there is good cause not to exclude the Affected Medicaid Provider from the Medicaid Program.

To request Department of Finance and Administration notification described in part A (above), Affected Medicaid Providers should contact the Sales and Use Tax Unit. **View or print the Department of Finance and Administration Sales and Use Tax Unit contact information.**

Department of Finance and Administration notification must be delivered to the Medicaid Provider Enrollment Unit. **View or print the Provider Enrollment contact information.**

To establish that a Medicaid Provider is not an Affected Medicaid Provider as defined by Ark. Code Ann. § 20-77-130 or that good cause exists for the Medicaid Program to continue the Affected Medicaid Provider's enrollment as a Medicaid provider, the Affected Medicaid Provider should contact the Medicaid Provider Enrollment Unit. **View or print the Provider Enrollment contact information.**

145.000 Electronic Visit Verification (EVV) for In-Home Personal Care, Attendant Care, Respite-Services, and Home Health Services

145.100 Legal Basis and Scope of EVV Requirement 1-1-24

In accordance with section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)), the Arkansas Department of Human Services (DHS) is implementing an electronic visit verification (EVV) system for in-home personal care services (PCS), attendant care, respite services, and home health services paid by Medicaid.

An EVV system is a telephone, computer, or other technology-based system under which visits conducted as part of personal care services or home health care services are electronically verified with respect to:

A. The type of service(s) performed;

B. The individual receiving the service(s);

C. The date of the service(s);

D. The location of service delivery;

E. The individual providing the service(s); and

F. The time the service(s) begins and ends.

The EVV requirement establishes utilization standards for provider agencies to electronically verify home visits and verify that beneficiaries receive the services authorized for their support and for which Medicaid is being billed.

The EVV requirement applies to Medicaid PCS, attendant care, respite care, and home health care provided during an in-home visit under the Medicaid State Plan, the Provider-Led Arkansas Shared Savings Entity (PASSE), the ARChoices Medicaid §1915(c) Home and Community-Based Services Waiver, or under any self-direction plan.

PCS, attendant care, respite services, and home health services provided to more than one (1) person throughout a shift in 24-hour residential settings are not subject to the EVV requirement because they do not involve an “in-home” visit. This includes without limitation: PCS, attendant care, respite services, and home health services provided in a group home, assisted living facility, hospital, nursing facility, or other congregate setting.

PCS, attendant care, respite services, and home health services provided to a student in a public school are not subject to the EVV requirement because they do not involve an “in-home” visit.

Additional information regarding EVV is available from the DHS EVV Vendor. **View or print the DHS EVV Vendor contact information.**

145.200 EVV Participation Requirements 1-1-24

To submit a claim for any service that is subject to the EVV requirement or pay based upon a self-directed plan of care subject to the EVV requirement, a provider must:

A. Submit and maintain on file with both DHS Provider Enrollment and the DHS EVV Vendor a contact e-mail address for the provider. The e-mail address must be an address that is active and is controlled and regularly checked by the provider. The e-mail address must be a business address that is unique to the provider and must not be an employee’s personal e-mail address or other shared address. The e-mail address submitted by a provider to DHS Provider Enrollment will be the e-mail address used by the DHS EVV Vendor to create the provider’s account to access the EVV system;

B. Obtain from DHS a Medicaid Practitioner Identification Number (PIN) for each and every caregiver employed or contracted by the provider to furnish care for which Medicaid PCS, attendant care, or respite care claims may be submitted;

C. Submit, with every claim for a service subject to the EVV requirement, the PIN for the caregiver providing the service to the beneficiary. The PIN shall be listed in the field for the Rendering Provider ID number;

D. Use an EVV system that documents and verifies every in-home visit resulting in a claim for reimbursement. A provider must use the EVV system furnished by the DHS EVV Vendor or they must use a third-party EVV system that has been certified by the DHS EVV Vendor;

E. Require caregivers, that are employed or contracted by the provider, to use EVV for all in-home Medicaid-paid PCS, attendant care, respite care, and home health care and to train the caregivers on the use of the provider's chosen EVV system;

F. If the provider uses the DHS EVV system, register the provider's caregivers with the EVV system. By registering a caregiver with the DHS EVV system, the provider is attesting that all applicable requirements, including without limitation training requirements, have been satisfied for that caregiver (A caregiver who is excluded or debarred from participation in Medicaid under any state or federal law is not eligible to register with the DHS EVV system);

G. Create and maintain documentation to justify any manual modifications, adjustments, or exceptions made by the provider in the EVV system after a caregiver has entered or failed to enter any required information;

H. Comply with EVV requirements established by the Centers for Medicare & Medicaid Services (CMS);

I. Comply with applicable federal and state laws regarding confidentiality of information about beneficiaries receiving services; and

J. Ensure that DHS may review documentation generated by an EVV system or obtain a copy of that documentation at no charge.

145.300 EVV Claims Requirements 1-1-24

EVV is required for the following procedure codes and modifiers when the Place of Service is coded as the beneficiary's home (POS code 12):

Procedure Code	Modifier	Service Description
T1019		Personal Care for a (non-RCF) Beneficiary Under 21
T1019	U3	Personal Care for a non-RCF Beneficiary Aged 21 or Older
S5125	U2	Agency Attendant Care Traditional
S5150		Respite Care – In-Home
T1021	TD	Home Health RN Visit, per visit
T1021	TE	Home Health LPN Visit, per visit
T1021		Home Health Aide Visit
S9131	UB	Home Health Physical Therapy by a Qualified Physical Therapy Assistant
S9131		Home Health Physical Therapy by a Qualified Licensed Physical Therapist

A claim for any of these procedure codes and modifiers may be rejected or denied, or subject to recoupment, if delivery of the service was not verified by EVV or if there is any inconsistency among or between:

A. The data submitted in the claim;

B. The data recorded by EVV for the claimed service;

C. The data in the approved prior authorization or plan of care applicable to the claimed service; or

D. Address or other eligibility data maintained in the Medicaid Management Information System (MMIS) or other eligibility system maintained by DHS.

A claim for any of these procedure codes and modifiers is subject to the EVV requirement regardless of how the claim is submitted, including third-party EVV vendors, through a PASSE claims system, or through a self-direction plan.

For PCS, attendant care, respite, and Home Health services delivered in a beneficiary's home, it is a fraudulent billing practice to list any Place of Service (POS) code other than POS code 12, unless the Provider Manual or other Rule explicitly permits the use of a different POS code.

A. The EVV Requirement also applies to any equivalent services provided to a beneficiary through the Independent Choices program, or any other self-direction program made available under the state plan or ARChoices. Such equivalent services may be rejected or denied if delivery of the service was not verified by EVV or if there is any inconsistency among or between:

1. The data submitted in the claim;
2. The data recorded by EVV for the claimed service;
3. The data in the approved prior authorization or the plan of care that is applicable to the claimed service; or
4. Address or other eligibility data maintained in the Medicaid Management Information System (MMIS) or other eligibility system maintained by DHS.

145.400 Third Party EVV System Requirements 12-1-20

A third-party EVV system procured and chosen by a provider or Managed Care Organization (MCO) or self-directed services vendor must be certified by the DHS EVV Vendor as meeting the following requirements:

1. The provider must submit a written attestation that the third-party EVV system meets or exceeds all applicable CMS and DHS requirements. Certification of a third-party EVV system is valid only so long as the system continues to meet or exceed all applicable CMS and DHS requirements;
2. The DHS EVV Vendor must certify that the third-party EVV system has the technical capabilities to receive and transmit all EVV data in a way that is compatible with the DHS EVV system; and
3. The third-party EVV system must timely collect and submit to the DHS EVV Vendor all data required for EVV verification of a claim, including without limitation:
    a. The procedure code and modifier for the service(s) delivered, and the specific ADL/IADL task(s) performed by the caregiver during the visit;
    b. Identifying information for the beneficiary, including without limitation the beneficiary's Medicaid identification number;
    c. The date of the service(s);
    d. The location where the service(s) were delivered;
    e. Identifying information for the agency and the individual caregiver providing the service(s), including without limitation a Practitioner Identification Number (PIN) as assigned by DHS for the individual caregiver who is listed as the rendering

provider;

f. Universal Time Code (UTC) for the time the service(s) begins and ends; and

g. EVV capture method (including without limitation telephony, GPS, or fixed visit) and corresponding validation data (including without limitation phone number, coordinates, or encryption key); and

4. By including a caregiver in any EVV data submitted to the DHS EVV Vendor, the provider is attesting that all applicable requirements, including without limitation training requirements and background checks, have been satisfied for that caregiver. Claims made for services performed by a caregiver who is excluded or debarred from participation in Medicaid may be denied or rejected and are subject to recoupment.

150.000 ADMINISTRATIVE REMEDIES AND SANCTIONS

151.000 Grounds for Sanctioning Providers 9-15-09

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

A. Non-compliance with any provision of federal laws and rules contained in or related to Title XIX or XXI of the Social Security Act, federal regulations promulgated thereunder, state medical assistance (Medicaid) law and rules or any applicable Medicaid provider manual.

B. Any act or omission that is inconsistent with sound fiscal, business or medical practices and results in unnecessary cost to the Arkansas Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

C. Accepting beneficiaries for whom all prescribed and medically necessary care and services cannot be provided at the time of acceptance, unless otherwise required by the Emergency Medical Treatment and Active Labor Act (EMTLA). There is no violation if it appears, based upon information available at the time of admission, that the provider can meet the patient's needs.

D. Engaging in conduct that defrauds or abuses the Medicaid Program, regardless of whether the conduct is successful.

E. Failure to submit an acceptable corrective action plan when requested to do so by the Division of Medical Services or its agents in a written statement that complies with Section 190.006 of this manual.

F. Failure to comply with any remedy imposed under 42 U.S.C. §1320a-7(a) and implementing federal regulations, 42 U.S.C. §1320a-7(b) and implementing federal regulations, and state Medicaid law and rules, including, without limitation, this manual.

152.000 Sanctions 3-1-11

The following sanctions may be invoked against providers based on the grounds specified in Section 151.000:

A. Termination from participation in the Medicaid Program

B. Suspension of participation in the Medicaid Program

C. Suspension, withholding, recoupment, recovery or any combination thereof, of payments to a provider

D. Canceling or shortening an existing provider agreement

E. Mandatory attendance at provider education sessions

F. Requiring prior authorization of all services

G. Pre-payment review of some or all of the provider's billings

H. Referral to the State Licensing Board for investigation

I. Referral to the Medicaid Fraud Control Unit, Office of Attorney General

J. Conversion to a limited services provider agreement not to exceed 12 months

K. Referral to any appropriate federal or state legal agency for investigation and possible prosecution under applicable federal or state laws

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

M. Exclusion under current Arkansas Department of Human Services (DHS) Policy 1088, titled DHS Participant Exclusion Rule

153.000 Rules Governing the Imposition and Extent of Sanctions 9-15-09

A. Imposition of Sanction

1. The Director of the Division of Medical Services shall determine the sanction(s) to be imposed with respect to the following considerations:
   a. Seriousness of the offense(s)
   b. Extent of frequency and number of violation(s)
   c. Prior violation(s) history
   d. Whether an indictment or information was filed against the provider or a related party as defined in DHS Policy 1088, DHS Participant Exclusion Rule
2. Whenever a provider has been convicted of any Medicaid Program violation or is suspended or terminated from the Medicare Program for cause, the Department of Human Services shall institute proceedings to terminate the provider from the Medicaid Program.

B. Scope of Sanction

1. A sanction applies to all related parties as defined in DHS Policy 1088.
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 DHS for any services or supplies provided after the suspension or termination.
3. No individual or entity shall claim reimbursement for any goods or services provided by a person who has been debarred, excluded, suspended or terminated from participation in the Medicaid Program, except for those legitimate and lawful services or supplies provided before the suspension or termination.
4. Any provider violating the provisions of paragraph (B)(3), along with the provider's related parties as defined in DHS Policy 1088, shall be suspended, terminated or excluded from participation.

154.000 Notice of Violation 9-15-09

When the Division of Medical Services identifies an act or omission for which a sanction may be issued, the Division will notify the provider of the act or omission in writing.

Unless a timely and complete request for administrative reconsideration or appeal is received by the Department of Human Services, the findings of DHS as set forth in the notice shall be considered a final and binding administrative determination.

155.000 Notice of Provider Sanction 9-15-09

When a provider has been sanctioned, the Department of Human Services shall notify the applicable professional society, and any licensing, certifying or accrediting agency of the findings made and the sanctions imposed.

When a provider's participation in the Medicaid Program has been suspended or terminated, the Department of Human Services shall notify the beneficiaries, for whom the provider claims payment for services, that the provider has been suspended or terminated. The notice may include the reason for the suspension or termination.

156.000 Withholding of Medicaid Payments 4-1-06

Upon receipt of reliable evidence that the circumstances involve fraud, willful misrepresentation or both, DMS may withhold Medicaid payments, in whole or in part, without first notifying the provider of its intention to withhold.

Within five days of taking the action, the Division of Medical Services will send a Notice of Non-Compliance (form DMS-635) that explains the reasons for withholding payment and the provider's right to administrative reconsideration or appeal.

All withholdings or payment actions will be temporary and will not continue after:

A. DMS or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation. or

B. Legal proceedings relating to the provider's alleged fraud or willful misrepresentations are completed.

160.000 ADMINISTRATIVE RECONSIDERATION AND APPEALS

161.200 Administrative Reconsideration 1-1-16

A. Within 30 calendar days after notice of an adverse decision/action, the provider may request administrative reconsideration. Requests must be in writing and include:

1. A copy of the letter or notice of adverse decision/action
2. Additional documentation that supports medical necessity

Administrative reconsideration does not postpone any adverse action that may be imposed pending appeal.

B. Requests for reconsideration must be submitted as follows:

1. In situations where the adverse decision/action has been taken by a reviewing agent, the request must be directed to that reviewing agent. Contact information for the department's reviewing agents can be found in Section V of this manual. General rules regarding due process are contained in Section I of each provider manual; but some administrative reconsideration and appeal processes are program-specific and are set forth in Section II of the applicable program manual.
2. When an adverse decision/action has been taken by the Division of Medical Services, the request for reconsideration must be directed to Office of Medicaid Inspector General (OMIG). **View or print the Office of Medicaid Inspector General contact information.** Within 20 calendar days of receiving a timely and

complete request for administrative reconsideration, the Director of the Division of Medical Services will designate a reviewer, who did not participate in the initial determination leading to the adverse decision/action, who is knowledgeable in the subject matter of the administrative reconsideration, to review the reconsideration request and associated documents. The reviewer shall recommend to the Director that the adverse decision/action be sustained, reversed or modified. The Director may adopt or reject the recommendation in whole or in part.

A reconsideration request received within 35 calendar days of the written notice will be deemed timely. The request must be mailed or delivered by hand. Faxed or E-mailed requests will not be accepted.

No administrative reconsideration is allowed if the adverse decision/action is due to loss of licensure, accreditation or certification.

161.300 Administrative Appeals of Adverse Actions that are not Sanctions 9-15-09

In addition to sanction reconsiderations and appeal procedures set forth in Sections 160.000-169.000, providers may appeal any other decision of the Department of Human Services, its reviewers or contractors if that decision adversely affects a Medicaid provider or beneficiary with regard to receipt or payment of Medicaid-covered services. Such decisions and consequent actions are "non-sanction adverse actions."

Within 30 calendar days of receiving notice of non-sanction adverse action, the provider may appeal. An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions/actions that the provider alleges are not supported by applicable laws, including state and federal laws and rules, applicable professional standards, or both. Mail or deliver the appeal to the Office of Appeals and Hearings, Arkansas Department of Human Services, P.O. Box 1437, Slot N401, 7th and Main Streets, Little Rock, AR 72203-1437.

161.400 Sanction Appeals 9-15-09

Within 30 calendar days of receiving notice of adverse decision/action, or 10 calendar days of receiving an administrative reconsideration decision that upholds all or part of any adverse decision/action, whichever is later, the provider may appeal.

An appeal must be in writing and must specify in detail all findings, determinations, and adverse decisions/actions that the provider alleges are not supported by applicable laws; including state and federal laws and rules, applicable professional standards or both. Mail or deliver the appeal to the Director, Division of Medical Services, P.O. Box 1437, Slot S401, 7th and Main Streets, Little Rock, AR 72203-1437. No appeal is allowed if the adverse decision/action is due to loss of licensure, accreditation or certification.

161.500 Continued Services During the Appeal Process 9-15-09

The adverse action notice sent to the Medicaid beneficiary must comply with 42 CFR §431.230 entitled "Maintaining Services," which states in part:

(a) When the department mails the 10-day or 5-day notice, as required, and the beneficiary requests a hearing before the date of action, the department may not terminate or reduce services until a decision is rendered after the hearing unless:

(1) It is determined at the hearing that the sole issue is one of federal or state law or policy; and

(2) The department promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

162.000 Notice of the Appeal Hearing 9-15-09

When an appeal hearing is scheduled, the Office of Hearings and Appeals shall notify the provider, or if the provider is represented by an attorney, the provider's 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. Hearings shall be conducted in accordance with DHS Policy 1098. The decision of the Office of Appeals and Hearings is the final agency determination.

162.100 Conduct of Hearing 9-15-09

A. The hearing shall be conducted by a hearing officer who is authorized by the Director of the Division 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 opposing evidence.

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 that might make improper the admission of such evidence over objection in civil or criminal actions.

E. The hearing officer may provide for discovery by any means permitted by the Arkansas Rules of Civil Procedure and may assess the expense to the requesting party.

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. Before taking evidence, the hearing officer shall explain the issues and the order in which evidence will be received.

H. The provider shall have the burden of proving by a preponderance of the evidence that it delivered all billed services in accordance with all applicable requirements.

I. Except as provided in part H, the burden of producing evidence of a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

162.200 Representation of Provider at a Hearing 9-15-09

Individual providers may represent themselves. A partner may represent the partnership. A limited liability company or corporation may be represented by an officer or the chief operating official. A professional association may be represented by a principal of the association. Representatives must be courteous in all activities undertaken in connection with the appeal and must obey the orders of the hearing officer regarding the presentation of the appeal. Failure to do so may result in exclusion from the appeal hearing, or in the entry of an order denying discovery.

162.300 Right to Counsel 10-13-03

Any party may appear and be heard at any proceeding described herein through an attorney-at-law. All attorneys shall conform to the standards of conduct practiced by attorneys before the

courts of Arkansas. If an attorney does not conform to those standards, the hearing officer may exclude the attorney from the proceeding.

162.400 Appearance in Representative Capacity 9-15-09

A person appearing in a representative capacity shall file a written notice of appearance on behalf of a provider identifying himself or herself by name, address and telephone number; and identifying the party represented. He or she shall have written authorization to appear on behalf of the provider. The Division of Medical Services shall notify the provider in writing of the name and telephone number of the division's representative.

163.000 Form of Papers 4-1-06

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 and the docket number, if any.

The party and/or his authorized representative or attorney shall sign all papers, and all papers shall contain his/her address and telephone number. At a minimum, an original and two copies of all papers shall be filed with the Office of Hearings and Appeals.

163.100 Notice, Service and Proof of Service 9-15-09

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

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 an attorney, service upon the attorney shall be deemed service upon the party or parties.

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

D. Service by mail is presumptively complete upon mailing. When service is permitted upon an attorney, such service may be put into effect by electronic transmission, provided the attorney being served has facilities within his office to receive and reproduce verbatim electronic transmissions.

164.000 Witnesses 10-13-03

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

165.000 Amendments 4-1-06

At any time prior to the completion of the hearing, amendments to the adverse decision/action, the provider's notice of appeal, or both, may be allowed on just and reasonable terms to add or discontinue any party, change the allegations or defenses, or add new causes of action or defenses.

Where the Division of Medical Services seeks to add a party or a cause of action or change an allegation, notice shall be given pursuant to Section 154.000, "Notice of Violation," and Section 163.100, "Notice, Service and Proof of Service," to the appropriate parties except that the provisions of Section 161.200, "Administrative Reconsideration," and Section 162.000, "Notice of the Administrative Appeal Hearing," 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 163.100, "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 166.000, "Continuances or Additional Hearings."

166.000 Continuances or Additional Hearings 4-1-06

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

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

1. Continue the hearing to a later date and order one or both parties to produce additional evidence, or

2. Conclude 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.

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

167.000 Failure to Appear 4-1-06

If a party fails to appear at a hearing, the hearing officer may dismiss the appeal or enter a determination adverse to the non-appearing party. A copy of the decision shall be mailed to each party. The hearing officer may, upon motion, set aside the decision and reopen the hearing for mistake, inadvertence, surprise, excusable neglect, fraud, or misrepresentation.

168.000 Record of Hearing 10-13-03

The Division of Medical Services (DMS) shall tape-record the hearings, or cause the hearings to be tape-recorded. If the final DMS determination is appealed, the tape recording shall be transcribed, and copies of other documentary evidence shall be reproduced for filing under the Administrative Procedure Act.

169.000 Decision 4-1-06

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

B. The proposed decision shall be in writing and shall contain findings of fact and conclusions of law, separately stated, and a proposed order.

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 director's decision is the final agency determination under the Administrative Procedure Act. The director shall cause a copy of the decision to be mailed to the provider at the provider's last known address, or, if the provider was represented by an attorney, to the address provided by the attorney.

169.100 Recovery of the Costs of Services Continued During the Appeal Process 9-15-09

42 CFR §431.230 entitled "Maintaining Services," which states in part:

> (b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, to the extent they were furnished solely by reason of this section.

Federal regulation does not distinguish between beneficiary-filed and provider-filed appeals.

Providers filing appeals shall be subject to the same recovery procedures as beneficiaries. When both the provider and beneficiary appeal, liability shall be joint and several.

170.000 THE ARKANSAS MEDICAID PRIMARY CARE CASE MANAGEMENT PROGRAM

170.100 Introduction 8-1-18

Arkansas Medicaid's Primary Care Case Management (PCCM) Program operates statewide under the authority of the Medicaid State Plan.

A. Most Medicaid beneficiaries and all ARKids First-B participants must enroll with a primary care physician (PCP), also known as a primary care case manager (PCCM).

1. PCPs provide primary care services and health education.
2. PCPs make referrals for medically necessary specialty physician's services, hospital care and other services.
3. PCPs assist their enrollees with locating medical services.
4. PCPs coordinate and monitor their enrollees' prescribed medical and rehabilitation services.

B. Medicaid enrollees may receive services only from their PCP unless their PCP refers them to another provider, or unless they access a service that does not require a PCP referral.

C. If a beneficiary does not have a primary care provider, Arkansas Medicaid will allow up to four (4) visits per state fiscal year without a Primary Care Physician (PCP) referral to a hospital affiliated Walk-in Clinic or Emergent Clinic.

D. These visits apply to all related benefit limits.

171.000 Primary Care Physician Participation

171.100 PCP-Qualified Physicians and Advanced Practice Nurse Practitioners 4-1-24

A. Primary Care Provider (PCP)-qualified physicians are those whose sole or primary specialty is

1. Family practice
2. General practice
3. Internal medicine
4. Pediatrics and adolescent medicine
5. Obstetrics and gynecology

B. Obstetricians and gynecologists may choose whether to be PCPs.

C. Physicians with multiple specialties may elect to enroll as PCPs if a secondary or tertiary specialty in their Medicaid provider file is listed in part A above.

D. All other PCP-qualified physicians must enroll as PCPs.

E. Advanced practice registered nurses (APRN) licensed by the Arkansas State Board of Nursing may choose to enroll as PCPs.

171.110 Exclusions 4-1-24

A. Physicians whose only specialty is emergency care or who practice exclusively in hospital emergency departments may not enroll as PCPs.

B. Physician group practices may not be PCPs.

C. Rural Health Clinics (RHCs) may not be PCPs, but PCP-qualified physicians affiliated with RHCs must be PCPs.

D. Physicians who certify in writing that they are employed.

171.120 Hospital Admitting Privileges Requirement 7-1-05

A. Only physicians with hospital admitting privileges may be PCPs.

B. The state may waive this requirement to help ensure adequate access to services.

1. On the primary care case manager (PCCM) contract, a physician may name another physician who has hospital admitting privileges and with whom he or she has an agreement by which they handle hospital admissions.
2. A copy of the physicians' agreement must be submitted with the PCCM contract.

171.130 EPSDT Agreement Requirement 4-1-24

A. A PCP applicant must sign an agreement to participate as a screening provider in the Child Health Services (EPSDT) program.

B. Internists, obstetricians, gynecologists, and physicians who customarily carry a caseload of patients who are 21 years of age or older are not required to furnish EPSDT screens.

1. Their participation in the Child Health Services (EPSDT) program is optional.
2. They must, however, sign Child Health Services (EPSDT) agreements if they elect to be screening providers.

171.140 Primary Care Case Manager Agreement 4-1-24

A. Every PCP applicant must sign a Primary Care Case Manager (PCCM) contract.

171.160 PCP Instate and Trade-Area Restriction 7-1-05

With the following exceptions, PCPs must practice in Arkansas.

A. PCP-qualified physicians in the trade-area cities (Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee and Texarkana, Texas), may be PCPs.

B. To ensure adequate access to services, the state may waive the trade-area city rule for border-state physicians who are not in trade-area cities.

171.170 PCP for Out-of-State Services 6-1-08

Services that require PCP referral or PCP enrollment within Arkansas require PCP referral or PCP enrollment as applicable, when furnished outside of Arkansas.

171.200 PCCM Enrollee/Caseload Management

171.210 ConnectCare Caseload Maximum and PCP Caseload Limits 10-8-10

A. Each PCP may establish an upper limit to his or her Medicaid caseload, up to the default maximum of 2500.

1. The state may permit higher maximum caseloads in areas the federal government has designated as medically underserved.
2. The state may permit higher maximum caseloads for PCPs who state in writing that the default maximum will create a hardship for them, their patients and/or the community they serve.

B. The state will not require any PCP to accept a caseload greater than the PCP's requested caseload maximum.

C. At any time, a PCP may increase or decrease his or her maximum desired caseload by any amount, up to the default maximum by submitting a written request to the Provider Enrollment Unit, or on-line through the Medicaid website (**https://medicaid.mmis.arkansas.gov/**), Provider Enrollment Information, and Access to the Provider Information Portal.

D. To request an increase in a PCP caseload above the default maximum, the PCP must submit a written request to the Provider Enrollment Unit. **View or print Provider Enrollment Unit contact information.**

E. Prior to making the request for an increase of a caseload that is already at the default maximum, PCPs are encouraged to review their caseload for inactive patients to determine if those patients should be removed from their caseload. To do so, PCPs may use the Arkansas Medicaid Information Interchange (AMII) web portal. If it is determined that the inactive patients should be removed from his or her caseload, the PCP must:

1. Contact the patient in writing at least 30 days in advance of the effective date of the termination to give the patient the option of making a visit to the PCP to remain an active patient. If the patient does not choose to make a visit to the PCP, the termination can be effective at the end of 30 calendar days.
2. With approval from his or her Provider Relations Representative, the PCP may add and see new patients during the 30 calendar day notification process of inactive patients.
3. The notice must state that the enrollee has 30 calendar days in which to enroll with a different PCP.
4. The PCP must forward a copy of the notice to the enrollee and to the local DHS office in the enrollee's county of residence.

171.220 Illegal Discrimination 7-1-05

A. A PCP may not reject a potential enrollee, and may not discriminate against a beneficiary because of the individual's age, sex, race, national origin or type of illness or condition.

B. Rejecting a potential enrollee based on the individual's age or sex does not constitute unlawful discrimination if the physician customarily sees only patients of one sex and/or a particular age range. For instance:

1. An obstetrician/gynecologist doesn't treat males, so he or she is not expected to enroll males.
2. A pediatrician specializing in adolescent medicine may only see patients in a particular age range, such as 12 through 18.

C. PCPs may specify the minimum and maximum ages of Medicaid and ARKids First-B enrollees they will accept.

171.230 Primary Care Case Management Fee 1-1-23

A. In addition to reimbursing PCPs on a fee for service basis for physician services, Arkansas Medicaid pays them a monthly case management fee for each enrollee on their caseloads.

B. The amount due for each month is determined by multiplying the established case management fee by the number of enrollees on the PCP's caseload.

1. Medicaid pays case management fees quarterly.
2. The accompanying Medicaid Remittance and Status Report (RA) itemizes the payments and lists the number of enrollees and each enrollment month.
3. Enrollees are listed alphabetically by name, with their Medicaid identification numbers and addresses also displayed.

C. PCP case management fees are paid according to the PCP's direction. The PCP may choose to have the case management fee paid to his or her individual provider ID number or to the group provider ID number with whom the PCP is affiliated.

D. If the PCP's case management fees are paid to a group and the PCP changes his or her affiliation, the PCP must submit a new PCP Agreement Form to Provider Enrollment within thirty (30) calendar days of changing affiliation. The PCP must also notify the beneficiaries on his or her caseload of the change.

E. If a PCP fails to submit a new PCP Agreement Form, the case management fees will pay to the provider of record until a new PCP Agreement Form is received by Provider Enrollment.

F. If a Group Affiliation Form is received by Provider Enrollment to disassociate a PCP from a group but the PCP Agreement Form is not received, the case management fees will be paid to the individual PCP's provider ID number.

G. If a PCP's case management fees were paid to a group in which the PCP is no longer affiliated, it is the responsibility of that group to reimburse Medicaid the fees they were not entitled to receive.

H. **No case management fees will be back paid to a PCP who has failed to follow the process described in Paragraph D of this Section.**

I. Case management fees will be reconciled at least quarterly, and may be reconciled at any time determined necessary to resolve immediate issues.

171.300 Required Case Management Activities and Services

171.310 Investigating Abuse and Neglect 7-1-05

A PCP must perform an examination and/or make necessary referrals within 24 hours of contact by government officials in alleged or substantiated cases of abuse, neglect or maltreatment of a Medicaid-eligible individual and when the state has custody of a Medicaid-eligible individual.

171.320 Child Health Services (EPSDT) Requirements 9-15-09

A. A PCP must monitor and maintain the Child Health Services (EPSDT) screening periodicity of each of his or her enrollees under the age of 21, regardless of who screens those enrollees. The periodic EPSDT screening schedule recommended by the American Academy of Pediatrics can be found in Section 215.100 of the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment manual.

B. A PCP may refer his or her enrollees to other providers for EPSDT screens and related lab work.

1. Screening providers must report the results to the referring PCP.
2. The PCP must coordinate and monitor subsequent referrals, treatment or testing.

171.321 Childhood Immunizations 7-1-05

A PCP must monitor and coordinate the immunization status of his or her enrollees under the age of 21. **View or print the Arkansas Department of Health Immunizations Registry Help Desk contact information.**

171.400 PCP Referrals 1-1-18

A. Referrals may be only for medically necessary services, supplies or equipment.

B. Enrollee free choice by naming two or more providers of the same type or specialty.

C. PCPs are not required to make retroactive referrals.

D. Since PCPs are responsible for coordinating and monitoring all medical and rehabilitative services received by their enrollees, they must accept co-responsibility for the ongoing care of patients they refer to other providers.

E. PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. (This requirement varies somewhat in some programs; applicable regulations are clearly set forth in the appropriate Arkansas Medicaid Provider Manuals.)

F. There is no limit on the number of times a referral may be renewed, but renewals must be medically necessary and at least every six months (with exceptions as noted in part E, above).

G. An enrollee's PCP determines whether it is necessary to see the enrollee before making or renewing a referral.

H. Medicaid beneficiaries and ARKids First-B participants are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in Section 172.100.

I. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

171.410 PCCM Referrals and Documentation 7-1-05

A. Medicaid provides an optional referral form, form DMS-2610, to facilitate referrals. **View or print form DMS-2610.**

1. Additionally, PCP referrals may be oral, by note or by letter.
2. Referrals may be faxed.

B. Regardless of the means by which the PCP makes the referral, Medicaid requires documentation of the referral in the enrollee's medical record.

1. Medicaid also requires documentation in the patient's chart by the provider to whom the referral is made.

2. Providers of referred services must correspond with the PCP to the extent necessary to coordinate patient care and as requested by the PCP.

171.500 Primary Care Case Management Activities and Services 7-1-05

A ConnectCare PCP is also known as a primary care case manager (PCCM). He or she provides primary care physician services as well as these additional services:

A. Health education

B. Assessing each enrollee's medical condition, initiating and recommending treatment or therapy when needed

C. Initiating referrals to specialty physicians and for hospital care and other medically necessary services

D. Assisting with locating needed medical services

E. Coordinating, with other professionals, prescribed medical and rehabilitation services

F. Monitoring enrollees' prescribed medical and rehabilitation services

171.510 Access Requirements for PCPs 7-1-05

A. A PCP must have hours of operation that are reasonable and adequate to serve all of his or her patients.

1. The PCP's office must be open to Medicaid enrollees during the same hours and for the same number of hours as it is for self-pay and insured patients.

2. ConnectCare enrollees must have the same access as private pay and insured persons to emergency and non-emergency medical services.

B. A PCP must make available 24-hour, 7 days per week telephone access to a live voice (an employee of the primary care physician or an answering service) or to an answering machine that will immediately page an on-call medical professional. The on-call professional will:

1. Provide information and instructions for treating emergency and non-emergency conditions,

2. Make appropriate referrals for non-emergency services, and

3. Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed.

C. Response to after-hours calls regarding non-emergencies must be within 30 minutes.

1. PCPs must make the after-hours telephone number as widely available as possible to their patients.

2. When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date.

D. PCPs in underserved and sparsely populated areas may refer their patients to the nearest facility available, but enrollees must be able to obtain the necessary instructions by telephone.

E. As regards access to services, PCPs are required to provide the same level of service for their ConnectCare enrollees as they provide for their insured and private-pay patients.

F. Physicians and facilities treating a PCP's enrollees after hours must report diagnosis, treatment, significant findings, recommendations and any other pertinent information to the PCP for inclusion in the patient's medical record.

G. A PCP may not refer ConnectCare enrollees to an emergency department for non-emergency conditions during the PCP's regular office hours.

171.600 PCP Substitutes

171.601 PCP Substitutes; General Requirements 4-1-07

A. Physicians substituting for PCPs are not required to be PCPs themselves.

B. In addition to the rules that apply to physician substitutes (found in the Arkansas Medicaid Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual), physicians substituting for PCPs are subject to the following regulations.

1. The PCP and the substitute must document the substitution in each enrollee's record(s) as a referral and include the reason for the substitution.
2. The substitute physician must furnish the PCP's name and provider identification number to any other provider to whom he or she refers the patient.

171.610 PCP Substitutes; Rural Health Clinics and Physician Group Practices 7-1-05

When a PCP is affiliated with a rural health clinic (RHC) or is a member of a physician group, other physicians affiliated with the RHC or other members of the physician group may substitute for the PCP when he or she is unavailable.

A. Acceptable reasons for a PCP not to be available include (but are not limited to):

1. The PCP's schedule is full because of an unusual number of urgent or time-consuming cases.
2. The PCP is in surgery or attending a delivery.
3. An unusual number of patients need services outside the PCP's normal working hours.
4. The PCP is ill or on vacation or other leave of absence.

B. Habitual over-scheduling of patients or having too great a caseload are not acceptable reasons for a PCP's use of a substitute.

171.620 PCP Substitutes; Individual Practitioners 7-1-05

A PCP that is an individual practitioner must designate a substitute physician to take calls, see patients and make appropriate referrals when the PCP is unavailable.

A. Acceptable reasons for a PCP not to be available are:

1. The PCP's schedule is full because of an unusual number of urgent or time-consuming cases.
2. The PCP is in surgery or attending a delivery.
3. An unusual number of patients need services outside the PCP's normal working hours.

4. The PCP is ill or on vacation or other leave of absence.

B. Habitual over-scheduling or having too great a caseload are not acceptable reasons for a PCP's use of a substitute.

171.630 Advanced Practice Registered Nurses and Physician Assistants in Rural Health Clinics (RHCs) 7-1-22

Advanced practice registered nurses (APRN) may function as Primary Care Providers at the performing provider level.

Licensed registered nurse practitioners (RNP) or licensed physician assistants (PA) employed by a Medicaid-enrolled rural health clinic (RHC) provider may not function as Primary Care Provider (PCP) substitutes, but they may provide primary care for a PCP's enrollees, with certain restrictions.

A. The PCP affiliated with the RHC must issue a standing referral, authorizing primary care services to be furnished

1. To the PCP's client enrollees
2. By registered nurse practitioners and physician assistants
3. In or on behalf of the RHC

B. Registered nurse practioners and physician assistants (PA) may not make referrals for medical services except for pharmacy services per established protocol.

C. The PCP must maintain a supervisory relationship with the registered nurse practitioners and physician assistants (PA).

172.000 Exemptions and Special Instructions

172.100 Services not Requiring a PCP Referral 2-1-24

The services listed in this section do not require a PCP referral:

A. Adult Developmental Day Treatment (ADDT) core services;

B. ARChoices waiver services;

C. Anesthesia services, excluding outpatient pain management;

D. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists. The physician and facility assessment services do not require a PCP referral (if the Medicaid beneficiary is enrolled with a PCP);

E. Chiropractic services;

F. Dental services;

G. Developmental Disabilities Services Community and Employment Support;

H. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS;

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

J. Family Planning services;

K. Gynecological care;

L. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

M. Mental health services, as follows:

1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner
2. Medication Assisted Treatment for Opioid Use Disorder
3. Rehabilitative Services for Youth and Children (RSYC) Program
4. Outpatient counseling services

N. Obstetric (antepartum, delivery, and postpartum) services

1. Only obstetric-gynecologic services are exempt from the PCP referral requirement
2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications
3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider

O. Nursing facility services and intermediate care facility for individuals with intellectual disabilities (ICF/IID) services;

P. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye;

Q. Optometry services;

R. Pharmacy services;

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

T. Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

U. Physician visits (except consultations, which do require PCP referral) in the outpatient departments of acute care hospitals but only if the Medicaid beneficiary 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, but only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations;

W. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services;

X. Transportation (emergency and non-emergency) to Medicaid-covered services; and

Y. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity or would create unnecessary hardship.

172.110 PCP Enrollment/Referral Guidelines for Medicaid Waiver Program Participants 7-1-05

Some individuals become Medicaid-eligible under the guidelines of a home- and community-based waiver program.

A. Participants in home- and community-based waiver programs do not need PCP referrals for services covered under the waiver program in which they participate.

B. When accessing any other Medicaid services, participants in waiver programs are subject to all applicable ConnectCare regulations.

172.200 Medicaid-Eligible Individuals Who May not Enroll with a PCP 1-1-16

All Medicaid-eligible participants must enroll with a PCP unless they:

A. Have Medicare as their primary insurance.

B. Are in a long term care aid category and a resident of a nursing facility.

C. Reside in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

D. Are in a Medically Needy Spend Down eligibility category.

E. Only have a retroactive eligibility period.

1. Medicaid does not require PCP enrollment for the period between the beginning of the retroactive eligibility segment and the fifth day (inclusive) following the eligibility authorization date.
2. If eligibility extends beyond the fifth day following the authorization date, Medicaid requires PCP enrollment unless the beneficiary is otherwise exempt from PCCM requirements.

172.300 Automated PCP Enrollment Verification 7-1-05

A. An electronic Medicaid eligibility verification response includes PCP name and telephone number and the beginning date of the current enrollment period.

1. If no current PCP is displayed on the eligibility response, the individual is not enrolled with a PCP.
2. Beneficiaries with no PCP should be referred to the ConnectCare Helpline for information and assistance. **View or print the ConnectCare Helpline contact information.**

B. Medicaid beneficiaries and ARKids First-B participants—whether or not they are enrolled with a PCP—are responsible for all charges for services they receive without obtaining required referrals.

173.000 PCCM Selection, Enrollment and Transfer 7-1-05

A. A Medicaid beneficiary or ARKids First-B participant must be enrolled with a PCP in order to obtain a PCP referral for medical services.

1. All newly eligible individuals are given opportunities to enroll.
2. Medicaid beneficiaries and ARKids First-B participants receive regular reminders from ConnectCare of the advantages of PCP enrollment.

B. An individual must select a PCP that is located near his or her residence.

1. A PCP may be in the beneficiary's county of residence, a county adjacent to the county of residence or a county that adjoins a county adjacent to the county of residence.
2. When the county of residence is an Arkansas county bordering another state, the individual may select a PCP in the state bordering the county of residence.

173.100 PCP Selection and Enrollment at Local County DHS Offices 9-15-09

A. Medicaid applicants receive from DHS county office staff, a description and explanation of ConnectCare.

1. By means of a Primary Care Physician Selection and Change form (DMS-2609 or DCO-2609,) an applicant indicates the first, second and third choice for PCPs of each family member included in the Medicaid case.
2. Individuals applying for ARKids First-A and B indicate their PCP preferences on the mail-in application (form DCO-995).
3. Family members may choose the same PCP whenever there is a PCP available that can serve all eligible family members.

B. When eligibility is determined, a DHS worker uses a web-based program or a telephonic voice response system to enroll the beneficiary with a PCP, beginning with each beneficiary/participant's first choice.

1. If the first choice has a full caseload, the worker tries the second choice and so on.
2. The county office forwards confirmation of PCP enrollment to each new enrollee.

173.200 PCP Selection and Enrollment at PCP Offices and Clinics 10-8-10

Physician and single-entity PCPs may enroll Medicaid beneficiaries and ARKids First-B participants by means of the telephonic voice response system (VRS.)

A. Enrollees must document their PCP choice on a Primary Care Physician Selection and Change form (DMS 2609 or DCO-2609.)

1. The form must be completed, dated and signed by the enrollee.
2. The enrollee may request and receive a copy of the form.
3. The PCP office must retain a copy of the form in the enrollee's file.

B. Enrolling the beneficiary is performed by accessing the VRS and following the instructions. **View or print Voice Response System (VRS) contact information.**

C. When a PCP wants to add a new enrollee but the PCP's Medicaid caseload is full or when a PCP wants to increase or decrease his or her caseload limit:

1. The PCP may increase or decrease his or her maximum desired caseload by any amount, at any time, up to the default maximum by submitting a signed request to their Medicaid Managed Care Services (MMCS) Provider Relations Representative or, on-line through the Medicaid website **https://medicaid.mmis.arkansas.gov/** Provider Enrollment Information, Access to the Provider Information Portal.
2. Prior to making the request for an increase of a caseload that is already at maximum, the PCP is encouraged to review their caseload using the AMII (Arkansas Medicaid Information Interchange) web portal for inactive patients, to determine if those patients should be removed from their caseload. An increase in PCP caseload above the default maximum requires a written request to the Provider Relations Representative. **View or print Provider Relations Representative contact information**.

173.300 PCP Selection and Enrollment Through the ConnectCare HelpLine 7-1-05

A. PCP enrollment through the ConnectCare HelpLine is recommended.

B. ConnectCare HelpLine is operated by Medicaid Outreach and Education for ConnectCare.

1. ConnectCare HelpLine staff is available for PCP enrollments and transfers 24 hours a day, Monday through Thursday, and Friday until midnight.
2. The HelpLine number (1-800-275-1131) is prominently displayed in ConnectCare publications, frequently in more than one place. **View or print ConnectCare contact information.**
3. HelpLine staff members help Medicaid beneficiaries and ARKids First-B participants locate PCPs in their area.
4. HelpLine staff can help non-English-speaking individuals locate PCP offices or clinics where they can communicate in their native language.

173.400 PCP Selection and Enrollment at Participating Hospitals 7-1-05

Arkansas Medicaid pays acute care hospitals for helping Medicaid beneficiaries enroll with PCPs.

A. Enrollment is by means of a Primary Care Physician Selection and Change form (DMS-2609 or DCO-2609) and the voice response system (VRS).

1. Hospital personnel enter the PCP selection via the VRS.
2. The enrollment is effective immediately upon its acceptance by the online transaction processor (OLTP) that interfaces with the VRS.
3. The OLTP automatically updates the Medicaid Management Information System (MMIS) within 24 hours, but in the meantime, the enrollment information is part of the Medicaid eligibility file in the system.

B. The effective date of the PCP enrollment is the date the enrollment is electronically accepted.

C. The enrollee may request and receive a copy of the completed selection form.

D. Hospital staff must forward a copy of the selection form to the PCP accepted by the VRS.

173.500 PCP Selection for Supplemental Security Income (SSI) Beneficiaries 7-1-05

Individuals that are eligible for Medicaid because they are Supplemental Security Income (SSI) beneficiaries do not have an opportunity to select a PCP when they apply for SSI, because SSI application is made in a federal government office.

A. When an SSI beneficiary's Medicaid eligibility determination is made, the Arkansas Medicaid fiscal agent generates a letter describing ConnectCare.

1. It includes instructions for selecting and enrolling with a PCP.
2. A Primary Care Physician Selection and Change form (DCO-2609) is enclosed in the mailing.

B. SSI beneficiaries may enroll with PCPs by any of the methods used by other Medicaid beneficiaries.

173.600 Transferring PCP Enrollment

173.610 PCP Transfers by Enrollee Request 9-15-09

ConnectCare enrollees may transfer their PCP enrollment at any time, for any stated reason.

A. Enrollees are encouraged to use the ConnectCare HelpLine when transferring their enrollment from one PCP to another. Enrollees may change their PCP by calling ConnectCare at 1-800-275-1311 or by completing the PCP Change Request form online at **www.seeyourdoc.org**.

B. Enrollees may also change their PCP at the local DHS county office in the enrollee's county of residence but the enrollee or the enrollee's parent or guardian must request the transfer in writing by means of an Arkansas Medicaid Primary Care Physician Selection and Change form (DMS-2609 or DCO-2609).

173.620 PCP Transfers by PCP Request 9-15-09

A PCP may request that an individual transfer his or her PCP enrollment to another PCP because the arrangement with that individual is not acceptable to the PCP.

A. Examples of unacceptable arrangements include, but are not limited to, the following.

1. The enrollee fails to appear for 2 or more appointments without contacting the PCP before the scheduled appointment time.
2. The enrollee is abusive to the PCP.
3. The enrollee does not comply with the PCP's medical instruction.

B. At least 30 days in advance of the effective date of the termination, the PCP must give the enrollee written notice to transfer his or her enrollment to another PCP.

1. The notice must state that the enrollee has 30 days in which to enroll with a different PCP.
2. The PCP must forward a copy to the enrollee and to the local DHS office in the enrollee's county of residence.

C. The PCP continues as the enrollee's primary care physician during the 30 days or until the individual transfers to another PCP, whichever comes first.

173.630 PCP Enrollment Transfers Initiated by the State 7-1-05

The state may initiate PCP enrollment transfers whenever they are necessary. State-initiated enrollment transfers come about because DMS, in exercising its regulatory function, sometimes must sanction, suspend or terminate a provider.

A. For instance, a provider may lose his or her PCP or Medicaid contract for:

1. Failure to meet PCP or Medicaid contractual obligations
2. Proven and consistent excessive utilization
3. Unnecessarily limited utilization of medically necessary services

B. When the State terminates a PCP's contract, DMS contacts the PCP's enrollees with instructions for transferring their PCP enrollment.

180.000 EPISODES OF CARE 10-1-20

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021, the final reconciliation report will be generated. The reconciliation report period allows Principal Accountable Providers the opportunity to improve their gain share/risk share or incentive position.

181.000 Incentives to Improve Care Quality, Efficiency and Economy 7-1-16

A. Definitions

1. An "episode" refers to a defined bundle of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.
2. An "episode type" is defined by a diagnosis, health care intervention or condition during a specific timeframe (or performance period).
3. "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.
4. A "valid episode" is defined as any episode that meets criteria for inclusion in a calculation of cost and quality measures for which a PAP is accountable during a performance period.
5. An "invalid (excluded) episode" refers to an episode in which the services or the patient do not meet standard criteria for inclusion set by the definition of each episode type. (Refer to the Episodes of Care Medicaid Manual for episode-specific criteria.)
6. An "incentive" can either be positive (gain-share) or negative (risk-share).

B. Medicaid has established a payment improvement initiative ("payment improvement program") to incentivize improved care quality, efficiency and economy. The program uses Medicaid paid claims data to evaluate the quality, efficiency and economy of care delivered in the course of the episode and to apply payment incentives. **Please refer to the Episodes of Care Medicaid Manual for information about specific Episodes of Care.**

C. The payment improvement program is separate from, and does not alter, current methods for reimbursement.

D. The payment improvement program promotes efficiency, economy and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and when provider referrals are necessary, encouraging referrals to efficient and economic providers who furnish high-quality care.

E. All medical assistance provided in the delivery of care for an episode may be included in the determination of an incentive under the payment improvement program.

F. Incentives may be positive (gain share) or negative (risk share). Incentives are calculated and made retrospectively, after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentives are based on the aggregate of valid, paid claims across a provider's episodes and are not relatable to any individual provider claim for payment.

G. Medicaid establishes episode definitions, levels of incentives and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical practices information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from quality measurement organizations, peer-reviewed medical literature or any combination thereof.

H. Principal Accountable Providers

The Principal Accountable Provider(s) (PAPs) for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAPs after an episode is complete using algorithms described in the episode definition.

I. Incentives

For each PAP for each applicable episode type:

1. Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all valid episodes completed during the performance period will be calculated, based on the set of services included in the episode definition. Please refer to the Episodes of Care Medicaid Manual for information about specific Episodes of Care.
2. Some episodes may be excluded based on clinical factors derived from paid claims. Other exclusions may be determined from coverage factors for each individual patient.
3. Reimbursement for some episodes may be adjusted as described in the definition of each episode. The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds which are established by Medicaid in consultation with providers.
4. If a PAP's average adjusted episode reimbursement is lower than the commendable threshold and the PAP has met the quality measures established by Medicaid for each episode type, the PAP is eligible for gain share and Medicaid will make a positive incentive to the PAP. This will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain-sharing percentage for the episode. Where necessary, a gain-sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain-sharing limit will receive an incentive calculated as though their average adjusted episode reimbursement were equal to the gain-sharing limit.
5. If the average adjusted episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative (risk-share) incentive. This incentive to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk-sharing percentage defined by Medicaid for the episode.

J. Principles for Determining "Thresholds"

1. The threshold process aims to incentivize high-quality clinical care delivered efficiently and to consider several factors including the potential to improve patient access, the impact on provider economics and the level and type of practice pattern changes required for performance improvement.
2. The acceptable threshold is set such that average cost per episode above the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.
3. The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically-feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.

4. The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

5. The gain- and risk-sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

K. Outlier Patient Exclusions

Calculation of average adjusted episode reimbursement for each PAP will exclude outlier patients who have extraordinarily high or low cost episodes and/or comorbid conditions so that one or a few cases do not misrepresent a provider's overall performance across the provider's broader patient population.

L. Provider-Level Adjustments

1. Incentives for each PAP take into account provider-level adjustments, which may include stop-loss provisions, adjustments for cost-based facilities, adjustments or exclusions for providers with low case volume or any combination thereof.

2. Stop-loss protection: Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all Episodes of Care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

3. Temporary stop-loss provisions may apply when necessary to ensure access to care.

4. Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive (gain-share) and negative (risk-share) incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

5. Each episode has a designated minimum case volume that must be reached in order for the PAP to be eligible for incentives. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive (gain-share) or negative (risk-share) incentives for that episode type.

M. Quality Measures

1. For each episode type, there is a set of quality measures "to pass" and/or a set of quality measures "to track." These quality measures are based on paid claims data or based on additional data when specified by Medicaid and which PAPs are required to report through the Advanced Health Information Network (AHIN) provider portal.

2. To qualify for positive (gain-share) incentives, PAPs must report required data and meet specific quality measures "to pass."

3. Providers who do not report data or who do not meet minimum quality measures may still incur negative (risk-share) incentives if their average adjusted episode reimbursement exceeds the acceptable threshold.

N. Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

190.000 PROVIDER DUE PROCESS

190.001 The Medicaid Fairness Act 12-15-11

The Medicaid Fairness Act, Ark. Code Ann. §§ 20-77-1701 – 20-77-1716, requires that the Department of Human Services and its outside contractors treat providers with fairness and due process.

190.002 Definitions 9-15-09

A. Adverse decision/adverse action: any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for Medicaid claims and services including but not limited to decisions as to:

1. Appropriate level of care or coding,
2. Medical necessity,
3. Prior authorization,
4. Concurrent reviews,
5. Retrospective reviews,
6. Least restrictive setting,
7. Desk audits,
8. Field audits and onsite audits, and
9. Inspections.

B. Appeal: an appeal under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

C. Claim: a request for payment of services.

D. Concurrent review or concurrent authorization: a review to determine whether a specified beneficiary currently receiving specific services may continue to receive services.

E. Denial: denial or partial denial of a claim or authorization of services.

F. Department:

1. The Arkansas Department of Human Services,
2. All of the divisions and programs of the Arkansas Department of Human Services, including the state Medicaid Program, and
3. All of the Arkansas Department of Human Services' contractors, fiscal agents, and other designees and agents.

G. Medicaid: the medical assistance program under Title XIX of the Social Security Act that is operated by the Arkansas Department of Human Services and its contractors, fiscal agents, and all other designees and agents.

H. Person: any individual, company, firm, organization, association, corporation, or other legal entity.

I. Primary care physician: a physician whom the department has designated as responsible for the referral or management, or both, of a Medicaid beneficiary's health care.

J. Prior authorization: the approval by the state Medicaid Program for specified services for a specified Medicaid beneficiary before the requested services may be performed and before payment will be made by the state Medicaid Program.

K. Provider: a person enrolled to provide health or medical care services or goods authorized under the state Medicaid Program.

L. Recoupment: any action or attempt by the Department of Human Services to recover or collect Medicaid payments already made to a provider with respect to a claim by:

1. Reducing, withholding or affecting in any other manner current or future payments to a provider, or
2. Demanding payment back from a provider for a claim already paid.

M. Retrospective review: the review of services or practice patterns after payment, including, but not limited to:

1. Utilization reviews,
2. Medical necessity reviews,
3. Professional reviews,
4. Field audits and onsite audits, and
5. Desk audits.

N. Reviewer: any person, including reviewers, auditors, inspectors, surveyors and others who, in reviewing a provider or a provider's provision of services and goods, perform review actions, including, but not limited to:

1. Reviews for quality,
2. Reviews for quantity,
3. Utilization,
4. Practice patterns,
5. Medical necessity,
6. Peer review, and
7. Compliance with Medicaid standards.

O. Technical deficiency: an error or omission in documentation by a provider that does not affect direct patient care of the beneficiary. Technical deficiency does not include:

1. Lack of medical necessity or failure to document medical necessity in a manner that meets professionally recognized applicable standards of care,
2. Failure to provide care of a quality that meets professionally recognized local standards of care,
3. Failure to obtain prior, concurrent or mandatory authorization if required by regulation,
4. Fraud,
5. A pattern of abusive billing,
6. A pattern of noncompliance, or
7. A gross and flagrant violation.

190.003 Administrative Appeals 12-1-05

A. The following appeals are available in response to an adverse decision:

1. A beneficiary may appeal on his or her own behalf.
2. A provider of medical assistance that is the subject of the adverse action may appeal on the beneficiary's behalf.
3. If the adverse action denies a claim for covered medical assistance that was previously provided to a Medicaid-eligible beneficiary, the provider of such medical assistance may appeal on the provider's behalf. The provider does not have standing to appeal a non-payment decision if the provider has not furnished any service for which payment has been denied.

B. All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

C. Providers may appear in person, through a corporate representative or with prior notice to the department, through legal counsel.

D. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

E. A Medicaid beneficiary may attend any hearing related to his or her care, but the department may not make his or her participation a requirement for provider appeals. The department may compel the beneficiary's presence via subpoena, but failure of the beneficiary to appear shall not preclude the provider's appeal.

F. If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

G. Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

H. This rule shall apply to all pending and subsequent appeals that have not been finally resolved at the administrative or judicial level as of April 5, 2005.

190.004 Records 9-15-09

When the Department of Human Services makes an adverse decision in a Medicaid case and a provider then lodges an administrative appeal, the department shall deliver its file on the matter to the provider well in advance of the appeal so that the provider will have time to prepare for the appeal. The file shall include the records of any utilization review contractor or other agent, subject to any other federal or state law regarding confidentiality restrictions.

190.005 Technical Deficiencies 9-15-09

The Department of Human Services may not recoup from providers for technical deficiencies if the provider can substantiate through other documentation that the services or goods were provided and that the technical deficiency did not adversely affect the direct patient care of the beneficiary.

A technical deficiency in complying with a requirement in federal statutes or regulations shall not result in a recoupment unless:

A. The recoupment is specifically mandated by federal statute or regulation, or

B. The state can show that failure to recoup will result in a loss of federal matching funds or in another penalty against the state.

The Department of Human Services may initiate a corrective action plan or other non-monetary measure in response to technical deficiencies. If a provider fails to comply with a corrective

action plan for a pattern of non-compliance with technical requirements, then appropriate monetary penalties may be imposed if permitted by law. However, the department first must be clear as to what the technical requirements are by providing clear communication in writing or a promulgated rule where required.

190.006 Explanations of Adverse Decisions Required 9-15-09

Each denial or other deficiency that the Department of Human Services makes against a Medicaid provider shall be prepared in writing and shall specify:

A. The exact nature of the adverse decision,

B. The statutory provision or specific rule alleged to have been violated, and

C. The specific facts and grounds constituting the elements of the violation.

190.007 Rebilling at an Alternate Level Instead of Complete Denial 9-15-09

The denial notice from the department shall explain the reason for the denial in accordance with rule 190.006 above and shall specify the level of care that the department deems appropriate based on the documentation submitted by the provider.

If a legally qualified and authorized provider's claim is denied, the provider shall be entitled to re-bill at the level that would have been appropriate according to the department's basis for denial, absent fraud or a pattern of abuse by the provider. A referral from a primary care physician or other condition met prior to the denial shall not be re-imposed.

A provider's decision to re-bill at the alternate level does not waive the provider's or beneficiary's right to appeal the denial of the original claim.

Nothing prevents the department from reviewing the claim for reasons unrelated to the level of care and taking action that may be warranted by the review, subject to other provisions of law.

190.008 Prior Authorizations – Retrospective Reviews 9-15-09

The Department of Human Services may not retrospectively recoup or deny a claim from a provider if the department previously authorized the care unless the retrospective review establishes that:

A. The previous authorization was based upon misrepresentation by act or omission, and

B. If the true facts had been known, the specific level of care would not have been authorized, or

C. The previous authorization was based upon conditions that later changed, thereby rendering the care medically unnecessary.

Recoupment based upon lack of medical necessity shall not include payments for any care that was delivered before the change of circumstances that rendered the care medically unnecessary.

190.009 Medical Necessity 12-1-05

There is a presumption in favor of the medical judgment of the attending physician in determining medical necessity of treatment.

190.010 Promulgation Before Enforcement 9-15-09

The Department of Human Services may not use state policies, guidelines, manuals, or other such criteria in enforcement actions against providers unless the criteria have been promulgated.

Nothing in this rule requires or authorizes the department to attempt to promulgate standards of care that physicians use in determining medical necessity or rendering medical decisions, diagnoses, or treatment.

Medicaid contractors shall use Medicaid provider manuals promulgated pursuant to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

190.011 Copies 12-1-05

If the department or its contractor requires a provider to supply duplicates of documents already furnished to the department or its contractors, the department division or contractor making the request shall pay the actual cost of photocopies, not to exceed 15 cents per page, for duplicates produced and supplied by providers in response to such requests.

190.012 Notices 9-15-09

When the Department of Human Services sends letters or other forms of notices with deadlines to providers or beneficiaries, the deadline shall not begin to run before the next business day following the date of the postmark on the envelope, the facsimile transmission confirmation sheet, or the electronic record confirmation unless otherwise required by federal statute or regulation.

190.013 Deadlines 9-15-09

The Department of Human Services may not issue a denial or demand for recoupment to providers for missing a deadline if the department or its contractor contributed to the delay or if the delay was reasonable under the circumstances, including, but not limited to:

A. Intervening weekends or holidays,

B. Lack of cooperation by third parties,

C. Natural disasters, or

D. Other extenuating circumstances.

This rule is subject to good faith on the part of the provider.

190.014 Federal Law 12-1-05

If any provision of these policies and procedures are found to conflict with current federal law, including promulgated federal regulations, the federal law shall override that provision.

191.000 BENEFICIARY DUE PROCESS

191.001 Definitions 9-15-09

A. Adverse decision/adverse action: any decision or action by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for Medicaid claims and services by limiting, terminating, suspending, or reducing Medicaid eligibility or covered services in connection with, but not limited to:

1. Appropriate level or care or coding,
2. Medical necessity,
3. Prior authorization,
4. Concurrent reviews,

5. Retrospective reviews,
6. Least restrictive setting,
7. Desk audits,
8. Field audits and onsite audits, and
9. Inspections.

B. Beneficiary:

1. A person who has applied for medical assistance under the Arkansas Medicaid Program, or
2. A person who is a beneficiary of medical assistance under the Arkansas Medicaid Program.

C. Department: The Department of Human Services.

191.002 Notice 12-1-05

A. If an application or claim for medical assistance is denied in whole or in part or is not acted upon with reasonable promptness, the department shall provide written notice:

1. Of the beneficiary's right and opportunity for a fair hearing under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218,
2. Of the method by which the beneficiary may obtain a fair hearing, and
3. Of the beneficiary's right to:
   a. Represent himself or herself, or
   b. Be represented by legal counsel, a friend, or any other spokesperson except a corporation.

B. A notice required under this rule shall include but not be limited to:

1. A statement detailing the type and amount of medical assistance that the beneficiary has requested,
2. A statement of the adverse action that the department has taken or proposes to take,
3. The reasons for the adverse action which shall include but not be limited to:
   a. The specific facts regarding the individual beneficiary that support the action, and
   b. The sources from which the facts were derived.
4. An explanation of the beneficiary's right to request a fair hearing, if available, or in cases of an adverse action based on a change in law:
   a. The circumstances under which a fair hearing will be granted, and
   b. An explanation of the circumstances under which medical assistance is provided or continued if a fair hearing is requested.

191.003 Determination of Medical Necessity – Content of Notice 12-1-05

If the adverse action that the department has taken or proposes to take is based on a determination of medical necessity or other clinical decision, the notice required under Rule 191.002 shall include all of the following:

A. Specification of the medical records upon which the physician or clinician relied in making the determination,

B. Specification of any portion of the criteria for medical necessity or coverage that is not met by the beneficiary,

C. The specific regulation(s) that support the adverse action, or the change in federal or state law that has occurred since the application was filed that requires adverse action, and

D. A brief statement of the reasons for the adverse action based upon the individual beneficiary's circumstances.

The department and others acting on behalf of the department may not cite or rely on policies that are inconsistent with federal or state laws and regulations or that were not properly promulgated. Generic rationales or explanations shall not suffice to meet the requirements of this rule.

191.004 Administrative Appeals 9-15-09

When notice of an adverse decision is received from the Division of Medical Services, the beneficiary may appeal. The appeal request must be in writing and submitted to the Department of Human Services, Appeals and Hearings Section. **View or print the Department of Human Services, Appeals and Hearings Section contact information.** The appeal request must be received by the Appeals and Hearings Section no later than thirty (30) days from the next business day following the date of the postmark on the envelope containing the written notice of an adverse decision.

All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

191.005 Conducting the Hearing 12-1-05

If a beneficiary appeals an adverse action under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218, the reviewing authority shall consider only those adverse actions that were included in the written notice to the beneficiary as required under Rules 191.002 and 191.003.

All determinations of the medical necessity of any request for medical assistance shall be based on the individual needs of the beneficiary and on his or her medical history.

191.006 Records 12-1-05

When the department receives an appeal from a beneficiary regarding an adverse action, the department shall provide the beneficiary all records or documents pertaining to the department's or its contractor's decision to take the adverse action.

If the adverse action is based upon a determination that the requested medical assistance is, or was, not medically necessary, the records and documents required to be provided under this rule shall include all material that contains relevant information concerning the medical necessity determination produced by the department or its contractor.