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

CONTENTS

200.000 HOSPITAL, CRITICAL ACCESS HOSPITAL (CAH) AND END-STAGE RENAL DISEASE (ESRD) GENERAL INFORMATION

200.100 Introduction 8-1-05

A. This manual is the Arkansas Medicaid provider policy manual for the Hospital Program, the Critical Access Hospital (CAH) Program and the End-Stage Renal Disease (ESRD) Program.

1. Hospital general information begins at Section 201.000.

2. CAH general information begins at Section 201.400.

3. ESRD facility general information begins at Section 204.000.

B. Provider enrollment information for each program is divided into participation requirements and enrollment procedures. All providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the criteria below to be eligible to participate in the Arkansas Medicaid Program.

C. Guidelines for the Arkansas Medicaid Hospital Program generally apply to the Arkansas Medicaid Critical Access Hospital Program.

1. For the user's convenience, this manual contains separate sections for hospital and CAH participation requirements and enrollment procedures.

2. Wherever there are differences between the Hospital Program and the CAH Program, the differences are explained in detail in clearly marked CAH sections of this manual.

D. Arkansas Medicaid dialysis coverage is identical in ESRD facilities and outpatient hospitals; therefore, dialysis coverage and billing are discussed in the ESRD sections of this manual.

200.101 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

201.000 Hospital General Information 8-1-05

The Division of Health of the Arkansas Department of Health and Human Services licenses several types of hospitals, facilities and institutions that may qualify for participation in the Arkansas Medicaid Program.

A. The Division of Health licenses four types of acute care hospitals that are eligible for enrollment in the Arkansas Medicaid Hospital Program. They are

1. General hospitals,

2. Maternity and general medical care hospitals,

3. Maternity hospitals and

4. Surgery and general medical care hospitals.

B. The Arkansas Title XIX (Medicaid) State Plan employs the terms "acute care" and "acute care/general" interchangeably as general references to any of these four types of hospitals (or their counterparts in other states) to avoid repeating the entire list each time that a reference is made to hospitals that are eligible for participation in the Arkansas Medicaid Hospital Program.

201.100 Arkansas Medicaid Participation Requirements for Acute Care/General Hospitals 8-1-05

Following are the minimum requirements for participation in the Arkansas Medicaid Hospital Program.

A. An in-state hospital must be licensed by the Division of Health of the Arkansas Department of Health and Human Services as an acute care/general hospital.

B. An out-of-state hospital must be licensed as an acute care/general hospital by the appropriate licensing agency within its home state.

C. A hospital must be certified as an acute care/general hospital Title XVIII (Medicare) provider.

201.110 Arkansas Medicaid Participation Requirements for Pediatric Hospitals 8-1-05

A. A pediatric hospital is a hospital in which the majority of patients are individuals under the age of 21.

B. Arkansas Medicaid participation requirements for pediatric hospitals are as follows.

1. An in-state pediatric hospital must be licensed by the Division of Health as an acute care/general hospital.
2. An out-of-state pediatric hospital must be licensed by the appropriate licensing agency within its home state as an acute care/general hospital.
3. A pediatric hospital must be certified as a pediatric hospital Title XVIII (Medicare) provider.
4. A pediatric hospital must be designated by the Centers for Medicare and Medicaid Services (CMS) as a children's hospital that is exempt from Medicare's prospective payment system.

201.120 Arkansas Medicaid Participation Requirements for Arkansas State-Operated Teaching Hospitals 8-1-05

A hospital is an Arkansas State-Operated Teaching Hospital if it

A. Is licensed by the Division of Health as an acute care/general hospital,

B. Has in effect an agreement to participate in Medicaid as an acute care hospital,

C. Is operated by the State of Arkansas and

D. Has current accreditation from the North Central Association of Colleges and Schools.

201.200 Routine Services Providers and Limited Services Providers 8-1-05

Arkansas Medicaid enrolls a hospital as a routine services provider or as a limited services provider depending on the state in which the hospital is located.

201.210 Hospitals in Arkansas and in Bordering States 8-1-05

Qualifying hospitals in Arkansas and in the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as routine services providers.

201.211 Routine Services Providers 8-1-05

A. Routine services providers in the Arkansas Medicaid Hospital Program may routinely furnish Medicaid-covered hospital services to Arkansas Medicaid beneficiaries in accordance with the regulations in this provider manual.

B. All hospital providers of routine services are subject to the same Arkansas Medicaid regulations regarding coverage, restrictions and exclusions.

C. Reimbursement methodologies may vary, depending on such factors as the hospital's specialty, the type of service provided (e.g., inpatient or outpatient services) and the hospital's location.

201.220 Hospitals in States Not Bordering Arkansas 3-1-11

A. Hospitals in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file.

To enroll, a non-bordering state hospital must download an Arkansas Medicaid provider application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Provider Enrollment Unit Contact information.**

B. Limited services providers remain enrolled for one year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period the provider may file any subsequent claims directly to the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement

201.300 Provider Enrollment and Provider File Maintenance 8-1-05

The Provider Enrollment Unit is automating provider enrollment and provider file maintenance.

A. The automated enrollment system can obtain and maintain required enrollment materials and documentation by means of web-based and other electronic applications, mail, personal contact and telephone contact.

B. The Provider Enrollment Unit will optimize its electronic access to providers' licensure, certification, accreditation etc.; however, applicants and enrolled providers are responsible for ensuring that required documentation is on file with Provider Enrollment.

1. During the initial enrollment process, Provider Enrollment will contact applicants for corrections and to request missing documentation, specifying a required timeframe for the provider's response.
2. When a provider's continuing participation is contingent on the renewal of licensure, certification or accreditation and Provider Enrollment has not received verification of the renewal within 30 days of the renewal date, the Medicaid Management Information System (MMIS) generates a letter asking the provider to forward a copy of the renewal document within a specified timeframe.

   Enrolled providers and applicants can query the automated enrollment system regarding the status of their files. **View or print Medicaid Provider Enrollment Unit contact information.**

201.301 Provider Enrollment Procedures 8-1-05

A. All Medicaid provider applications and Medicaid contracts must be approved by the Arkansas Department of Health and Human Services before a provider may enroll.

B. In addition to meeting the requirements listed in Section 140.000 of this manual, applicants for enrollment in the Arkansas Medicaid Hospital Program must have on file with the

Medicaid Provider Enrollment Unit the applicable credentialing documentation specified in Sections 201.310 through 201.313.

C. The Medicaid Provider Enrollment Unit reviews the accuracy and completeness of provider applications, Medicaid contracts and all other required documentation.

1. Provider Enrollment contacts applicants to correct errors or omissions in the enrollment documents. Some errors, such as failure to provide an original signature, necessitate returning the documents to the applicant for correction.

2. When the provider application materials are complete and correct, and the Arkansas Department of Health and Human Services approves the application and contract, Provider Enrollment assigns a provider number and forwards to the provider written confirmation of the provider number and the effective date of the provider's enrollment.

201.310 Provider Enrollment and Provider File Maintenance 8-1-05

An acute care/general hospital must ensure that the following documents are on file with the Medicaid Provider Enrollment Unit.

A. A copy of the hospital's current license as an acute care/general hospital.

B. A copy of the hospital's Title XVIII (Medicare) certification as an acute care/general hospital provider.

201.311 Enrollment and Provider File Maintenance – Pediatric Hospitals 8-1-05

In addition to complying with the participation and enrollment requirements for acute care/general hospitals, a pediatric hospital must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of the letter from the Centers for Medicare and Medicaid Services (CMS) stating that the hospital is a children's hospital that is exempt from Medicare's prospective payment system.

201.312 Enrollment and Provider File Maintenance – Arkansas State-Operated Teaching Hospitals 8-1-05

In addition to complying with the participation and enrollment requirements for acute care/general hospitals, an Arkansas State operated teaching hospital must ensure that the following documents are on file with the Medicaid Provider Enrollment Unit.

A. A copy of the hospital's current accreditation from the North Central Association of Colleges and Schools and

B. A copy of the most current Arkansas licensure application stating that the operation or management of the hospital is by the State.

201.313 Enrollment and Provider File Maintenance – Critical Access Hospitals (CAHs) in Other States 8-1-05

See Sections 140.000, 201.410 and 210.412.

201.400 Critical Access Hospital (CAH) General Information 8-1-05

Only CAHs located in Arkansas and licensed by the Division of Health of the Arkansas Department of Health and Human Services may enroll in the Arkansas Medicaid Critical Access Hospital Program.

A. Out-of-state CAHs may participate only in the Arkansas Medicaid Hospital Program.

B. CAHs in states not bordering Arkansas may participate in the Arkansas Medicaid Hospital Program as limited services providers.

201.401 Arkansas Medicaid Participation Requirements for CAHs 8-1-05

A CAH must meet the following requirements to participate in the Critical Access Hospital Program.

A. The hospital must be certified as a CAH by the Secretary of the U.S. Department of Health and Human Services.

B. The hospital must be licensed as a CAH by the Division of Health of the Arkansas Department of Health and Human Services.

C. The hospital must hold Title XVIII (Medicare) certification as a CAH.

201.402 Participation of Out-of-State CAHs 8-1-05

A. The Division of Medical Services enrolls qualifying out-of-state CAHs as acute care/general hospitals in the Arkansas Medicaid Hospital Program.

1. CAHs in states bordering Arkansas may enroll as routine services providers in the Arkansas Medicaid Hospital Program. See Sections 201.200 through 201.211.
2. CAHs in states that do not border Arkansas may participate in the Arkansas Medicaid Hospital Program as limited services acute care/general hospital providers only.

B. Out-of-state CAHs applying for enrollment must meet the following requirements.

1. The hospital must be certified as a CAH by the Secretary of the Department of Health and Human Services.
2. The hospital must be licensed as a CAH by its home state licensing authority.
3. The hospital must hold Title XVIII (Medicare) certification as a CAH.

201.410 Provider Enrollment Procedures 8-1-05

A. All Medicaid provider applications and Medicaid contracts must be approved by the Arkansas Medicaid Program before a provider may enroll.

B. In addition to meeting the requirements listed in Section 140.000 of this manual, applicants for enrollment in the Arkansas Medicaid Critical Access Hospital Program and the Arkansas Medicaid Hospital Program must have on file with Provider Enrollment the applicable credentialing documentation specified in Section 201.411 or Section 201.412.

C. The Medicaid Provider Enrollment Unit reviews the accuracy and completeness of provider applications, Medicaid contracts and all other required documentation.

1. Provider Enrollment contacts applicants to correct errors or omissions in the enrollment documents. Some errors, such as failure to provide an original signature, necessitate returning the documents to the applicant for correction.
2. When the provider application materials are complete and correct and Arkansas Medicaid approves the application and contract, Provider Enrollment assigns a provider number and forwards to the provider written confirmation of the provider number and the effective date of the provider's enrollment.

201.411 Provider Enrollment – In-State CAH 8-1-05

In addition to complying with the enrollment requirements for Arkansas in-state CAHs, a hospital must ensure that the following documents are on file with the Medicaid Provider Enrollment Unit.

A. Proof of certification as a CAH by the Secretary of the U.S. Department of Health and Human Services

B. Proof of current licensure as a CAH by the Division of Health

C. Proof of Title XVIII (Medicare) certification as a CAH

201.412 Out-of-State CAH Enrollment in the Hospital Program 8-1-05

In addition to complying with the enrollment requirements for CAHs outside Arkansas, a hospital must ensure that the following documents are on file with the Medicaid Provider Enrollment Unit.

A. Proof of certification as a CAH by the Secretary of the U.S. Department of Health and Human Services

B. Proof of current licensure as a CAH by its home state licensing authority

C. Proof of Title XVIII (Medicare) certification as a CAH in its home state

202.000 Hospital and CAH Medical Record Requirements 8-1-05

A. Hospitals and CAHs must maintain a medical record for each inpatient and outpatient.

1. Medical records must be accurately written, promptly completed, properly filed and retained and accessible.
2. The facility's system of author identification and record maintenance must ensure the integrity of the authentication and protect the security of all record entries.

B. The medical record must

1. Justify admission and continued hospitalization,
2. Support the diagnosis and
3. Describe the patient's progress and response to medications and services.

C. All entries must be legible and complete and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing or evaluating the service furnished.

1. The author of each entry must be identified and must authenticate his or her entry.
2. Authentication may include signatures, written initials or computer entry.

D. All records must document the following, as appropriate:

1. Required primary care physician (PCP) or other referrals, when applicable
2. A physical examination, including a health history, performed no more than 7 days before admission or within 48 hours after admission
3. Admitting diagnosis
4. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient
5. Documentation of complications, hospital-acquired infections and unfavorable reactions to drugs and anesthesia

6. Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by federal or state law when applicable, to require written patient consent
7. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, vital signs and other information necessary to monitor the patient's condition
8. Discharge summary with outcome of hospitalization, disposition of case and provisions for follow-up care
9. Final diagnosis with completion of medical records within 30 days following discharge

202.100 Availability of Hospital and CAH Medical Records 10-1-08

The Medicaid Program, its designees and other state and federal agencies review medical records for documentation of services provided and billed, and to evaluate the medical necessity of delivered services. Refer to Section 142.300 for information regarding record retention and availability requirements.

204.000 End-Stage Renal Disease (ESRD) General Information 8-1-05

Outpatient dialysis and related facility services for individuals with end-stage renal disease (ESRD) may be provided by hospitals and by specialized treatment facilities known as “suppliers of end-stage renal disease services.”

204.100 Arkansas Medicaid Participation Requirements for Providers of ESRD Services 8-1-05

In addition to meeting the applicable requirements enumerated in Section 140.000, ESRD providers that are not hospitals must meet the following requirements to participate in the Arkansas Medicaid Program:

A. The provider must be certified by the Centers for Medicare and Medicaid Services (CMS) as an ESRD supplier.

B. The provider must be enrolled in the Title XVIII (Medicare) Program as an ESRD supplier.

204.110 ESRD Providers in Arkansas and In Bordering States 8-1-05

End-Stage Renal Disease facilities located in Arkansas or one of the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may enroll with Arkansas Medicaid as routine services providers if they meet Arkansas Medicaid participation requirements.

204.111 ESRD Routine Services Providers 8-1-05

A. Routine services providers are regular providers of routine services.

B. All ESRD routine services providers are subject to the same regulations, restrictions and reimbursement methodology.

204.120 ESRD Providers in States not Bordering Arkansas 3-1-11

A. Facilities in states not bordering Arkansas may enroll in the Arkansas Medicaid program only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file.

To enroll, a non-bordering state provider must download an Arkansas Medicaid provider application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Provider Enrollment Unit Contact information.**

B. Limited services providers remain enrolled for one year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period the provider may file any subsequent claims directly to the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

204.200 ESRD Medical Records 8-1-05

A. The ESRD facility must maintain complete medical records on all patients, including self-dialysis patients within the self-dialysis unit and home dialysis patients whose care is under the supervision of the facility, in accordance with accepted professional standards and practices.

B. Each patient's medical record must contain sufficient information to identify the patient, justify the diagnosis and treatment and accurately document the results.

C. Each patient's medical record must include

1. The assessment of the patient's needs
2. The treatment plan
3. Documentation of the care and services provided
4. Documentation that the patient was informed of the results of the assessment
5. Signed consent forms
6. Referral information with authentication of diagnosis; medical and nursing history of patient
7. Report(s) of physician examination(s)
8. Diagnostic and therapeutic orders
9. Observations and progress notes
10. Reports of treatments and clinical findings
11. Reports of laboratory and other diagnostic tests and procedures
12. Discharge summary including final diagnosis and prognosis

D. Current medical records and those of discharged patients must be completed promptly.

E. Daily dialysis information generated by self-dialysis patients may be entered in the record by facility staff or by trained self-dialysis patients, trained home dialysis patients or trained assistants and countersigned by staff.

204.210 Availability of ESRD Medical Records 8-1-21

The Arkansas Department of Health and Human Services, its designees and other state and federal agencies review medical records for documentation of services provided and billed and to evaluate the medical necessity of delivered services.

A. All records must be retained in their original or legally reproduced form for at least five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.

B. Pertinent records concerning the provision of Medicaid-covered health care services are to be made available, upon request, during regular business hours to authorized representatives of the Arkansas Division of Medical Services (DMS) who are acting within the scope and course of their employment.

1. All requested documentation must be made available to DMS representatives at the time of an audit.
2. All documentation must be available at the provider's place of business.

C. Pertinent records are also to be made available to DMS's contracted Quality Improvement Organization (QIO).

D. Additionally, providers are required to furnish records, when so requested, to the Office of Medicaid Inspector General (OMIG); Medicaid Fraud Control Unit (MFCU) of the Arkansas Office of the Attorney General and to representatives of the Secretary of the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS).

1. When requested records are stored off-premises or they are in active use, the provider may so certify in writing and set a date and hour within three (3) working days that the records will be available.
2. Failure to furnish medical records upon request will result in the imposition of sanctions. (See Section I of the Arkansas Medicaid provider manual.)

210.000 PROGRAM COVERAGE – HOSPITAL AND CRITICAL ACCESS HOSPITAL

210.100 Introduction 11-1-23

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

A. Medicaid coverage is based on medical necessity.

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

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

1. When Arkansas Medicaid's Division of Medical Services' Medical Director for Clinical Affairs determines that a service is never medically necessary, the Division of Medical Services (DMS) enters the service's procedure code, revenue code and/or

diagnosis code into the Medicaid Management Information System (MMIS) as non-payable, which automatically prevents payment.

2. A number of services are covered only with the Program's prior approval or prior authorization. One of the reasons for requiring prior approval of payment or prior authorization for a service is that some services are not always medically necessary and Medicaid wants its own medical professionals to review the case record before making payment or before the service is provided.

3. Lastly, Medicaid retrospectively reviews medical records of services for which claims have been paid in order to verify that the medical record supports the service(s) for which Medicaid paid and to confirm or refute the medical necessity of the services documented in the record.

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

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

212.000 Inpatient Hospital Services

212.100 Scope – Inpatient 7-15-12

"Inpatient hospital services" are defined in the Arkansas Medical Assistance Program as those items and services ordinarily furnished by the hospital for care and treatment of inpatients and are provided under the direction of a licensed practitioner (physician or dentist with staff affiliation) of a facility maintained primarily for treatment and care of injured persons, individuals with disabilities, or sick persons. Such inpatient services must be medically justified, documented, certified and re-certified by the Quality Improvement Organization (QIO) and are payable by Medicaid if provided on a Medicaid covered day.

A "Medicaid covered day" is defined as a day for which the beneficiary is Medicaid eligible, the patient's inpatient benefit has not been exhausted, the patient's inpatient stay is medically necessary, the day is not part of a hospital stay for a non-payable procedure or non-authorized procedure (see Sections 220.000 and 244.000), and the claim is filed on time. (See Section III of this manual for reference to "Timely Filing.")

The following services are covered inpatient hospital services if medically necessary for treatment of the patient and if the date of service is a Medicaid covered day:

A. **Accommodation**
"Accommodation" means the type of room provided for the patient while receiving inpatient hospital services. The Medicaid Program will cover the semi-private room or ward accommodations and intensive care. A private room will only be covered when such accommodations are medically necessary, as certified by the patient's attending physician. Private rooms are considered medically necessary only when the patient's condition requires him or her to be isolated to protect his or her health or welfare, or to protect the health of others.

B. **Operating Room**
Operating room charges for services and supplies associated with surgical procedures are covered inpatient hospital services.

C. **Anesthesia**
Anesthesia charges for services and/or supplies furnished by the hospital are covered inpatient hospital services.

D. **Blood Administration**
Blood, blood components and blood administration charges are covered when not available to the beneficiary from other sources. Hospitals are encouraged to replace blood that is used by a Medicaid beneficiary through his or her friends and relatives, or through the Red Cross whenever possible.

E. **Pharmacy**
Drugs and biologicals furnished by the hospital for the care and treatment of patients are covered inpatient hospital services. Take-home drugs are non-covered inpatient hospital services under the Arkansas Medicaid Program.

F. **Radiology and Laboratory**
The coverage of inpatient hospital services includes the non-physician services related to machine tests, laboratory and radiology procedures provided to inpatients. The hospital where the patient is hospitalized will be responsible for providing or securing these services. The party who furnishes these non-physician services is permitted to bill only the hospital.

If a patient is transferred to another hospital to receive services on an outpatient basis, the cost of the transfer is included in the hospital reimbursement amount. The ambulance company may not bill Medicaid or the beneficiary for the service.

G. **Medical, Surgical and Central Supplies**
Necessary medical and surgical supplies and equipment that are furnished by the hospital for the care and treatment of patients are covered inpatient hospital services. Supplies and equipment for use outside the hospital are not covered by Medicaid.

H. **Physical and Inhalation Therapy**
Physical and inhalation therapy and other necessary services, as well as supply charges for these services that are furnished by the hospital, are covered inpatient hospital services.

I. **Delivery Room**
Delivery room charges for services and supplies associated with obstetrical procedures are covered inpatient hospital services.

J. **Other**
Services other than the non-covered services identified in Section 212.200, which are not specified above.

212.200 Exclusions – Inpatient 11-1-23

The following items are not covered as inpatient hospital services:

A. Beauty shop

B. Cot for visitors

C. Meals for visitors

D. Television

E. Telephone

F. Guest tray

G. Private duty nurse

H. Take-home drugs and supplies

I. Services not reasonable or necessary for the treatment of an illness or injury

J. Private room (unless physician certifies that it is medically necessary or unless no semi-private rooms are available)

K. Autopsies

Medicaid does not cover services that are cosmetic, not medically necessary, or that are not generally accepted by the medical profession. Medicaid does not cover services that are not documented by diagnoses that certify medical necessity. Arkansas Medicaid has identified some ICD diagnosis codes that do not certify medical necessity. See Sections 272.460 and 272.470 for diagnosis codes that are not covered by Arkansas Medicaid.

212.300 Therapeutic Leave 10-13-03

The Arkansas Medicaid Program allows a maximum of 7 days per beneficiary per SFY for therapeutic leave for patients in an acute care/general or rehabilitative hospital. The therapeutic leave will be allowed for hospital leave when the leave is prescribed as a part of the treatment and/or discharge planning.

The following documentation is required when providing therapeutic leave:

A. The purpose of the therapeutic leave (the leave must be listed in the plan of care along with the objectives, goals and frequency of this therapy)

B. The destination or location (the place where the beneficiary will go for this therapy must be recorded as well as the date and time of departure and return and the person(s) responsible for the beneficiary during the leave period)

C. A therapeutic leave evaluation (documentation must be in a form which will provide unquestionable support to the plan of care objectives and goals)

D. Progress notes (progress notes must provide periodic statements which track a beneficiary's actions and reactions and must clearly reveal the beneficiary's achievements or regressions)

A Medicaid beneficiary who has been admitted to the hospital may not leave the hospital and receive Medicaid covered outpatient services prior to being discharged. Unless a patient has been discharged from the hospital and is no longer considered an inpatient, the patient is not eligible for outpatient services covered by Medicaid. For example, a patient may not be prescribed therapeutic leave for 8 hours per day in order to receive day treatment services through a Community Mental Health Center. Even though a patient is on therapeutic leave from an acute care/general hospital, he or she is still considered an inpatient.

212.400 Inpatient Hospital Benefit Limitation

212.401 Inpatient Hospital Services Benefit Limit 8-1-21

A. There is no benefit limit for acute care/general and rehabilitative hospital inpatient services for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. Inpatient services must be approved by the QIO as medically necessary.

B. The benefit limit for acute care/general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged twenty-one (21) and older.

C. Included in the total of paid inpatient days are any days covered by primary third party resources (except Medicare and Railroad Retirement) for which Medicaid receives a secondary-payer claim that it adjudicates as paid. A Medicaid-secondary claim that adjudicates as a paid claim is counted toward the inpatient benefit limit.

1. Medicaid, when it is secondary to a third party resource other than Medicare or Railroad Retirement, covers only the difference between the primary resource's remittance and Medicaid's per diem or maximum allowable fee for Medicaid-covered services reimbursed by the primary resource.

2. Even when the Medicaid paid amount is $0.00 because the third party payment equals or exceeds Medicaid's per diem, the days thus paid are counted toward the benefit limit.

D. Extension of the 24-day inpatient benefit is available under the Medicaid Utilization Management Program (MUMP).

E. Inpatient stays that are prior authorized for heart, liver and lung transplants are not counted toward the 24-day inpatient benefit limit.

F. See Section 272.406 regarding special billing instructions for beneficiaries who turn age 21 during an inpatient hospital stay.

212.419 Swing Beds and Recuperative Care Beds 10-13-03

The Arkansas Medicaid Program does not cover swing-bed services or recuperative care days. Medicaid covers the Medicare coinsurance and deductible for both swing-bed and recuperative care services for dually eligible beneficiaries (Medicare/Medicaid).

212.500 Medicaid Utilization Management Program (MUMP) 8-1-21

A. DHS or its designated vendor determines covered lengths of stay in acute care/general and rehabilitative hospitals in Arkansas and states bordering Arkansas. **View or print DHS or designated vendor contact information to obtain MUMP information.** Determination are made in accordance with the guidelines of the MUMP.

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

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

212.501 Length of Stay Determination 8-1-21

A. The *Solucient Length of Stay by Diagnosis and Operation Data Files* is used to assist non-physician reviewers in determining appropriate Arkansas Medicaid Utilization Management Program (MUMP) lengths of stay.

B. Nurse-reviewers are not authorized to deny certification requests.

1. The nurse-reviewer refers to an in-house physician adviser when:

   a. The length of stay requested is beyond that indicated by the Solucient guide or

   b. A beneficiary's medical condition does not appear to meet the guidelines or

   c. It technically meets the guidelines, but in the nurse's judgment inpatient care may not be necessary.

2. The in-house physician adviser determines, based on his or her medical judgment, whether to approve, partially approve or deny the certification request.

212.502 Administrative Reconsiderations 6-1-25

Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

212.503 Paper Review After Administrative Reconsiderations: Special Cases 6-1-25

A. Infrequently, the following sequence of events may occur: An extension of days is denied or only partially approved and the determination is upheld on reconsideration; however, before the patient can be discharged, he or she becomes acutely ill and remains hospitalized for treatment of that illness.

B. In strict accordance with the regulation above in Section 212.502, the provider would be precluded from requesting certification of any of the inpatient days required for treatment of the late-appearing acute illness, because the case has already been reconsidered once.

C. However, if the beneficiary had not been hospitalized when he or she became acutely ill, Medicaid would have covered up to four (4) inpatient days without certification and the beneficiary's case would have been eligible for consideration for certification if the stay for treatment had been longer than four (4) days.

D. In order to give due consideration to cases of true medical necessity while avoiding repeated reviews of the same admission, the following procedure for reviewing cases of this nature has been established.

E. After the beneficiary's discharge, the provider may submit the medical record for the entire admission and indicate in writing the dates to be considered for certification.

1. Only the dates requested by the provider will be considered for possible authorization,
2. The review and determination procedure is the same as described in Section 212.501.

F. AFMC will not reconsider denials and partial denials of these requests; however, the beneficiary may appeal the decision or the provider may appeal on behalf of the beneficiary.

212.504 Appeals 6-1-25

When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal the decision and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

212.505 Continuation of Services Pending the Outcome of an Appeal 6-1-25

Refer to Section 161.500 of Section I of this Manual regarding the continuation of services pending the outcome of an appeal.

212.506 Reserved 6-1-25

212.507 Post Payment Review 6-1-06

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

212.510 MUMP Applicability 8-1-21

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer. The days are subject to retrospective review for medical necessity.

B. If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified.

C. When a patient is transferred from one hospital to another, the stay must be certified from the first day.

212.511 MUMP Exemptions 6-1-06

A. Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age 1, are subject to this policy. Medicaid beneficiaries under age 1 at the time of admission are exempt from MUMP requirements for dates of service before their first birthday.

1. When a Medicaid beneficiary reaches age 1 during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the MUMP.
2. The MUMP becomes effective on the one-year birthday.
    a. The patient's birthday is the first day of the four days not requiring MUMP certification.
    b. If the patient is not discharged before or during the fourth day following the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.

B. The MUMP does not apply to inpatient stays for bone marrow, liver, liver/bowel, heart, lung, skin and pancreas/kidney transplant procedures.

C. When there is primary coverage by a third party resource and the provider seeks secondary coverage by Medicaid, Medicaid covers the same number of inpatient days as the primary resource whether the number of covered days is less than, equal to or greater than four.

1. Therefore, MUMP certification is not required in this circumstance.
2. Medicaid processes the provider's claim in accordance with regulations governing third party liability.

212.520 MUMP Certification Request Procedure 8-1-21

When a patient is transferred from another hospital (see Section 212.530 below) or when a patient's attending physician determines the patient should not be discharged by the fifth day of hospitalization, hospital utilization review or case management personnel may request an extension of inpatient days. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting MUMP certification.**

A. Additional extensions may be requested as needed.

B. The Arkansas Medicaid Utilization Management Program (MUMP) certification process is separate from prior authorization requirements.

1. Prior authorization for medical procedures must be obtained by the appropriate providers.

2. Hospital stays for restricted procedures are disallowed when required prior authorizations are not obtained.

C. Except for the exemptions listed in Section 212.511, Medicaid does not cover fifth and subsequent days of inpatient hospital admissions unless they have been certified, in accordance with applicable procedures for concurrent or retroactive MUMP certification.

212.521 Non-Bordering State Admissions 6-1-06

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

212.530 Transfer Admissions 8-1-21

When a patient is transferred from one hospital to another, the receiving facility must contact DHS or designated contractor within twenty-four (24) hours of admission to certify the inpatient stay. **View or print contact information to obtain instructions for submitting the transfer request.**

212.540 Post Certification Due to Retroactive Eligibility 8-1-21

When eligibility is determined while the patient is still an inpatient, the hospital may request post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. **View or print contact information to obtain instructions for submitting the request.**

212.550 Third Party and Medicare Primary Claims 8-1-21

If a provider did not request MUMP certification of an inpatient stay because of apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted etc., post-certification required by the MUMP may be obtained. **View or print contact information to obtain instructions for submitting the request.**

213.000 Outpatient Hospital Services

213.100 Scope – Outpatient 10-13-03

"Outpatient hospital services" are preventive, diagnostic, therapeutic, rehabilitative or palliative services that:

A. Are furnished to outpatients and

B. Except in the case of nurse midwife services, are furnished by or under the direction of a physician or dentist.

213.200 Coverage 10-13-03

Medicaid covers medically necessary outpatient services typically available in hospitals.

For the purposes of reimbursement determination and benefit limitation, outpatient hospital services are divided into four types of service:

A. Emergency services

B. Non-emergency services

C. Therapy and treatment services

D. Outpatient surgical procedures

213.210 Emergency Services 10-13-03

Arkansas Medicaid complies with the requirements at Section 1932(b)(2)(B) and 1932(b)(2)(C) of the Social Security Act, in accordance with the interpretation of the Centers for Medicare and Medicaid Services.

A. Emergency services are inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, must be obtained at the most accessible hospital available and equipped to furnish those services.

B. Emergency services comprise the following non-physician facility accommodations and services.

1. Initial assessment to evaluate the patient's complaint or presenting condition.
    a. Assessment is included in the coverage of the basic emergency or non-emergency service.
    b. If, following assessment, the patient is discharged or leaves the facility without being treated for an emergent or non-emergent condition, only the assessment and related medically necessary diagnostic services are covered.
2. Treatment room and related non-physician services.
3. Outpatient hospital emergency supplies
4. Outpatient hospital emergency drugs and injections.

C. Emergency services do not require prior authorization.

D. Emergency services do not require a primary care physician (PCP) referral.

E. Emergency department services—whether emergency, non-emergency or assessment--that are provided before an inpatient admission, and which take place on the same calendar day as the inpatient admission, are covered as inpatient services.

F. Coverage of emergency outpatient surgical procedures includes the outpatient non-physician facility and ancillary services that would be covered separately if there were no surgery.

G. Lab, radiology and diagnostic machine tests performed in conjunction with facility emergency services or emergency surgery are covered separately from surgical and facility services.

H. Arkansas Medicaid requires special billing procedures for all emergency services. Providers not following correct billing procedures are at risk of delayed or non-payment for covered services and of preventing beneficiaries from receiving covered benefits.

213.220 Outpatient Surgical Procedures 10-13-03

A. Arkansas Medicaid covers medically necessary surgeries that have been approved as outpatient procedures.

B. Some surgeries have special medical necessity and informed consent requirements. Refer to the Contents section, under the name of the surgery, for specifics.

C. Some surgical procedures require prior authorization (PA). See the prior authorization section for PA request procedures.

213.230 Non-Emergency Services

213.231 Non-Emergency Services in Emergency Departments and Outpatient Clinic Services 6-1-08

A. Non-emergency services in the emergency department and outpatient hospital clinic services are not covered separately on the same date of service as an inpatient admission.

B. Coverage of outpatient surgeries and treatment/therapy services include the coverage of outpatient hospital clinic services (room) and basic non-emergency services (room) in the emergency department that occur on the same date of service.

C. See Sections 172.100 and 172.200 for exceptions to the PCP referral requirement.

213.232 Non-Emergency Services in the Emergency Department 10-13-03

The basic non-emergency outpatient facility service is provision of a treatment/examination room with non-physician staffing and routine disposable supplies.

A. Coverage of the basic non-emergency facility service is included in the coverage of outpatient surgery and most treatment/therapy services.

B. Diagnostic lab, X-ray and machine tests are covered separately from the basic non-emergency service.

C. Some services, such as observation bed or fetal monitoring, may be covered separately when provided in conjunction with the basic non-emergency service.

213.233 Non-Emergency Services in Outpatient Clinics 10-13-03

A. Hospitals that maintain part-time or full-time clinics that operate separately from the hospital's emergency department must designate a basic non-emergency outpatient service as an outpatient hospital clinic service when:

1. Some patients are instructed to go to the clinic instead of to the emergency department,
2. Patients arrive at the clinic by appointment or
3. Non-emergent patients presenting to the emergency department are:
   a. Referred directly to the clinic or
   b. They are assessed and referred to the clinic.

B. The basic non-emergency service in the outpatient hospital clinic is covered alone or in conjunction with:

1. Laboratory, X-ray and machine test procedures and
2. Observation bed or external fetal monitor.

C. Refer to special billing instructions that apply to non-emergency services in outpatient clinics.

213.240 Outpatient Hospital Treatment and Therapy Services 10-13-03

Covered outpatient hospital treatment and therapy services are:

A. Burn Therapy

B. Certain Injections

C. Chemotherapy Administration

D. Chemotherapy Agents

E. Factor VIIa

F. Factor 8 Products

G. Factor 9 Products

H. Hemodialysis

I. Occupational Therapy (including Occupational Therapy Evaluations)

J. Peritoneal Dialysis

K. Physical Therapy (including Physical Therapy Evaluations)

L. Radiation Therapy

M. Respiratory Therapy

N. Speech Therapy

213.241 Treatment and Therapy Coverage that Includes Emergency or Non-Emergency Facility Services 10-13-03

A. Coverage of the following treatment and therapy procedures includes coverage of the basic emergency *or* non-emergency services:

1. Burn Therapy
2. Hemodialysis
3. Peritoneal Dialysis
4. Occupational Therapy (including Occupational Therapy Evaluations)
5. Physical Therapy (including Physical Therapy Evaluations)
6. Speech Therapy (including Speech Therapy Evaluations)

B. Coverage of the following services includes the basic emergency services:

1. Injections
2. Chemotherapy Administration
3. Chemotherapy agents
4. Factor VIIa
5. Factor 8 Products
6. Factor 9 Products
7. Radiation Therapy
8. Respiratory Therapy

The basic non-emergency facility service (room charge) is covered separately when provided in conjunction with the services listed above in part B.

C. When a patient receives burn dressing changes and physical therapy, a copy of the attending physician's order reflecting the frequency of dressing changes and the mode(s)

of therapy to be administered must be maintained in the patient's chart and must be available upon request by any authorized representative of Arkansas Division of Medical Services.

D. Coverage of the following services includes the basic emergency service:

1. Certain Injections
2. Chemotherapy Administration
3. Chemotherapy Agents
4. Factor 8 Products
5. Factor 9 Products
6. Radiation Therapy
7. Respiratory Therapy

The basic non-emergency service (room charge) is covered separately when provided in conjunction with the services listed above in part D.

213.242 Burn Therapy 10-13-03

When a patient's treatment includes burn dressing changes and physical therapy, a copy of the attending physician's order reflecting the frequency of dressing changes and the mode(s) of therapy to be administered must be maintained in the patient's chart and must be available upon request by any authorized representative of Arkansas Division of Medical Services.

213.243 Dialysis 10-13-03

Medicaid covers peritoneal dialysis and hemodialysis in outpatient hospitals and ESRD facilities.

213.244 Occupational, Physical and Speech Therapy (Including Evaluations) 1-15-15

A. Occupational, physical and speech therapy services include, in addition to therapy evaluations, as follows:

1. **Occupational therapy:** Individual* and group* sessions by a licensed occupational therapist or an occupational therapy assistant.
2. **Physical therapy:** Individual* and group* sessions by a licensed physical therapist or a physical therapy assistant.
3. **Speech therapy:** Individual* and group* sessions by a licensed speech and language pathologist, or a speech and language pathology assistant.

B. Occupational, physical and speech therapy require a written prescription from the attending physician.

C. Occupational, physical and speech therapy require PCP referral.

D. When a patient receives burn dressing changes and physical therapy, a copy of the attending physician's order reflecting the frequency of dressing changes and the mode(s) of therapy to be administered must be maintained in the patient's chart and must be available upon request by any authorized representative of Arkansas Division of Medical Services.

Refer to the Occupational, Physical and Speech Therapy Services Provider Manual for policy and billing information related to all therapy services.

*See Glossary – Section IV – for definitions of “individual” and “group” as they relate to therapy services.

213.245 Augmentative Communication Device (ACD) Evaluations 10-13-03

Arkansas Medicaid covers ACD Evaluations for all ages. Primary Care Physician (PCP) referral is required. Prior authorization (PA) is required. See Section 240.000 for prior authorization procedures.

A. Requirements for the ACD Multidisciplinary Team

A multidisciplinary team must provide the ACD evaluation. A speech-language pathologist who has earned a Master’s Degree in speech-language pathology must lead the team. The individual is also required to have a Certification of Clinical Competence from the American Speech-Language and Hearing Association.

The team must also include an occupational therapist who has been fully licensed with the Arkansas State Medical Board. Both the speech-language pathologist and occupational therapist must have verifiable training and experience in the use and evaluation of ACD equipment. Their knowledge must include, but not be limited to, the use of the equipment, working capabilities, mounting and training requirements, warranties, and maintenance of the equipment.

A physical therapist may be added to the team if it is determined that there is a need for assistance in the evaluation as it relates to the positioning and seating in utilizing specific ACD equipment.

The team may also include regular and special educators, caregivers and parents. Vocational rehabilitation counselors may be included for beneficiaries of all ages.

B. Requirements for the ACD Evaluation

The team must use an interdisciplinary approach in the evaluation, incorporating the goals, objectives, skills and knowledge of various disciplines. The team must use at least three augmentative communication device systems, with written documentation of each usage included in the ACD assessment.

The evaluation report must also indicate the medical reason for the augmentative communication device. The report must give specific recommendations of the system and justification of why one system is more appropriate than another. The evaluation report must be submitted to the prosthetics provider who will request prior authorization for the augmentative communication device.

The speech-language pathologist must sign the ACD evaluation report.

213.300 Outpatient Assessment in the Emergency Department 10-13-03

A. The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that anyone presenting to a hospital emergency department be assessed to determine whether and how urgently they need treatment.

1. Evaluation of an emergency medical condition (as “emergency medical condition” is defined by Section 1932(b)(2)(C) of the Social Security Act) is a covered service under the Arkansas Medicaid Primary Care Case Management (“ConnectCare”) Program.
2. This evaluation service, known as “Outpatient Assessment in the Emergency Department”, is neither a State Plan service nor an emergency service.

B. The prudent layperson standard of the Balanced Budget Act of 1997 forbids Medicaid denial of a hospital's claim for outpatient assessment based on the discharge diagnosis.

1. The law establishes that a person who believes that he or she should seek medical attention at a hospital emergency department must be permitted to do so. Medicaid may not require the individual or the hospital to obtain prior approval for the visit and may not refuse coverage of the visit based on a non-emergent discharge diagnosis.
2. Arkansas Medicaid provides separate coverage of assessment in the emergency department when the assessment is the only service provided.
3. An assessment is covered only as a single service and only when the individual leaves the hospital without treatment.
4. Only the administrative fee for enrolling a Medicaid-eligible individual with a PCP, and medically necessary diagnostic procedures are covered in conjunction with outpatient assessment in the emergency department.

C. Most individuals that present to an emergency department are diagnosed whether or not they are subsequently treated, admitted, discharged or transferred. Of those diagnosed, most receive treatment or instruction regarding how to care for themselves, or they receive both treatment and instruction.

1. To the extent that some medical decisions and treatments are neither difficult nor time-consuming for a medical professional; assessment, diagnosis and treatment sometimes take place virtually simultaneously, with no testing, further examination or treatment needed.
2. In such a case, with no other diagnostic or treatment services provided, Medicaid makes no judgment whether the encounter should be called an assessment or an outpatient visit.
3. However, assessment is not treatment or therapy.
    a. Once treatment or therapy begins, the assessment by hospital staff is covered as a component of the complete hospital service—emergency, non-emergency or inpatient.
    b. Treatment and therapy are not covered in conjunction with assessment.

D. If a beneficiary is assessed in the emergency department, then sees a physician in the hospital's outpatient clinic or undergoes testing in the outpatient clinic, the outpatient assessment in the emergency department is covered as a component of the outpatient clinic service. Assessment is neither the primary service nor a separate service.

E. When a physician's assistance is required to complete an assessment, Arkansas Medicaid covers the professional services through the Physician Program. The physician's assessment is covered under the same definitions, restrictions and regulations as those listed above in parts A through D.

F. Assessment does not require a PCP referral; however, the individual being assessed must be enrolled with a PCP in order for the assessment to be covered.

1. If a Medicaid beneficiary is not already enrolled with a PCP when he or she presents to the outpatient department, hospital staff may enroll the individual via the Medicaid Voice Response System (VRS).
2. PCP enrollment on the same day as outpatient assessment in the emergency department permits coverage of the assessment without PCP referral.
3. Medicaid pays the hospital an additional PCP enrollment fee as well.

213.400 PCP Enrollment in the Hospital Outpatient Department 10-13-03

Medicaid covers emergency services only for beneficiaries with no PCP.

A. Staff at participating hospitals may facilitate beneficiaries' PCP selections.

1. A Medicaid beneficiary must complete a form DMS-2609, *Primary Care Physician Selection and Change Form*, in order to enroll with a PCP. **View or print form DMS-2609.**
2. Hospital personnel enter the PCP selection via the Voice Response System (VRS). **View or print VRS contact information.**
3. The enrollment is effective immediately and its effective date is the date of entry.
4. The hospital staff must forward a copy of the form DMS-2609 to the PCP entered on the VRS and give a copy to the enrollee.

B. Arkansas Medicaid reimburses hospitals (PCP Enrollment Fee—see Section 272.400 for special billing instructions) for the enrollment assistance.

213.500 Laboratory, Radiology and Machine Test Services 10-13-03

Laboratory and X-ray services are mandatory services in the Title XIX (Medicaid) Program. The Arkansas Title XIX State Plan describes the services thus covered as: "Other lab and X-ray services when ordered and provided by a physician or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent lab that meets requirements for participation in Title XVIII."

A. Laboratory, radiology and machine test procedures are covered in conjunction with each of the four categories of outpatient services listed in this manual.

B. Laboratory, radiology and machine test procedures are also covered in hospitals as reference services for non-patients. Refer to the special billing procedures that apply to reference diagnostic services for non-patients.

213.510 Telemedicine 8-1-18

See Section I for Telemedicine policy and Section III for Telemedicine billing protocol.

213.600 Observation Bed Status and Related Ancillary Services

213.610 Arkansas Medicaid Criteria Regarding Inpatient and Outpatient Status 10-13-03

Observation bed status is an outpatient designation. Coverage of hospital observation services is contingent upon medical service providers' following Arkansas Medicaid criteria regarding inpatient and outpatient status.

A. If a patient is expected to remain in the hospital for less than 24 consecutive hours, and this expectation is realized, the hospital and the physician should consider the patient an outpatient; i.e., the patient is an outpatient unless the physician has admitted him or her as an inpatient.

B. If the physician or hospital expects the patient to remain in the hospital for 24 hours or more, Medicaid deems the patient admitted at the time the patient's medical record indicates the existence of such an expectation, regardless of whether the physician has formally admitted the patient.

C. Medicaid also deems a patient admitted to inpatient status at the time the patient has remained in the hospital for 24 consecutive hours, even though the physician or hospital may have had no prior expectation of a stay of that or greater duration.

D. If a patient receives any outpatient services (including observation services) and is subsequently admitted to inpatient status on the same date of service, Medicaid's coverage of the inpatient service includes coverage of the outpatient services.

E. Medicaid covers observation to perform external fetal monitoring of a patient in suspected labor, if the hospital does not subsequently admit the patient to inpatient status on the same date of service as the initiation of external fetal monitoring.

213.611 Medical Necessity Requirements 10-13-03

A. Medicaid covers medically necessary services only.

1. The Quality Improvement Organization (QIO) denies coverage of inpatient admissions and subsequent inpatient services upon determination that inpatient care was not necessary.
2. Inpatient services are subject to QIO review for medical necessity whether the physician admitted the patient, or whether Medicaid deemed the patient admitted.

B. Whether a patient's condition is emergent or non-emergent, the attending physician must document the medical necessity of admitting a patient to observation.

C. All claims for hospital observation services, including observation for external fetal monitoring, are subject to post payment review to verify medical necessity.

213.612 Services Excluded from Observation Bed Status 10-13-03

A. Outpatient surgery and observation bed are not covered for the same patient on the same date of service.

1. Arkansas Medicaid has assigned each outpatient surgical procedure to one of four surgical groups.
2. Coverage of each surgical group includes coverage of supplies, equipment, staff time and recovery room time.

B. A blood transfusion and an observation bed are not covered for the same patient on the same date of service because Outpatient Surgical Group I includes blood transfusion procedures.

C. Observation for social reasons is not covered because Medicaid covers medically necessary services only.

215.000 Benefit Limitations for Outpatient Hospital Services

215.010 Benefit Limit for Emergency Services 10-13-03

Emergency services are subject to retrospective review by the QIO; therefore, no benefit limits are placed on emergency services. Special billing procedures are required in order for emergency claims to bypass the benefit limitation audits. See Section 272.400 for special billing instructions.

215.020 Benefit Limit for Non-Emergency Services 10-1-15

A. Non-emergency outpatient hospital services are:

1. Non-emergency outpatient hospital and related physician services and
2. Outpatient hospital treatment and therapy services and related physician services.

B. Beneficiaries age 21 and older are limited to a total of 12 non-emergency outpatient hospital visits per state fiscal year, July 1 through June 30.

1. The outpatient hospital benefit limit includes outpatient hospital services provided in an acute care/general hospital, a rehabilitative hospital or both.
2. Treatment and therapy services are included in the non-emergency outpatient hospital services limit of 12 visits per state fiscal year.
3. Services that Medicaid covers separately when furnished in conjunction with one another *and* that occur during the same outpatient encounter count against this benefit limit as only *one* non-emergency outpatient hospital service.

C. Requests for extension of this benefit are considered for patients who require supportive treatment for maintaining life.

D. Extension of this benefit is automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (**View ICD Codes**.)
2. HIV infection and AIDS (**View ICD Codes.**)
3. Renal failure (**View ICD Codes.**)
4. Pregnancy (**View ICD Codes.**)

E. Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit-limited, except with respect to the services listed in Section 215.021.

*OB ultrasounds and fetal non stress tests are not exempt from Extension of Benefits. See Section 215.041 for additional coverage information.

215.021 Benefit Limit for Occupational, Physical, and Speech-Language Therapies For Beneficiaries 21 Years of Age and Older 1-1-21

A. Occupational, physical, and speech-language therapies are subject to the benefit limit of 12 outpatient hospital visits per state fiscal year (SFY), as explained in Section 215.020, for beneficiaries age 21 and over.

1. Outpatient therapy services furnished by acute care hospitals and rehabilitative hospitals are combined when tallying utilization of this benefit.
2. This limit does not apply to eligible Medicaid beneficiaries under the age of 21.
3. Outpatient occupational, physical, and speech-language therapy services for beneficiaries over age 21 require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements; if exempt from PCP, a referral from their attending physician is required.

B. For range of benefits, see the following procedure codes: **View or print the procedure codes for therapy services.**

C. All requests for benefit extensions for therapy services for beneficiaries over age 21 must comply with Sections 215.100 through 215.110.

215.030 Benefit Limit for Outpatient Assessment in the Emergency Department 10-13-03

Outpatient assessment in the emergency department is included in the benefit limit for non-emergency outpatient hospital services. See Section 215.020 for detailed information.

215.040 Benefit Limit in Outpatient Diagnostic Laboratory and Radiology/Other Procedures 7-1-22

A. Arkansas Medicaid limits claims payment for outpatient diagnostic laboratory services and radiology/other services per beneficiary twenty-one (21) years of age or older.

1. The benefit limits are based on the State Fiscal Year (SFY: July 1 through June 30).
2. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per SFY, and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
3. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
4. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

   View or print the essential health benefit procedure codes.

B. The benefit limits apply to claims payments made to the following providers, individually or in any combination: outpatient hospitals, independent laboratories, physicians, osteopaths, podiatrists, Certified Nurse-Midwives (CNMs), Nurse Practitioners (NP), and Ambulatory Surgical Centers (ASCs).

C. Requests for extensions of both benefits are considered for beneficiaries who require supportive treatment for maintaining life.

D. Extension of these benefits are automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (**View ICD Codes**);
2. HIV infection and AIDS (**View ICD Codes**);
3. Renal failure (**View ICD Codes**);
4. Pregnancy* (**View ICD Codes**): or
5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes**) Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD (**View Laboratory and Screening Codes**).

E. *Obstetric (OB) ultrasounds and fetal non stress tests have benefit limits that are not exempt from Extension of Benefits request requirements. (See Section 215.041 for additional coverage information.)

F. Magnetic Resonance Imaging (MRI) is exempt from the five-hundred-dollar radiology/other services benefit limit. Medical necessity for each MRI must be documented in the beneficiary's medical record. (Refer to Section 270.000 for billing information.)

G. Cardiac catheterization procedures are exempt from the five-hundred-dollar outpatient diagnostic laboratory services benefit limit and the five-hundred-dollar radiology/other benefit limit. Medical necessity for each procedure must be documented in the beneficiaries' medical record.

H. There are no benefit limits on outpatient diagnostic laboratory services or radiology/other services for beneficiaries under twenty-one (21) in the Child Health Services/Early and

Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

*OB ultrasounds and fetal non stress tests are not exempt from Extension of Benefits. See Section 215.041 for additional coverage information.

215.041 Benefit Limits for Fetal Non-Stress Test and Fetal Ultrasound 10-13-03

A. Fetal echography (ultrasound) is limited to two (2) per pregnancy.

B. Fetal non-stress test is limited to two (2) per pregnancy.

C. Extension of benefits for these procedures will be considered for reasons of medical necessity.

215.100 Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests to extend benefits for outpatient hospital visits and diagnostic laboratory or X-ray services, including those for fetal ultrasounds and fetal non-stress tests, must be submitted to DHS or its designated vendor.

View or print contact information to obtain instructions for submitting the benefit extension request.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

C. Submit a copy of the Medical Assistance Remittance and Status Report that reflects the claim's denial for exhausted benefits with the request. Do not send a claim.

D. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

E. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.101 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services, Form DMS-671 7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services," form (Form DMS-671). **View or print Form DMS-671.**

C. The date of the request and the signature of the provider's authorized representative are required on the form. Stamped or electronic signatures are accepted.

D. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extensions for more than four (4) procedures, use a separate form for each set of procedures.

E. Enter a valid ICD diagnosis code and a brief narrative description of the diagnosis.

F. Enter a valid revenue code or procedure code (and modifiers when applicable) and a brief narrative description of the procedure.

G. Enter the number of units of service requested under the extension.

215.102 Documentation Requirements 2-1-05

Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests.

A. Clinical records must:

1. Be legible and include records supporting the specific request
2. Be signed by the performing provider
3. Include clinical, outpatient and/or emergency room records for dates of service in chronological order
4. Include related diabetic and blood pressure flow sheets
5. Include current medication list for date of service
6. Include obstetrical record related to current pregnancy when applicable
7. Include clinical indication for laboratory and X-ray services ordered with a copy of orders for laboratory and X-ray services signed by the physician

B. Laboratory and radiology reports must include:

1. Clinical indication for laboratory and X-ray services ordered
2. Signed orders for laboratory and radiology services
3. Results signed by the performing provider
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable

215.103 Provider Notification of Benefit Extension Determinations 8-1-21

Approvals or denials of a benefit extension request—or ask for additional information—shall be made within thirty (30) calendar days.

A. Provider notification of benefit extension approval includes:

1. The procedure code approved,
2. The total number of units approved for the procedure code,
3. The benefit extension control number and
4. The approved beginning and ending dates of service.

B. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied.

215.104 Reserved 6-1-25

215.110 Reserved 6-1-25

215.200 Exclusions – Outpatient 10-13-03

The following are not covered as outpatient hospital services:

A. Take-home drugs and supplies

B. Durable medical equipment

C. Non-payable and non-authorized procedures

D. Procedures that require prior authorization that has not been requested or that was requested but not granted.

215.300 Non-Covered Services 11-1-23

Medicaid does not cover services that are cosmetic, not medically necessary or that are not generally accepted by the medical profession. Medicaid does not cover services that are not documented by diagnoses that certify medical necessity. Arkansas Medicaid has identified some ICD diagnosis codes that do not certify medical necessity. See Sections 272.460 and 272.470 for diagnosis codes that are not covered by Arkansas Medicaid.

215.301 Routine Standard of Care Associated with Qualifying Clinical Trials 11-1-23

Effective for items and services furnished on or after 01/01/2022, Medicaid covers the routine costs of qualifying clinical trials, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials.

In and out of state providers must submit the **Medicaid attestation form** for all members participating in a clinical trial to the Utilization Review Section of the Division of Medical Services. (Contact Information is listed on the **Medicaid attestation form**.

All other Medicaid rules apply.

Routine costs of a clinical trial are defined as:

Items and services that are otherwise generally available to Medicaid clients (i.e., there exists a benefit category, it is not statutorily excluded, and there is not a national non-coverage decision) that are provided in either the experimental or the control arms of a clinical trial except:

A. The investigational item or service, itself unless otherwise covered outside of the clinical trial;

B. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); and

C. Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

Routine costs in clinical trials include:

A. Items or services that are typically provided absent a clinical trial (e.g., conventional care);

B. Items or services required solely for the provision of the investigational item or service (e.g., administration of a noncovered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

C. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, for the diagnosis or treatment of complications.

215.400 Critical Access Hospitals (CAH) Coverage

215.410 CAH Scope of Coverage 10-13-03

Arkansas Medicaid covers medically necessary inpatient and outpatient hospital services that are permitted under the Critical Access Hospitals' licensures, to the extent that the same services are covered under the Arkansas Medicaid Hospital Program.

215.420 CAH Coverage Restrictions 8-1-21

A. Arkansas Department of Health regulations stipulate that Critical Access Hospitals (CAH) may provide medically necessary acute inpatient care for a period not to exceed ninety-six (96) hours, unless:

1. A longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions or
2. A peer review organization or equivalent entity, upon request, waives the ninety-six (96) hour restriction on a case-by-case basis.

B. DHS or its designated vendor shall determine and certify lengths of stay in the Medicaid Utilization Management Program (MUMP). **View or print contact information to obtain the DHS or designated vendor regarding coverage restrictions.**

1. CAHs shall follow MUMP procedures to certify stays longer than four (4) days.
2. CAHs receiving inpatients by transfer from a hospital or another CAH must obtain certification of inpatient stays of any length.
3. In addition to MUMP criteria of medical necessity, DHS or its designated vendor will, when applicable, review a CAH's justification for retaining a patient instead of transferring the patient to a hospital.
    a. Inpatient stays of any length may be retrospectively reviewed for medical necessity.
    b. Inpatient stays of any length may be retrospectively reviewed to ascertain justification for retaining a patient instead of transferring the patient to a hospital.

C. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the 96-hour inpatient stay limitation and the MUMP policy for dates of service before their first birthday.

D. A CAH may provide medically necessary acute inpatient care for a period that does not exceed, as determined on an annual average basis, ninety-six (96) hours per patient.

1. Discharges and average stays are identified and calculated by the Medicare fiscal intermediary and are the same as those used for Medicare purposes.

2. The CAH's average lengths of stay will be reported to the CMS regional office by the Medicare fiscal intermediary.

a. If a CAH exceeds the average length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS regional office.

b. If the CAH fails to implement the corrective action plan, the CAH will be subject to termination of its Medicaid provider agreement and other sanctions established under Title XVIII of the Social Security Act.

215.430 CAH Exclusions 10-13-03

A. Services excluded from coverage in the Arkansas Medicaid Hospital Program are also excluded from the Arkansas Medicaid Critical Access Hospital Program, unless stated otherwise in official Program documentation or correspondence.

B. Medicaid does not cover nursing facility beds ("swing-beds") in hospitals or in CAHs.

215.440 CAH Benefit Limits 7-1-22

Inpatient stays, non-emergency outpatient visits, diagnostic laboratory, and radiology/other services in Critical Access Hospitals (CAHs) are subject to the same benefit limits that apply to facilities enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program.

Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Benefit-limited services that are received in CAHs are counted with benefit-limited services received in hospitals enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program to calculate a Medicaid-eligible individual's benefit status.

216.000 Family Planning 1-1-24

States participating in the Medicaid Program are required to cover family planning services. Arkansas Medicaid covers family planning services in a variety of settings, including hospitals. See Sections 216.100-216.110, 216.130-216.132, 216.515 and 216.540-216.550 for Family Planning Information.

Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

A. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).

B. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an

inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.

C. Physician charges can be billed for insertion and removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. **See LARC billing combinations for billing codes**.

D. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

216.100 Outpatient Hospital's Role in Family Planning Services 1-1-23

A. Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services.

1. Medicaid clients' family planning services are in addition to their other medical benefits.
2. Family planning services do not require a PCP referral. PCPs electing not to provide some or all family planning services can use the information in this manual to counsel their Medicaid-eligible patients and help them locate family planning services.
   a. Refer to Section 216.110 of this manual for family planning services benefit limitations.
   b. Refer to Section 216.130 of this manual for service descriptions and coverage information.
   c. Refer to Sections 216.515, and 216.540 through 216.550 of this manual for family planning services, billing instructions, and procedure codes.

B Arkansas Medicaid covers family planning services for women in some limited aid categories. Refer to Sections 216.500 through 216.510 for more information on coverage of family planning services for these eligibility categories.

216.120 Reserved 1-15-15

216.130 Family Planning Coverage Information 1-15-15

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, clinics and hospitals for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Hospitals desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 to Medicaid beneficiaries of childbearing age.

C. Hospitals preferring not to provide family planning services may share with their patients other sources for these services. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists

3. Nurse practitioners
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics

D. Complete billing instructions for family planning services are in Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 of this manual

216.131 Basic Family Planning Visit 1-15-15

Medicaid covers one basic family planning visit per beneficiary per Arkansas state fiscal year (July 1 through June 30). The basic family planning visit comprises the following:

A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight and blood pressure.

B. Counseling and education regarding:

1. Breast self-exam
2. The full range of contraceptive methods available
3. HIV/STD prevention

C. Prescription for any contraceptives selected by the patient.

D. Laboratory services, including, as necessary:

1. Pregnancy test
2. Urinalysis testing for albumin and glucose
3. Hemoglobin and Hematocrit
4. Papanicolaou smear for cervical cancer
5. Sickle cell screening
6. Testing for sexually transmitted diseases

216.132 Periodic Family Planning Visit 1-15-15

Medicaid covers three periodic family planning visits per beneficiary per state fiscal year (July 1 through June 30).

A. The periodic visit includes:

1. Follow-up medical history
2. Weight
3. Blood pressure
4. Counseling regarding contraceptives and possible complications of contraceptives.

The purpose of periodic visits is to evaluate the patient's contraceptive program, renew or change the contraceptive prescription and to provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

216.200 Reserved 1-15-15

216.300 Hysteroscopy for Foreign Body Removal 2-1-22

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Procedure code requires paper billing and clinical documentation for justification.

216.310 Reserved 1-15-15

216.400 Reserved 1-15-15

216.410 Reserved 1-15-15

216.500 Reserved 10-1-15

216.510 Family Planning Services for Women in Aid Category 61 (PW) 1-1-23

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered family planning services.

Clients in Aid Category 61, Pregnant Women (PW) are eligible for family planning services through the last day of the month in which the 60th day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

See Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 for family planning services, billing, and coverage restrictions.

216.513 Contraception 12-1-21

A. Prescription and Non-Prescription Contraceptives

1. Medicaid covers birth control pills and other prescription contraceptives as a family planning prescription benefit.
2. Medicaid covers non-prescription contraceptives as a family planning benefit when a physician writes a prescription for them.

B Contraceptive Implant Systems

1. Medicaid covers the contraceptive implant systems, including implants and supplies. However, the Arkansas Medicaid family planning Aid Category 69 (FP-W) does not cover this device. However, Medicaid covers the removal of this device.
2. Medicaid covers insertion, removal and removal with reinsertion.

C. Intrauterine Device (IUD)

1. Medicaid pays for IUDs as a family planning benefit.
2. Alternatively, Medicaid reimburses hospitals that supply the IUD at the time of insertion.
3. Medicaid pays hospitals for IUD insertion and removal.
4. Outpatient Global Surgery rules apply. See Section 272.160.

D. Medroxyprogesterone Acetate

Medicaid covers medroxyprogesterone acetate injections for birth control.

E. Sterilization

1. All adult (21 or older) male or female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures as long as they remain Medicaid-eligible.
2. Medicaid covers Occlusion by Placement of Permanent Implants. Coverage includes the procedure, the implant device and follow-up procedures as specified in Section 216.515.
3. Refer to Section 216.514 of this manual for Medicaid policy regarding sterilization.
4. Refer to Sections 216.100, 216.130-216.132, 216.510-216.515, and 216.540-216.550 of this manual for family planning procedure codes and billing instructions for family planning services.

216.514 Sterilization 1-15-15

A. Non-therapeutic sterilization means any procedure or operation for which the primary purpose is to render an individual permanently incapable of reproducing. Non-therapeutic sterilization is neither (1) a necessary part of the treatment of an existing illness or injury nor (2) medically indicated as an accompaniment of an operation of the female genitourinary tract. The reason the individual decides to take permanent and irreversible action is irrelevant. It may be for social, economic or psychological reasons or because a pregnancy would be inadvisable for medical reasons.

1. Prior authorization is not required for a sterilization procedure. However, all applicable criteria described in this manual must be met.

B. Federal regulations are very explicit concerning coverage of non-therapeutic sterilization. Therefore, Medicaid reimbursement will be made only when the following conditions are met:

1. The person on whom the sterilization procedure is to be performed voluntarily requests such services.
2. The person is mentally and legally competent to give informed consent.
3. The person is 21 years of age or older at the time informed consent is obtained.
4. The person to be sterilized shall not be an institutionalized individual. The regulations define “institutionalized individual” as a person who is:
   a. involuntarily confined or detained, under a civil or criminal statute in a correctional or rehabilitative facility including those for a mental illness,

      or

   b. confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

   If you have any questions regarding this requirement, contact the Arkansas Medicaid Program **before** the sterilization.
5. The person has been counseled, both orally and in writing, concerning the effect and impact of sterilization and alternative methods of birth control.
6. Informed consent and counseling must be properly documented. Only the official Form DMS-615 – Sterilization Consent Form, properly completed, complies with documentation requirements. **View or print form DMS-615 (English) and the checklist.** **View or print form DMS-615 (Spanish) and the checklist.** If the patient needs the Sterilization Consent Form (DMS-615) in an alternative format, such as large print, contact the Americans with Disabilities Act Coordinator. **View or print the Americans with Disabilities Act Coordinator contact information.**
   a. By signing the consent form, the patient certifies that she or he understands the entire process. By signing the consent form, the person obtaining consent and the physician certify that, to the best of their knowledge, the patient is mentally

competent to give informed consent. If any questions concerning this requirement exist, you should contact the Arkansas Medicaid Program for clarification BEFORE the sterilization procedure is performed.

b. The person obtaining the consent for sterilization must sign and date the form after the beneficiary and interpreter, if one is used. This may be done immediately after the beneficiary's and interpreter's signatures or it may be done at some later time, but always before the sterilization procedure. The signature will attest to the fact that all elements of informed consent were given and understood and that consent was voluntarily given.

c. A copy of the consent form given to the beneficiary of a sterilization procedure must be an identical copy of the one he or she signed and dated and must reflect the signature of the person obtaining the consent.

d. By signing the physician's statement on the consent form, the physician is certifying that shortly before the sterilization was performed, he again counseled the patient concerning the sterilization procedure. In keeping with federal interpretation of federal requirements, Arkansas Medicaid has defined "shortly before" as one week (seven days) prior to the performance of the sterilization procedure.

The physician's signature on the consent form must be an <u>original</u> signature and not a rubber stamp.

7. Informed consent may not be obtained while the person to be sterilized is:

a. In labor or during childbirth,

b. Seeking to obtain or obtaining an abortion, or

c. Under the influence of alcohol or other substances that affect the individual's state of awareness.

8. The sterilization must be performed at least 30 days, but not more than 180 days, after the date of informed consent. The following are exceptions to the 30-day waiting period:

a. In the case of premature delivery, provided at least 72 hours have passed between giving the informed consent and performance of the sterilization procedure and counseling and informed consent was given at least 30 days before the expected date of delivery and

b. In the case of emergency abdominal surgery, provided at least 72 hours have passed between giving of informed consent and the performance of the sterilization procedure.

NOTE: Either of these exceptions to the 30-day waiting period must be properly documented on the DMS-615.

9. The person is informed, prior to any sterilization discussion or counseling, that no benefits or rights will be lost as a result of refusal to be sterilized and that sterilization is an entirely voluntary matter. This should be explained again just prior to the performance of the sterilization.

10. If the person is physically disabled and signs the consent form with an "X," two witnesses must also sign and include a statement regarding the reason the patient signed with an "X," such as stroke, paralysis, legally blind, etc. If a claim is received which does not have the statement attached, the claim will be denied.

C. A copy of the properly completed Sterilization Consent Form DMS-615, with all items legible, must be attached to each claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists and assistant surgeons. **It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist and assistant surgeon.**

Though prior authorization is not required, an improperly completed Sterilization Consent Form DMS-615 results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met.

View or print form DMS-615 (English) and the checklist. **View or print form DMS-615 (Spanish) and the checklist.**

216.515 Coverage and Billing Protocols for Procedures Related to 58565 10-1-15

Family planning services are covered for beneficiaries in full coverage for Aid Category 61(PW-PL). The primary detail diagnosis on the claim must be a family planning diagnosis. Billing protocols have been changed to allow providers to bill and to be reimbursed for the portion of service that they provide when this method of sterilization is chosen. Billing may be for the procedure, provision of the device or both.

A. Billing Protocol for **58565**

All providers are to separate their charges when billing for:

1. **Performance of the "procedure"** for: "Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants – PROCEDURE ONLY" (**CPT procedure code 58565**). This service includes all supplies except provision of the device. Claims must be billed on paper with a correct DMS-615 form attached. **View or print form DMS-615 (English) and the checklist.** **View or print form DMS-615 (Spanish) and the checklist.**
2. **Provision of the implant "device"** for: "Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants – DEVICE ONLY". Claims may be billed electronically or on paper.

   NOTE: Payment of the claim for the "device" will not be made without a paid or pending 58565 "procedure" claim.

B. Procedures Relating to **58565** "Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants"

Performance of the "procedure" for: "Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants – PROCEDURE ONLY" (**CPT procedure code 58565**). This service includes all supplies except provision of the device. Claims must be billed on paper with a correct DMS-615 attached. **View or print form DMS-615 (English) and the checklist.** **View or print form DMS-615 (Spanish) and the checklist.**

To file claims for facility services, the primary detail diagnosis for each procedure **must** be a family planning diagnosis code.

C. **Outpatient hospitals** may bill for the Essure procedure and device following the protocol below:

Procedure Code	Modifier	Description
58565	U3	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants—PROCEDURE ONLY
58565	U1	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants—DEVICE ONLY

D. **Hospital-based outpatient clinics** may bill for the Essure procedure and provision of the device as shown below.

Procedure Code	Modifier	Description
58565	U3	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants—PROCEDURE ONLY
58565	U2	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants—DEVICE ONLY

E. Procedure codes **58340**, **58345**, **72190**, **74740** and **74742** are payable as **family planning services** only when provided within six months of the **58565 "procedure"** date of service. For the post-**58565 "procedure" services** limit, 6 months is 180 days, with the count beginning the day after the procedure.

NOTE: Payment of any of these procedure codes requires that 58565 is already a paid or pending claim.

1. The following instructions apply when procedures **58340** and **58345** are performed in an outpatient clinic associated with a hospital:
2. Facility claims for **58340, 58345** and **72190** require a primary diagnosis of family planning whether billing electronically or on paper.

F. Procedure codes **J1050, 11976** and **58301** are currently payable family planning services. These procedures are covered up to six months, as necessary for follow-up services to procedure **58565.** When provided for post-**58565** follow-up care, billing protocol for **J1050**, **11976** and **58301** is unchanged for all providers.

G. All facility visits related to post-**58565** services during the six months following the procedure are included in the allowable fee for the **58565** "procedure".

All facility fees for services for **J1050**, **11976** and **58301** are bundled under **58565** if provided on the same date of service as **58565**.

216.520 Reserved 1-15-15

216.530 Reserved 1-15-15

216.540 Family Planning Procedures 2-1-22

The following procedure code table lists family planning procedures payable to hospitals. These codes require a primary diagnosis of family planning on the claim.

Sterilization procedures require paper billing with DMS-615 attached. View or print form DMS-615. View or print form DMS-615 Spanish.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

*CPT code represents a procedure to treat medical conditions as well as for elective sterilizations.

Family planning laboratory codes are found in Section 216.550.

216.550 Family Planning Lab Procedures 2-1-22

Family planning services are covered for beneficiaries in full coverage for Aid Category 61 (PW-PI). For additional information on Family Planning Services, see Sections 216.100-216.110, 216.130-216.132, 216.515, and 216.540-216.550.

Collection fees for laboratory procedures are included in the reimbursement for the laboratory procedure.

The following procedure codes table lists payable family planning laboratory procedure codes that require a primary diagnosis of Family Planning on the claim form:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.*Procedure codes are limited to one unit per beneficiary per state fiscal year.

217.000 Coverage Limitations

217.010 Abortions 10-13-03

Prior authorization is required for all abortions. See Section 241.000 of this manual for instructions for obtaining prior authorization. Only medically necessary abortions are authorized. Federal regulations prohibit expenditures for abortions except when the life of the mother would be endangered if the fetus were carried to term or if a pregnancy is the result of rape or incest as certified in writing by the woman's attending physician.

217.011 Abortions When the Life of the Mother Would Be Endangered if the Fetus Were Carried to Term 10-13-03

Providers submitting claims to Medicaid for an abortion procedure when the life of the mother would be endangered if the fetus were carried to term must attach the following information to the claim:

A. A completed Form DMS-2698 (Certification Statement for Abortion). The DMS-2698 form must include the name and address of the patient and must be dated prior to the date of the surgery. View or print form DMS-2698.

B. The patient may sign the Certification Statement for Abortion (DMS-2698) for herself at eighteen (18) years of age or older. If a guardian signs the Certification Statement for Abortion (DMS-2698), the guardian must furnish a copy of the order appointing him or her guardian, or furnish the letters of guardianship issued by the court clerk.

C. Patient history and physical examination records.

D. Discharge summary, when requesting post-procedural authorization.

The physician performing the abortion is responsible for providing the required documentation to other providers (e.g., hospital, anesthetist, etc.) for billing purposes.

217.012 Abortion for Pregnancy Resulting From Rape or Incest 10-13-03

The following procedures must be utilized for abortions in the case of rape or incest:

A. The woman's physician must complete the certification form (DMS-2698) certifying that the pregnancy resulted from forcibly compelled sexual intercourse or incest as defined under Ark. § Code Ann. 5-14-103 and § 5-22-202. **View or print form DMS-2698.**

1. The DMS-2698 form must include the name and address of the patient and must be dated prior to the date of the surgery.
2. The patient may sign the Certification Statement for Abortion (DMS-2698) for herself at eighteen (18) years of age or older.
3. If a guardian signs the Certification Statement for Abortion (DMS-2698), the guardian must furnish a copy of the order appointing him or her guardian, or furnish the letters of guardianship issued by the court clerk.

B. The physician must contact the Department of Human Services (DHS), Division of Medical Services (DMS), Administrator, Utilization Review, for prior authorization of the abortion procedure. **View or print Utilization Review contact information.**

C. DHS, DMS, conveys its decision to the physician within 24 hours or, if necessary, requests more information for the physician's review that is required when reviewers deny authorization or need a physician's expertise.

D. The provider submits the claim and required documentation for payment (see Section 217.011) to the Department of Human Services, Division of Medical Services, Attention Administrator, Utilization Review. If the documentation is complete with the claim, the DMS Utilization Review nurse will approve the claim for processing. Processing includes determination of Medicaid eligibility and third party availability.

E. DHS, DMS, notifies the third party source of prior authorization of the procedure.

F. A Health Insurance Portability and Accountability Act (HIPAA) Explanation of Benefits (HEOB) Message will be returned on the provider's remittance advice, stating that the abortion procedure is covered by a standing third party source. The message includes instruction to seek reimbursement from the third party source.

G. The third party source will provide payment to the provider. Payment will be in accordance with 42 USCA 433.139.

If the patient needs the Certification Statement for Abortion (Form DMS-2698) in an alternative format, such as large print, contact our Americans with Disabilities Act Coordinator. **View or print the Americans with Disabilities Act Coordinator contact information.**

217.020 Cosmetic Surgery 10-13-03

Cosmetic surgery is NOT generally covered under the Medicaid program except in the following areas and then only after prior authorization has been obtained. (See Section 241.000 of this manual for instructions for obtaining prior authorization.) This provision applies to all surgery.

A. Reduction mammoplasty. Reduction mammoplasty is a covered service under the Medicaid program.

B. Otoplasty (lop ears). Surgical correction of lop ears and similar congenital abnormalities is covered when performed on children prior to the 21st birthday. Criteria used in the evaluation of such procedures will include the attending physician's statement regarding the degree to which such conditions are detrimental to the patient's psychological well-being.

C. Rhinoplasty. Surgical correction involving rhinoplasty procedures is covered when performed on children prior to the 21st birthday. Criteria used in the evaluation of such procedures will include the attending physician's statement regarding the degree to which such conditions are detrimental to the patient's physical and functional abilities.

217.030 Dental Treatment 10-13-03

Inpatient and outpatient hospitalization for dental treatment are covered with prior authorization when the patient's age, medical or mental problems, or extensiveness of treatment necessitates hospitalization. Consideration is given in cases of traumatic accidents and extenuating circumstances. Whenever feasible, dentists are encouraged to use outpatient hospitalization for dental surgery. It is the dentist's responsibility to request the prior authorization and to provide the hospital with a copy of the authorization. When the hospital files a claim requiring prior authorization, the Prior Authorization Control Number must be entered on the claim.

217.040 Bariatric Surgery for Treatment of Morbid Obesity 11-1-09

Bariatric surgery for morbid obesity is payable under the Medicaid Program with prior authorization. (See Section 241.000 of this manual for instructions on obtaining prior authorization.)

Morbid obesity is defined as a condition in which the presence of excess weight causes physical trauma; pulmonary and circulatory insufficiencies and complications related to treatment of other medical conditions.

Requirements for Bariatric Surgery

A. The beneficiary must be between 18 and 65 years of age.

B. The beneficiary has a documented body-mass index >35 and has at least one co-morbidity related to obesity.

C. The beneficiary must be free of endocrine disease as supported by an endocrine study consisting of a T3, T4, blood sugar and a 17-Keto Steroid or Plasma Cortisol.

D. Under the supervision of a physician, the beneficiary has made at least one documented attempt to lose weight in the past. The medically supervised weight loss attempt(s) as defined above must have been at least six months in duration.

E. Medical and psychiatric contraindications to the surgical procedure have been ruled out (and referrals made as necessary)

1. A complete history and physical, documenting the beneficiaries:
   a. Height, Weight, and BMI;
   b. The exclusion or diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome
2. A psychiatric evaluation no more than three months prior to requesting authorization. The evaluation should address the following:
   a. Ability to provide, without coercion, informed consent;
   b. Family and social support;
   c. Patient ability to comply with the postoperative care plan and identify potential psychiatric contraindications.

Note: Documentation that female beneficiaries have received counseling regarding potential birth defects from nutritional deficiencies if they should become pregnant during the weight stabilization period following bariatric surgery.

Documentation all beneficiaries have been informed of possible adverse events related to the surgery.

Covered Procedures:

- Open and laparoscopic Roux-en-Y gastric bypass (RYGBP)
- Open and laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS)
- Laparoscopic Adjustable gastric banding(LAGB)
- Vertical banded gastroplasty
- Gastric Bypass

Non-Covered Procedures:

- Open adjustable gastric banding
- Open and laparoscopic sleeve gastrectomy

217.050 Hysterectomies 5-17-10

All hysterectomies, except those performed for malignant neoplasm, carcinoma in-situ and severe dysplasia will require prior authorization regardless of the age of the beneficiary. (See Sections 240.000-244.000 of this manual for instructions for obtaining prior authorization.) Those hysterectomies performed for carcinoma in-situ or severe dysplasia must be confirmed by a tissue report. The tissue report must be obtained prior to surgery. Cytology reports alone will not confirm the above diagnoses, nor will cytology reports be considered sufficient documentation for performing a hysterectomy. Mild or moderate dysplasia is not included in the above, and any hysterectomy performed for mild or moderate dysplasia requires prior authorization.

A. Informed Consent

Any Medicaid beneficiary who is to receive a hysterectomy, regardless of the diagnosis or the age of the patient, must be informed both orally and in writing that the hysterectomy will render the patient permanently incapable of reproduction. The patient or her representative may receive this information from the individual who secures the usual authorization for the hysterectomy procedure.

The patient or her representative, if any, must sign and date the Acknowledgement of Hysterectomy Information (Form DMS-2606) not more than 180 days prior to the hysterectomy procedure being performed.

If the person is physically disabled and signs the consent form with an “X,” two witnesses must also sign and include a statement regarding the reason the patient signed with an “X,” such as stroke, paralysis, legally blind, etc.

For hysterectomies for the mentally incompetent, the acknowledgement of sterilization statement is required. A guardian must petition the court for permission to sign for the patient giving consent for the procedure to be performed. A copy of the court petition and the acknowledgement statement must be attached to the claim.

The acknowledgement statement must be submitted with the claim for payment. The acknowledgement statement must be signed by the patient or her representative. The Medicaid agency will not approve payment for any hysterectomy until the acknowledgement statement has been received.

Copies for DMS-2606 can be ordered from the Arkansas Medicaid fiscal agent according to the procedures in Section III or printed. **View or print form DMS-2606 and instructions for completion.**

If the patient needs the Acknowledgement of Hysterectomy Information (Form DMS-2606) in an alternative format, such as large print, contact Americans with Disabilities Act Coordinator. **View or print the Americans with Disabilities Act Coordinator contact information.**

B. Random Audits of Hysterectomies

All hysterectomies paid for by federal and state funds will be subject to random selection for post-payment review. At the time of such review, the medical records must document the medical necessity of hysterectomies performed for carcinoma in-situ and severe dysplasia and must contain tissue reports confirming the diagnosis. The tissue must have been obtained prior to surgery.

The medical record of those hysterectomies performed for malignant neoplasms must contain a tissue report confirming such diagnosis. However, the tissue may be obtained during surgery, i.e., frozen sections. Any medical record found on post-payment review which does not contain a tissue report confirming the diagnosis or any medical record found which does not document the medical necessity of performing such surgery will result in recovery of payments made for that surgery.

C. Hysterectomies Performed for Sterilization

Medicaid will not pay for any hysterectomy performed for the sole purpose of sterilization.

217.060 Transplants 8-1-21

A. All transplants require prior approval.

B. Medicaid covers the following transplants for beneficiaries of all ages: bone marrow, corneal, heart, kidney, liver and lung.

C. Medicaid covers the following transplants for beneficiaries under the age of twenty-one (21) who are participating in the Child Health Services (EPSDT) Program: liver/bowel, pancreas/kidney and skin transplants for burns.

D. Inpatient hospital stays for corneal, kidney, pancreas/kidney and skin transplants are subject to Medicaid Utilization Management Program (MUMP) precertification.

E. Regarding inpatient stays related to all organ transplants except bone marrow, corneal, kidney, pancreas/kidney and skin:

1. Hospital days in excess of transplant length of stay averages require medical review and approval by DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor regarding transplants.**

2. Reference sources for organ transplant length-of-stay (LOS) averages are the *Centers for Medicare and Medicaid Services (CMS) Acute Inpatient Prospective Payment System (PPS)*—using the “Arithmetic Mean LOS” method—and/or the most recently published *Medicare National Coverage Decisions*.

F. Except for cornea, kidney and pancreas/kidney acquisition, Medicaid covers hospitals’ organ acquisition costs by means of the reimbursement methodologies explained in detail in Section 250.714.

G. Except for bone marrow transplants, inpatient days between the admission date and the date of the transplant procedure are subject to MUMP guidelines.

217.061 Bone Marrow Transplants 3-15-05

A. Medicaid covers the following hospital services related to bone marrow transplantation.

1. Hospital services related to harvesting the bone marrow from a living donor.
2. Hospital services related to transplantation of the bone marrow into the receiver.
3. Post-operative services for the donor and the beneficiary.

B. Inpatient stays for bone marrow transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of admission for the transplant procedure to the date of discharge.

217.062 Corneal Transplants 2-1-22

A. Medicaid covers hospitalization related to corneal transplants from the date of the transplant procedure until the date of discharge, subject to the beneficiary's inpatient benefit utilization status if he or she is aged 21 or older and subject to MUMP precertification requirements.

B. Coverage includes the preservation of the organ from a cadaver donor but not the harvesting of the organ.

C. For processing, preserving and transporting corneal tissues, use procedure code. Requires paper billing and a manufacturer's invoice attached to the claim.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

217.063 Heart Transplants 8-1-21

A. Medicaid covers the following hospital services related to heart transplantation.

1. Hospital services related to the transplantation of the heart into the receiver.
2. Post-operative services.

B. Inpatient stays for heart transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from medical review. (See Section 217.060, part E.)

217.064 Liver Transplants 8-1-21

A. Medicaid covers the following hospital services related to liver transplantation.

1. Hospital services related to harvesting a partial organ from a living donor.
2. Hospital services related to the transplantation of the liver (or of a partial liver from a living donor) into the receiver.
3. Post-operative services (including those for the donor, when applicable).

B. Inpatient stays for liver transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of

discharge, subject to any limitations resulting from medical review. (See Section 217.060, part E.)

217.065 Liver/Bowel Transplants 8-1-21

A. Medicaid covers liver/bowel transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

B. The following hospital services related to liver/bowel transplants are covered:

1. Hospital services related to the transplantation of the liver/bowel into the receiver.
2. Post-operative services.

C. Inpatient stays for liver/bowel transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP). The services that are excluded from the MUMP are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from medical review. (See Section 217.060, part E.)

217.066 Lung Transplants 8-1-21

A. The following conditions and diseases are those for which it is believed patients can benefit significantly from a lung transplant when the disease has reached an end-stage cycle or level.

1. Pulmonary vascular diseases:
   a. Primary pulmonary hypertension
   b. Eisenmenger's Syndrome (ASD, VSD, PVA, truncus, other complex anomalies)
   c. Pulmonary hypertension secondary to thromboembolic disease
2. Obstructive lung diseases:
   a. Emphysema (idiopathic)
   b. Emphysema (alpha antitrypsin deficiency)
   c. Bronchopulmonary dysplasia
   d. Post-transplant obliterative bronchiolitis
   e. Bronchiolitis obliterans organizing pneumonia (BOOP)
3. Restrictive lung diseases:
   a. Idiopathic pulmonary fibrosis
   b. Sarcoidosis
   c. Asbestosis
   d. Eosinophilic granulomatosis
   e. Desquamative interstitial pneumonitis
   f. Lymphangioleiomyomatosis

B. Medicaid covers the following hospital services related to lung transplantation.

1. Hospital services related to the transplantation of the lung into the receiver.
2. Post-operative services.

C. Inpatient stays for lung transplants are exempt from the Arkansas Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of

discharge, subject to any limitations resulting from medical review. (See Section 217.060, part E.)

217.067 Kidney (Renal) Transplants 3-15-05

A. When a candidate for a renal transplant is not eligible under Medicare, but is eligible under the Medicaid program, Medicaid will cover a prior-approved transplant.

B. Medicaid covers the following hospital services related to renal transplantation.

1. Hospital services related to the surgical procedure for the removal of the organ from a living donor.
2. Hospital services related to the transportation and/or preservation of the organ from a living donor.
3. Hospital services related to the transplantation of the kidney into the receiver.
4. Post-operative services (including those for a living donor, when applicable.)

C. Renal transplants are subject to the same inpatient hospital and outpatient hospital benefit limits (including MUMP) as all other inpatient and outpatient services, for both donor and receiver.

217.068 Pancreas/Kidney Transplants 3-15-05

A. Medicaid covers prior-approved pancreas/kidney transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program who have a diagnosis of juvenile diabetes with renal failure.

B. Inpatient stays for pancreas/kidney transplants are subject to the MUMP.

217.069 Skin Transplants 3-15-05

A. Medicaid covers prior-approved skin transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program who have burns of greater than 70% of the body's surface area with more than 50% of that area being full-thickness or third-degree burns.

B. Medicaid covers the following hospital services related to skin transplantation.

1. Hospital services related to the removal of the skin from the donor site.
2. Hospital services related to the transplantation of the skin.
3. Post-operative services, subject to the limitations of the MUMP.

217.090 Bilaminate Graft or Skin Substitute Coverage Restriction 2-1-22

A. Indications and Documentation:

When the diagnosis is a burn injury (**View ICD Codes.**) (indicated on the claim form), no additional medical treatment documentation is required.

This modality/product will be covered for other restricted diagnoses (indicated below) when all of the following provisions are met and are documented in the beneficiary's medical record:

1. Partial or full-thickness skin ulcers due to venous insufficiency or full-thickness neuropathic diabetic foot ulcers,
2. Ulcers of more than three (3) months duration and

3. Ulcers that have failed to respond to documented conservative measures of more than two (2) months duration.
4. There must be measurements of the initial ulcer size, the size of the ulcer following cessation of conservative management, and the size at the beginning of skin substitute treatment.
5. For neuropathic diabetic foot ulcers, appropriate steps to off-load pressure during treatment must be taken and documented in the patient's medical record.
6. The ulcer must be free of infection and underlying osteomyelitis; treatment of the underlying disease (e.g., peripheral vascular disease) must be provided and documented in conjunction with skin substitute treatment.

B. Diagnosis Restrictions:

Coverage of the bilaminate skin product and its application is restricted to the diagnosis represented by the following ICD codes:

(**View ICD Codes**.)

C. Outpatient Billing:

The manufactured viable bilaminate graft or skin substitute product is manually priced. It must be billed to Medicaid by paper claim with procedure code. The manufacturer's invoice, the wound size description and the operative report must be attached.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Outpatient procedures to apply bilaminate skin substitute are payable using the appropriate procedure code(s). These codes must be listed separately when filing claims and may be billed electronically.

217.100 Observation Bed Status and Related Ancillary Services 10-13-03

"Observation bed status" is an outpatient designation. Coverage of hospital observation services is based on Arkansas Medicaid policies regarding inpatient and outpatient status.

217.110 Determining Inpatient and Outpatient Status 6-1-06

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

A. When a patient is expected to remain in the hospital for less than 24 consecutive hours and that expectation is realized, the patient is deemed an outpatient unless the attending physician admits him or her as an inpatient before discharge.

B. When the attending physician expects the patient to remain in the hospital for 24 hours or longer, Medicaid deems the patient admitted at the time the patient's medical record indicates that expectation, whether or not the physician has formally admitted the patient.

C. Medicaid deems a patient admitted to inpatient status at the time he or she has remained in the hospital for 24 consecutive hours, whether or not the attending physician expected a stay of that duration.

D. When a patient receives outpatient services and is subsequently admitted as an inpatient on the same date of service (whether by deemed admission or by formal admission), the patient is an inpatient for that entire date of service.

217.111 Medical Necessity Requirements 10-13-03

Medicaid covers medically necessary services only. The Quality Improvement Organization (QIO) will deny coverage of inpatient admissions and subsequent inpatient services for inpatient care that was not necessary. Inpatient services are subject to QIO review for medical necessity whether the physician admitted the patient, or whether Medicaid deemed the patient admitted according to the criteria above.

The attending physician must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent.

217.112 Services Affected by Observation Policy 10-13-03

A. Outpatient surgical procedures:
Arkansas Medicaid has assigned each outpatient surgical procedure to one of four groups for reimbursement purposes. Coverage of each surgical group includes supplies, equipment, staff time and recovery room time. Medicaid does not cover observation and outpatient surgery for the same patient on the same date of service.

B. Blood transfusions are in outpatient Surgical Group I.

C. Observation for social reasons is not medically necessary.

217.113 Gastrointestinal Tract Imaging with Endoscopy Capsule 2-1-22

A. Arkansas Medicaid covers wireless endoscopy capsule for diagnosis of occult gastrointestinal bleeding in the anemic patient under the conditions listed below.

1. The site of the bleeding has not been identified by previous gastrointestinal endoscopy, colonoscopy, push endoscopy or other radiological procedures.
2. An abnormal x-ray of the small intestine is documented without an identified site of bleeding by endoscopic means.
3. Diagnosis of angiodysplasias of the GI tract is suspected, or
4. Individuals with confirmed Crohn's disease to determine whether there is involvement of the small bowel.

B. This procedure is covered for individuals of all ages based on medical necessity when performed with FDA-approved devices and by providers formally trained in upper and lower endoscopies.

C. Documentation of medical necessity requires a primary diagnosis of one of the following ICD diagnosis codes: (**View ICD Codes**.)

D. GI tract capsule endoscopy is not covered in the patient who has not undergone upper GI endoscopy and colonoscopy during the same period of illness in which a source of bleeding is not revealed.

E. This test is covered only for those beneficiaries with documented continuing blood loss and anemia secondary to bleeding.

F. See **Section 272.405** for procedure code and billing instructions.

217.120 Cochlear Implants 10-13-03

The Arkansas Medicaid Program covers cochlear implantation for beneficiaries in the Child Health Services (EPSDT) Program. This procedure will require prior authorization. See Prior Authorization, Section 240.000.

217.130 Hyperbaric Oxygen Therapy (HBOT) 8-1-21

Hyperbaric Oxygen Therapy (HBOT) involves exposing the body to oxygen under pressure greater than one atmosphere. Such therapy is performed in specially constructed hyperbaric chambers holding one or more patients, although, oxygen may be administered in addition to the hyperbaric treatment itself. Patients should be assessed for contraindications such as sinus disease or claustrophobia prior to therapy. In some diagnoses, hyperbarics is only an adjunct to standard surgical therapy. These indications are taken from "The Hyperbaric Oxygen Therapy Committee Report" (2003) of The Undersea and Hyperbaric Medical Society (Kensington, MD).

HBOT prior authorizations will be issued by DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.** All hyperbaric oxygen therapy will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which post-authorization will be allowed per protocol. See Section 242.000. Prior authorization will be issued for a specific number of treatments. Subsequent treatments will require another review and an additional prior authorization. The caller must be able to provide demographic and clinical information to support the medical necessity of treatment. All information that is submitted to acquire the prior authorization must be documented in the beneficiary's medical record. **View or print contact information to obtain instructions for submitting the request for prior authorization.**

NOTE: When approved, only one authorization will be issued. The prior authorization and the number of approved HBOT treatments must be communicated to the physician provider so that both the facility and physician may claim reimbursement for the number of approved HBOT sessions. Additionally, if more HBOT sessions are required for the same beneficiary, a new prior authorization is required. A new prior authorization number will be assigned for any additional sessions approved. The prior authorization information between the facility and the physician must be reciprocal if the physician acquires the prior authorization.

The following table provides the diagnosis requirements, description of the problem, and number of treatments.

Diagnosis	Description	Number of Treatments
(**View ICD Codes**.)	Air or Gas Embolism	10
(**View ICD Codes**.)	Decompression Sickness	10
(**View ICD Codes**.)	Carbon Monoxide Poisoning	5
(**View ICD Codes**.)	Clostridial Myositis and Myonecrosis (Gas Gangrene)	10
(**View ICD Codes**.)	Crush injuries, compartment syndrome, other acute traumatic peripheral ischemias	6
(**View ICD Codes**.)	Enhancement of healing in selected problem wounds; diabetic foot ulcers, pressure ulcers, venous stasis ulcers; only in severe and limb or life-threatening wounds that have not responded to other treatments, particularly if ischemia that cannot be corrected by vascular procedures is present	30

Diagnosis	Description	Number of Treatments
(View ICD Codes.)	Intracranial abscess, multiple abscesses, immune compromise, unresponsive	20
(View ICD Codes.)	Necrotizing Soft Tissue Infections, immune compromise	30
(View ICD Codes.)	Refractory osteomyelitis after aggressive surgical debridement	40
(View ICD Codes.)	Delayed Radiation Injury	60
(View ICD Codes.)	Compromised skin grafts and flaps	20
(View ICD Codes.)	Thermal burns>20% TSBA +/or involvement of hands, face, feet or perineum that are deep, partial or full thickness injury	40
(View ICD Codes.)	Compartment syndrome, impending stage fasciotomy not required.	1
(View ICD Codes.)	Problem wounds after primary management	14

Refer to Section 272.404 of this manual for billing instructions.

217.140 Verteporfin (Visudyne) 6-1-06

A. Arkansas Medicaid covers Verteporfin for all ages for certain diagnoses and subject to certain conditions and documentation requirements.

B. Coverage of Verteporfin is separate from coverage of the injection procedure (the injection procedure is covered as an outpatient surgery).

C. The provider's medical record on file must contain documentation of an eye exam by which was made one of the following diagnoses.

1. Predominantly classic subfoveal choroidal neovascularization due to age-related macular degeneration
2. Pathologic myopia
3. Presumed ocular histoplasmosis

D. The lesion size determination must be included in the documentation of the exam.

1. The eye or eyes to be treated by Verteporfin administration must be documented, with current visual acuity noted.
2. If previous treatments with other modalities have been attempted, those attempts and outcomes must be documented as well.

217.141 Computed Tomographic Colonography (CT Colonography) 7-1-22

A. The procedure codes in the link below are covered for computed tomographic (CT) colonography for beneficiaries of all ages.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

B. CT colonography policy and billing:

1. Virtual colonoscopy, also known as CT colonography, utilizes helical-computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2D or 3D reconstruction. The test requires colonic preparation similar to that required for standard colonoscopy (instrument/fiberoptic colonoscopy) and air insufflation to achieve colonic distention.
2. Indications: Virtual colonoscopy is only indicated in those patients in whom an instrument/fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscopy proximately. Failure to advance the colonoscopy may be secondary to a neoplasmic or spasmic obstruction, a redundant colon, diverticulitis extrinsic compression, or aberrant anatomy/scarring from prior surgery. This is intended for use in pre-operative situations when knowledge of the unvisualized colon (proximal to the obstruction) would be of use to the surgeons in planning the operative approach to the patient.
3. Limitations:
    a. Virtual colonography is not reimbursable when used for screening or in the absence of any signs indicating symptoms of disease, regardless of family history or other risk factors for the development of colonic disease.
    b. Virtual colonography is not reimbursable when used as an alternative to instrument/fiberoptic colonoscopy, for screening, or in the absence of signs or symptoms of disease.
    c. Since any colonography with abnormal or suspicious findings would require a subsequent instrument/fiberoptic colonoscopy for diagnosis (such as a biopsy) or for treatment (such as a polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even if performed for signs or symptoms of disease.
    d. CT colonography procedure codes are counted against the beneficiary's benefit limit of five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30) for radiology/other services. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
    e. "Reasonable and necessary" services should only be ordered or performed by qualified personnel.
    f. The CT colonography final report should address all structures of the abdomen afforded review in a regular CT of abdomen and pelvis.

C. Documentation requirements and utilization guidelines:

1. Each claim must be submitted with ICD codes that reflect the condition of the patient and indicate the reason(s) for which the service was performed. ICD codes must be coded to the highest level of specificity or claims submitted with those ICD codes will be denied;
2. The results of an instrument/fiberoptic colonoscopy that was performed before the virtual colonoscopy (CT colonography), if the virtual colonoscopy (CT colonography) was incomplete, must be retained in the patient's record; and
3. The patient's medical record must include the following and be available upon request:
    a. The order or prescription from the referring physician;
    b. Description of polyps and lesion:
        i. Lesion size for lesions 6 mm or larger, the single largest dimension of the polyp (excluding stalk if present) on either multiplanar reconstruction or 3D views, and the type of view employed for measurement should be stated;
        ii. Location (standardized colonic segmental divisions: rectum, sigmoid

colon, descending colon, transverse colon, ascending colon, and cecum);

iii. Morphology (sessile-broad-based lesion whose width is greater than its vertical height; pedunculated-polyp with separate stalk; or flat-polyp with vertical height less than 3 mm above surrounding normal colonic mucosa);

iv. Attenuation (soft-tissue attenuation or fat);

c. Global assessment of the colon (C-RADS categories of colorectal findings):

i. C0 – Inadequate study
poor prep (can't exclude > 10 lesions);

ii. C1 – Normal colon or benign lesions
no polyps or polyps ≥5 mm
benign lesions (lipomas, inverted diverticulum);

iii. C2 – Intermediate polyp(s) or indeterminate lesion
polyps 6-9 mm in size, <3 in number
indeterminate findings;

iv. C3 – Significant polyp(s), possibly advanced adenoma(s)
Polyps ≥10 mm
Polyps 6-9 mm in size, ≥3 in number;

v. C4 – Colonic mass, likely malignant;

d. Extracolonic findings (integral to the interpretation of CT colonography results):

i. E0 – Inadequate Study limited by artifact;

ii. E1 – Normal exam or anatomic variant;

iii. E2 – Clinically unimportant findings (no work-up needed);

iv. E3 – Likely unimportant findings (may need work-up); for example, incompletely characterized lesions,
such as hypodense renal or liver lesion;

v. E4 – Clinically important findings (work-up needed), such as solid renal or liver mass, aortic aneurysm, adenopathy; and

e. CT colonography is reimbursable only when performed following an instrument/fiberoptic colonoscopy that was incomplete due to obstruction.

217.150 Vagus Nerve Stimulation 6-1-22

The Arkansas Medicaid Program covers vagus nerve stimulation therapy, device, and procedure. Vagus nerve stimulation therapy, device, and procedure require prior authorization for medical necessity.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.

218.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services 8-1-21

DHS or its designated vendor performs retrospective reviews of medical records to determine the medical necessity of services paid for by Medicaid. **View or print contact information to obtain the DHS or designated vendor retrospective reviews.**

Specific guidelines have been developed for retrospective review of occupational, physical and speech-language therapy services furnished to Medicaid beneficiaries under the age of twenty-one (21). These guidelines are included in this manual to assist providers in determining and

documenting the medical necessity of occupational, physical and speech-language therapy services and are found in Sections 218.100 through 218.110

218.100 Guidelines for Retrospective Review of Occupational and Physical Therapy for Beneficiaries Under the Age of 21 7-1-20

A. Medical Necessity

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is insufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Evaluations and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:

1. Date of evaluation;
2. Child's name and date of birth;
3. Diagnosis specific to therapy;
4. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

   NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

   7 months - [(40 weeks) - 28 weeks) / 4 weeks]

   7 months - [(12) / 4 weeks]

   7 months - [3]

   4 months

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores, or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services;
6. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone, or a narrative description of the child's functional mobility skills (strengths and weaknesses);

8. An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week;
9. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
10. Signature and credentials of the therapist performing the evaluation.

C. Interpretation and Eligibility: Ages Birth to 21

1. Tests used must be norm-referenced, standardized, and specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.
3. All subtests, components, and scores must be reported for all tests used for eligibility purposes.
4. Eligibility for therapy will be based upon a score of -1.50 standard deviations (SD) below the mean or greater in at least one (1) subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.
5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason a standardized test could not be used must be included in the evaluation.
6. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine reliability/validity. Refer to "Accepted Tests" sections for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.
7. Range of Motion: A limitation of greater than ten (10) degrees or documentation of how a deficit limits function.
8. Muscle Tone: Modified Ashworth Scale.
9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
10. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
11. Children (birth to age twenty-one (21)) receiving services outside of the public schools must be evaluated annually.
12. Children (birth to age two (2)) in the Early Intervention Day Treatment (EIDT) program must be evaluated every six (6) months.
13. Children (age three (3) to twenty-one (21)) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three (3) years; however, an annual update of progress is required.

D. Frequency, Intensity, and Duration of Physical or Occupational Therapy Services

The frequency, intensity, and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable

medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.

2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.
3. Duration of Services: Therapy services should be provided if reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring, or establishment of a home program should be implemented.

E. Progress Notes

1. Child's name;
2. Date of service;
3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of entry with a full signature and credentials; and
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

218.101 Reserved 11-1-10

218.102 Reserved 11-1-10

218.103 Reserved 11-1-10

218.104 Reserved 11-1-10

218.105 Frequency, Intensity and Duration of Therapy Services 11-1-05

A. The frequency, intensity and duration of therapy services must be medically necessary and realistic for the age of the patient and the severity of the deficit or disorder.

B. Therapy is indicated if there is a potential for functional improvement as a direct result of these services.

218.107 In-Home Maintenance Therapy 11-1-05

A. Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not routinely require the skilled services of a physical or occupational therapist to perform safely and effectively.

B. Such services can be provided to the child as part of a home program administered by the child's caregivers, with occasional monitoring by the therapist.

218.108 Monitoring In-Home Maintenance Therapy 11-1-05

A provider may monitor in-home maintenance therapy to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment, such as orthotics and durable medical equipment.

A. Monitoring frequency should be based on an interval that is reasonable for the complexity of the problem(s) being addressed.

B. If a hospital providing therapy services cannot monitor in-home maintenance therapy by seeing the patient in the outpatient hospital, the provider must ask the primary care physician (PCP) to refer the case to an individual or group provider in the Occupational, Physical and Speech Therapy Program or – when applicable to physical therapy – a Home Health provider.

218.110 Therapy Services For Beneficiaries Under Age 21 In Child Health Services (EPSDT) 1-1-21

Outpatient occupational, physical, and speech-language therapy services require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements. If the beneficiary is exempt from the PCP process, referrals for therapy services are required from the beneficiary's attending physician. All therapy services for beneficiaries under the age of 21 years require referrals and prescriptions be made utilizing the "Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21" form DMS-640. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year. Providers of therapy services are responsible for obtaining renewed PCP referrals every twelve (12) months. The PCP or attending physician is responsible for determining medical necessity for therapy treatment. Outpatient treatment limits do not apply to eligible Medicaid beneficiaries under the age of 21.

Arkansas Medicaid applies the following therapy benefits to all therapy services in the Child Health Services (EPSDT) program for children under age 21:

A. For range of benefits, see the following procedure codes: **View or print the procedure codes for therapy services.**

B. All requests for extended therapy services for beneficiaries under age 21 must comply with Sections 218.250 through 218.180.

218.115 Speech-Language Therapy Services For Beneficiaries up to Age 19 In ARKids First – B 1-1-21

Arkansas Medicaid applies speech-language therapy benefits in the ARKids First-B program for children under age 19 as found in the therapy services procedure codes: **View or print the procedure codes for therapy services**.

All requests for extended speech-language therapy services for beneficiaries age 18 and under must comply with Sections 218.250 through 218.280.

218.120 Accepted Tests for Occupational Therapy 3-15-12

To view a current list of Accepted Tests for Occupational Therapy, refer to Section 214.310 of the Occupational, Physical, Speech Therapy Services Manual.

218.130 Accepted Tests for Physical Therapy 3-15-12

To view a current list of Accepted Tests for Physical Therapy, refer to Section 214.320 of the Occupational, Physical, Speech Therapy Services Manual.

218.200 Speech-Language Therapy Guidelines for Retrospective Review for Beneficiaries Under Age 21 7-1-20

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is insufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.
3. There must be a reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Types of Communication Disorders

1. Language Disorders — Impaired comprehension or use of spoken, written, or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) or the perception/processing of language. Language disorders may involve one (1), all, or a combination of the above components.
2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice, or fluency. Speech Production disorders may involve one (1), all, or a combination of these components of the speech production system.

   An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete, or deviant use of the phonological system, i.e., phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal or oral apraxia, dysarthria.
3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures, or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

   Mild: Scores between 84-78; -1.0 standard deviation

   Moderate: Scores between 77-71; -1.5 standard deviations

   Severe: Scores between 70-64; -2.0 standard deviations

   Profound: Scores of sixty-three (63) or lower; -2.0+ standard deviations
2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 218.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Language disorder must include:
   a. Date of evaluation;
   b. Child's name and date of birth;

c. Diagnosis specific to therapy;

d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients, or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of the orofacial structures;

h. Formal or informal assessment of hearing, articulation, voice, and fluency skills;

i. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

j. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and

k. Signature and credentials of the therapist performing the evaluation.

3. SPEECH PRODUCTION (Articulation, Phonological, Apraxia): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 218.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:

a. Date of evaluation;

b. Child's name and date of birth;

c. Diagnosis specific to therapy;

d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week

gestational age infant has a corrected age of four (4) months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;

i. Formal or informal assessment of hearing, voice, and fluency skills;

j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

k. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and

l. Signature and credentials of the therapist performing the evaluation.

4. SPEECH PRODUCTION (Voice): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 218.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:

   a. A medical evaluation to determine the presence or absence of a physical etiology is a prerequisite for evaluation of voice disorder;

   b. Date of evaluation;

   c. Child’s name and date of birth;

   d. Diagnosis specific to therapy;

   e. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child’s dominant language; if not, an explanation must be provided in the evaluation.

      NOTE: To calculate a child’s gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

      7 months - [(40 weeks) - 28 weeks) / 4 weeks]

      7 months - [(12) / 4 weeks]

      7 months - [3]

4 months

f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

h. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;

i. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;

j. Formal or informal assessment of hearing, articulation, and fluency skills;

k. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

l. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and

m. Signature and credentials of the therapist performing the evaluation.

5. SPEECH PRODUCTION (Fluency): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 218.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:

a. Date of evaluation;

b. Child's name and date of birth;

c. Diagnosis specific to therapy;

d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;

i. Formal or informal assessment of hearing, articulation, and voice skills;

j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

k. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and.

l. Signature and credentials of the therapist performing the evaluation.

6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 218.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:

a. Date of evaluation;

b. Child's name and date of birth;

c. Diagnosis specific to therapy;

d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients, or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

f. If swallowing problems or signs of aspiration are noted, then include a statement indicating that a referral for a videofluoroscopic swallow study has been made;

g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

h. Formal or informal assessment of hearing, language, articulation, voice, and fluency skills;

i. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

j. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and

k. Signature and credentials of the therapist performing the evaluation.

D. Interpretation and Eligibility: Ages Birth to 21

1. LANGUAGE: Two (2) language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one (1) being a norm-referenced, standardized test with good reliability and validity. (Use of two (2) one-word vocabulary tests alone will not be accepted.)

   a. For children age birth to three (3): criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.

   b. For children age three (3) to twenty-one (21), criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 218.200, part D, paragraph 8.)

   c. Age birth to three (3): Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test, with corroborating data from a criterion-referenced measure. When these two (2) measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.

   d. Age three (3) to twenty-one (21): Eligibility for language therapy will be based upon two (2) composite or quotient scores that are -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both scores, a third standardized score indicating a -1.5 SD or greater is required to support the medical necessity of services.

2. ARTICULATION OR PHONOLOGY: Two (2) tests or procedures must be administered, with at least one (1) being from a norm-referenced, standardized test with good reliability and validity.

   Eligibility for articulation or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from accepted procedures can be used to support the medical necessity of services (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)

3. APRAXIA: Two (2) tests or procedures must be administered, with at least one (1) being a norm-referenced, standardized test with good reliability and validity.

   Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from a criterion-referenced test or accepted procedures can be used to support the medical necessity of services. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)

(Review Section 218.210 — Accepted Tests for Speech-Language Therapy.)

4. VOICE: Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.

   Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.

5. FLUENCY: At least one (1) norm-referenced, standardized test with good reliability and validity, and at least one (1) supplemental tool to address effective components.

Eligibility for fluency therapy will be based upon an SS of -1.5 SD below the mean or greater on the standardized test.

6. ORAL MOTOR/SWALLOWING/FEEDING: An in-depth, functional profile of oral motor structures and function.

   Eligibility for oral-motor/swallowing/feeding therapy will be based upon an in-depth functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by a videofluoroscopic swallow study, the patient can be treated for feeding difficulties via the recommendations set forth in the swallow study report.

7. All subtests, components, and scores must be reported for all tests used for eligibility purposes.

8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth functional profile of the child's communication abilities. An in-depth functional profile is a detailed narrative or description of a child's communication behaviors that specifically explains and justifies the following:

   a. The reason standardized testing is inappropriate for this child,

   b. The communication impairment, including specific skills and deficits, and

   c. The medical necessity of therapy.

   d. Supplemental instruments from Accepted Tests for Speech-Language Therapy may be useful in developing an in-depth functional profile.

9. Children (birth to age twenty-one (21)) receiving services outside of the schools must be evaluated annually.

10. Children (birth to twenty-four (24) months) in the Early Intervention Day Treatment (EIDT) Program must be evaluated every six (6) months.

11. Children (age three (3) to twenty-one (21)) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three (3) years; however, an annual update of progress is required.

12. Children (age three (3) to twenty-one (21)) receiving privately contracted services, apart from or in addition to those within the schools, must have a full evaluation annually.

13. IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

E. Progress Notes

1. Child's name;

2. Date of service;

3. Time in and time out of each therapy session;

4. Objectives addressed (should coincide with the plan of care);

5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form of measurement;

6. Progress notes must be legible;

7. Therapists must sign each date of the entry with a full signature and credentials; and

8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

218.210 Accepted Tests for Speech-Language Therapy 3-15-12

To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.

218.220 Intelligence Quotient (IQ) Testing 11-1-10

Children receiving language intervention therapy must have cognitive testing once they reach ten (10) years of age. This also applies to home-schooled children. If the IQ score is higher than the qualifying language scores, the child qualifies for language therapy; if the IQ score is lower than the qualifying language test scores, the child would appear to be functioning at or above the expected level. In this case, the child may be denied for language therapy. If a provider determines that therapy is warranted, an in-depth functional profile must be documented. However, IQ scores are not required for children under ten (10) years of age.

A. IQ Tests — Traditional

Test	Abbreviation
Stanford-Binet	S-B
The Wechsler Preschool & Primary Scales of Intelligence, Revised	WPPSI-R
Slosson	
Wechsler Intelligence Scale for Children, Third Edition	WISC-III
Kauffman Adolescent & Adult Intelligence Test	KAIT
Wechsler Adult Intelligence Scale, Third Edition	WAIS-III
Differential Ability Scales	DAS
Reynolds Intellectual Assessment Scales	RIAS

B. Severe & Profound IQ Test/Non-Traditional — Supplemental — Norm Reference

Test	Abbreviation
Comprehensive Test of Nonverbal Intelligence	CTONI
Test of Nonverbal Intelligence — 1997	TONI-3
Functional Linguistic Communication Inventory	FLCI

218.250 Process for Requesting Extended Therapy Services for Beneficiaries Under Twenty-One (21) Years of Age 7-1-22

A. Requests for extended therapy services for beneficiaries under twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services for beneficiaries under twenty-one (21) years of age.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits being exceeded.

2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.

3. With the request, submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial. Do not send a claim.

B. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services," must be utilized when requesting extended therapy services. **View or print Form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted, provided it complies with Arkansas Code Annotated §25-31-103. All applicable records that support the medical necessity of the request must be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization.

218.260 Documentation Requirements 1-1-09

A. To request extended therapy services, all applicable documentation that supports the medical necessity of extended benefits is required.

B. Documentation requirements are as follows. Clinical records must:

1. Be legible and include documentation supporting the specific request

2. Be signed by the performing provider

3. Include the physician referral and prescription for additional therapy based on clinical records and progress reports furnished by the performing provider

218.270 Extended Therapy Services Review Process 8-1-21

View or print contact information to obtain the DHS or designated vendor step-by-step process for extended therapy services review.

218.280 Reserved 6-1-25

218.300 Retrospective Review of Paid Therapy Services 10-1-08

A. Retrospective review of a paid service is a two-fold process.

1. First, a reviewer must find

   a. Whether a service was medically necessary and

2. Whether the scope, frequency and duration of the service were medically necessary.

3. Second, the reviewer must determine

   a. Whether the beneficiary received the services for which Medicaid paid and

4. Whether the case record correctly documents the services reimbursed by Medicaid.

B. The record must contain primary care physician (PCP) referral documentation and a valid prescription (form DMS-640) covering the dates of service.

1. The referral and the prescription must be written, signed and dated by the PCP or attending physician.

2. The record must contain verification that referrals and prescriptions have been issued and maintained in accordance with the regulations in Section 214.000 of this manual.

C. Each calendar quarter, the QIO contractor selects and reviews a random sample of all the therapy services paid during the previous quarter.

1. Each provider under review receives a written request for copies of patient records and instructions for mailing them to the QIO.

2. Requested materials must be received by the QIO no later than the 30th day following the postmark date of the envelope containing the request for records.

D. The QIO's established tracking system automatically generates notifications to providers that their records have been received.

218.301 Medical Necessity Review 10-1-08

A. Initial screening determines whether case records contain sufficient documentation to complete a medical necessity review.

B. Documentation passing the initial screening is reviewed in detail by a registered nurse to determine medical necessity.

C. When the nurse reviewer determines that therapy services were medically necessary, he or she proceeds to the utilization portion of the review.

D. When a nurse reviewer cannot determine that the therapy services were medically necessary, he or she must refer the record to a therapist whose professional discipline is the same as the therapy services under review (i.e., a physical therapist reviews physical therapy claims, an occupational therapist reviews occupational therapy claims, etc.).

1. The therapist may, on his or her own authority, approve the services in question; however, if the therapist cannot approve them, he or she must refer the case to the Associate Medical Director (AMD).

2. The therapist may recommend that the AMD deny all or some of the paid services under review.

E. The AMD has the final authority to approve or deny.

F. If the AMD's decision is to partially or completely deny the services, the QIO forwards written notification to the provider, the beneficiary and the referring physician.

1. Denial notifications are case-specific and state the AMD's rationale for the decision.

2. The provider and the beneficiary are given written instructions for requesting a reconsideration review or a fair hearing.

218.302 Utilization Review 10-1-08

A. When medical necessity is established, the nurse reviewer proceeds to the utilization portion of the retrospective review. The reviewer will compare the paid claims data to the medical records obtained from the provider, in order to verify that:

1. The proper coding was used wherever required,

2. Beginning and ending times correspond to billed units and are documented,

3. Written descriptions correctly identify each service that was paid for by Medicaid and

4. The performing therapist signed off on each therapy session and dated his or her signature each time.

5. When the documentation submitted supports the paid services, the nurse reviewer approves the services as billed and paid.

B. When the provider's documentation does not appear to support the paid services, the nurse reviewer must refer the records to a therapist whose professional discipline is that of the services under review.

1. The therapist may approve the services as billed or recommend that the AMD deny some or all of the services.
2. If the AMD's decision is to partially or completely deny the services, the reviewing QIO forwards written notification to the provider, the beneficiary and the referring physician.
   a. Denial letters are case specific and state the AMD's rationale for the decision.
3. Notification includes instructions for requesting reconsideration.

218.303 Reconsideration Review 6-1-25

A. When the reviewing QIO denies all or part of a previously paid claim on retrospective review, the therapy provider may request reconsideration of that decision by submitting additional information.

B. Additional information submitted for reconsideration must reach the QIO thirty (30) days following the postmark date on the envelope bearing the denial notification.

1. A therapist whose professional discipline is that of the denied service reviews the additional information.
2. The therapist reviewing a case being reconsidered will not be the same therapist who reviewed the case initially.

C. If the additional documentation enables the therapist to approve the services, he or she will reverse the previous denial.

D. If the case documentation still appears insufficient to allow the therapist to approve the services, he or she must refer the case to a physician advisor for final determination.

1. The physician advisor will not be an AMD who denied the services during the first review.
2. The therapist provides a written recommendation to the physician advisor.

E. The physician advisor reconsidering the case may uphold or reverse all or part of the previous decision.

1. A written notification of the outcome of each reconsideration review is mailed to all parties.
2. Notification includes the physician advisor's case-specific rationale for upholding or overturning the QIO's initial determination.

218.400 Acute Crisis Units 10-1-22

Medicaid covers Acute Crisis Units for all ages of clients who have the ability to benefit from care within the setting. To ensure the safety and age appropriate treatment of all clients, if beds are not physically separated, beds should be grouped by children age four (4) to twelve (12), adolescents age thirteen (13) to eighteen (18) and adults over age eighteen (18) with consideration within those ranges given for developmental functioning. Request for Extension of Benefits based upon medical necessity must be obtained for services extending beyond 96 hours.

View billing Instructions for Acute Crisis Unit reimbursement.

A. Acute Crisis Units can provide brief crisis treatment services to persons age four (4) years of age or older, who are experiencing a psychiatry- and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. These units provide hospital diversion and step-down services in a safe environment with psychiatry and substance use disorder services available on-site, as well as on-call psychiatry available 24 hours per day.

B. A Hospital that is operating an Acute Crisis Unit must ensure that, at a minimum, the following services are available:

1. Ongoing assessment and observation;
2. Crisis intervention;
3. Psychiatric, substance, and co-occurring treatment; and
4. Referral mechanisms for independent assessment and care planning as needed.

C. A Hospital that is operating an Acute Crisis Unit can also provide Substance Abuse Detoxification within the Acute Crisis Unit. Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize beneficiaries by clearing toxins from the beneficiary's body. Services are short-term and may be provided in a crisis unit, inpatient, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the beneficiary for ongoing treatment.

240.000 PRIOR AUTHORIZATION

241.000 Procedures for Obtaining Prior Authorization 8-1-21

There are certain medical, diagnostic and surgical procedures that are not covered without prior authorization, either because of federal requirements or because of the elective nature of a procedure. DHS or its designated vendor makes prior authorization (PA) determinations for most Medicaid-covered surgical procedures that require PA, and for some lab procedures that require PA.

Please refer to Section 244.000 of this manual for a list of procedures requiring prior authorization.

Prior authorization determinations are made utilizing established medical or administrative criteria combined with the professional judgment of physician advisors.

View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization.

If surgery is involved, a copy of the authorization will be sent to the hospital where the service will be performed. If the hospital has not received a copy of the authorization before the time of admission, the hospital will contact the admitting physician or DHS or its designated vendor to verify that prior authorization has been granted.

It is the responsibility of the primary surgeon to distribute a copy of the authorization to the assistant surgeon if the assistant has been requested and approved.

Prior authorization of service does not guarantee eligibility for a beneficiary. Coverage is contingent on the beneficiary's eligibility on the date(s) of service.

242.000 Post-authorization for Emergency Procedures and Periods of Retroactive Eligibility 8-1-21

Post-authorization will be granted only for emergency procedures or retroactively eligible beneficiaries.

A. Requests for emergency procedures must be applied for on the first working day after the procedure has been performed.

B. In cases of retroactive eligibility, DHS or its designated vendor must be contacted for post-authorization within sixty (60) days of the eligibility card issuance date.

C. In cases involving a hysterectomy, documentation must be provided that reflects the acknowledgement statement was signed prior to surgery or the attending physician must certify in writing. (Use form DMS-2606. **View or print form DMS-2606**.)

1. That the individual was already sterile, and the cause of sterility; or
2. That the hysterectomy was performed under a life-threatening emergency in which the physician determined prior acknowledgement was not possible. The physician must also include a description of the emergency.

FORM DMS-2606 MUST BE ATTACHED TO THE CLAIM FOR PAYMENT.

The document must be reviewed and approved by the Medicaid Program before payment will be considered. All guidelines must be met in order for payment to be made.

242.010 Reserved 1-15-15

243.000 Post Procedural Authorization for Eligible Beneficiaries Under Age 21 8-1-21

Providers performing surgical procedures that require prior authorization are allowed sixty 60 days from the date of service to obtain prior authorization if the beneficiary is under age twenty-one (21).

All requests for post-procedural authorizations for eligible beneficiaries are to be made to DHS or its designated vendor within sixty (60) days of the date of service. These calls will be tape-recorded. **View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits review.**

The beneficiary and provider identifying criteria and all of the medical data necessary to justify the procedures must be provided.

Consulting physicians are responsible for contacting DHS or its designated vendor to have procedures added to the PA file. Providers must obtain prior authorization for procedures requiring authorization in order to prevent risk of denial due to lack of medical necessity.

This policy applies only to those Medicaid beneficiaries under age twenty-one (21). This policy does not alter prior authorization procedures applicable to retroactive eligible beneficiaries.

244.000 Procedures that Require Prior Authorization 2-1-22

A. The procedures represented by the CPT and HCPCS codes in the following table require prior authorization (PA). The performing physician or dentist (or the referring physician or dentist, when lab work is ordered or injections are given by non-physician staff) is responsible for obtaining required PA and forwarding the PA control number to appropriate hospital staff for documentation and billing purposes. A claim for any hospital services that involve a PA-required procedure must contain the assigned PA control number or Medicaid will deny it. (See Sections 241.000 through 244.000 of this manual for instructions for obtaining prior authorization.)

See Section 272.449 for billing instructions for Molecular Pathology codes.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

B. For inpatient hospital facility abortion claims, the provider claim must use the following codes:

1. 10A00ZZ Abortion of Products of Conception, Open Approach
2. 10A03ZZ Abortion Products of Conception, Percutaneous Approach
3. 10AO7Z6 Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
4. 10A07ZW Abortion of Products of Conception, Laminaria, Via Natural or Artificial Opening
5. 10A07ZX Abortion of Products of Conception, Abortifacient, Via Natural or Artificial Opening
6. 10A07ZZ Abortion of Products of Conception, Via Natural or Artificial Opening

C. The following outpatient hospital abortion procedure codes will require PA:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

245.000 Prior Approval and Due Process Information 3-15-05

A. Organ transplants in Arkansas and in states that border Arkansas require prior approval from Arkansas Medicaid.

B. In states that do not border Arkansas, organ transplants *and* organ transplant evaluations require prior approval from Arkansas Medicaid.

245.010 Organ Transplant Prior Approval in Arkansas and Bordering States 8-1-21

The attending physician is responsible for obtaining prior approval for organ transplants.

A. The attending physician submits his or her transplant evaluation (workup) results to the Utilization Review (UR) Section, requesting approval of the transplant. **View or print the UR Section contact information.**

B. The request and its supporting documentation is reviewed by DHS or its designated vendor for a determination of approval or denial.

C. The requesting physician and the beneficiary are advised of determination by letter.

D. The physician is responsible for distributing documentation of prior approval to the hospital and to the other participating providers, such as the anesthetist, assistant surgeon, etc.

245.020 Organ Transplant and Evaluation Prior Approval in Non-Bordering States 8-1-21

A. In states that do not border Arkansas, prior approval is required for organ transplant evaluations and organ transplants.

B. The attending physician is responsible for obtaining prior approval for organ transplant evaluations and organ transplants.

1. The attending physician must request from the UR Section prior approval of a transplant evaluation, identifying the facility at which the evaluation is to take place and the physician who will conduct the evaluation. **View or print the UR Section contact information.**

2. UR reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.
3. The evaluation results must be forwarded to UR with a request for approval of the transplant procedure.
4. The request and the supporting documentation is reviewed by DHS or its designated vendor for a determination of approval or denial.
5. The requesting physician and the beneficiary are advised of the determination by letter.

245.030 Hyperbaric Oxygen Therapy (HBOT) Prior Authorization 8-1-21

All hyperbaric oxygen therapy will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which post-authorization will be allowed per protocol. See Section 242.000. Prior authorization will be for a certain number of treatments. Further treatments will require reapplication for a prior authorization. **In order to request a prior authorization for HBOT, the provider must contact DHS or its designated vendor. View or print contact information to obtain instructions for submitting the prior authorization request.**

245.031 Prior Authorization of Hyaluronon (Sodium Hyaluronate) Injection 2-1-22

Prior authorization is required for coverage of the Hyaluronon (sodium hyaluronate) injection. Providers must specify the brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization for the following procedure codes:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

A written request must be submitted to Division of Medical Services Utilization Review Section. **View or print the Division of Medical Services Utilization Review Section address.**

The request must include the patient's name, Medicaid ID number, physician's name, physician's provider identification number, patient's age, and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one series of injections per knee, per beneficiary, per lifetime.

245.040 Prior Authorization of Vagus Nerve Stimulation Therapy, Device, and Procedure 6-1-22

The Arkansas Medicaid Program requires prior authorization for vagus nerve stimulation therapy, device, and procedure for medical necessity.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.

245.100 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of a denied prior approval request. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a prior approval request, the beneficiary may appeal the denial and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000 and 190.000 of Section I of this Manual.

245.200 Reserved 6-1-25

250.000 REIMBURSEMENT

250.100 Introduction to Reimbursement 10-13-03

A. All Medicaid-enrolled acute care hospitals in Arkansas and some acute care hospitals in adjacent states are reimbursed for inpatient services by interim per diem and year-end cost settlement. Most hospitals outside Arkansas are reimbursed for inpatient services by means of a prospective payment system.

B. Reimbursement for outpatient hospital services and end-stage renal disease (ESRD) services is by a fee-for-service methodology in accordance with an established fee schedule and without cost settlement, with the following exceptions:

1. Arkansas Medicaid cost-settles for outpatient services with in-state pediatric hospitals.
2. Arkansas Medicaid cost-settles for outpatient services with Arkansas State Operated Teaching Hospitals, effective for cost reporting periods ending on and after June 30, 2000.
3. Effective May 18, 2000, Arkansas State Operated Teaching Hospitals receive an annual outpatient reimbursement adjustment based on the previous state fiscal year's (SFY) outpatient Medicare-related upper payment limit (UPL) for "as identified Medicaid-reimbursed" outpatient services. See Section 252.130.

250.101 Fee Schedules 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

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

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

250.110 Cost Report and Provider Statistical and Reimbursement Report (PS & RR) 7-1-07

A. Under a common audit agreement, the Medicare intermediary performs audits required for both Title XVIII (Medicare) and Title XIX (Medicaid) purposes.

1. Whenever the intermediary reopens a Title XVIII cost report, it also reopens the corresponding Title XIX cost report.

2. However, the Arkansas Medicaid Program may also audit independently of Medicare.

B. To facilitate the reconciliation of the Provider Statistical and Reimbursement Report (PS & RR) to the cost report, providers are required to ensure that the dates of service of paid claims are within the appropriate cost reporting period.

1. Providers must split claims for inpatient stays that span consecutive cost reporting periods *and* that contain Medicaid-covered days in each of those periods.

2. For related billing information, see the Official UB-04 Data Specifications Manual (UB-04 Manual) for the CMS-1450 (UB-04) and special billing instructions in this manual at Section 272.400.

250.200 Inpatient Reimbursement for Arkansas-Licensed and Bordering City Hospitals 10-13-03

Arkansas Medicaid's reimbursement methodology for inpatient services in Arkansas-licensed acute care hospitals and in participating hospitals that are located in states adjacent to Arkansas (and are designated "bordering city hospitals" by the Division of Medical Services) is by interim per diem rates with year-end cost settlements.

A. Reimbursement under this methodology is based on reasonable costs and is generally in accordance with the definitions and accounting procedures of the Title XVIII (Medicare) Program.

B. Certain limitations and adjustments apply, in accordance with state and federal regulations.

250.201 Interim Per Diem Rates 10-13-03

Annually upon receiving each hospital's initial, un-audited cost report for its most recent fiscal year-end, Arkansas Medicaid recalculates the hospital's interim per diem rate, which then becomes effective for dates of service in the succeeding fiscal year.

A. The calculation is performed by dividing the un-audited Medicaid allowable costs by the number of Medicaid-covered days paid.

B. The recalculated interim per diem rate is effective for dates of service on and after the first day of the hospital's new fiscal year.

1. Each fiscal year's interim per diem rate is calculated from the previous fiscal year's un-audited cost report data.

2. Each fiscal year's interim per diem rate is applied retroactively to the first day of that fiscal year. See Section 250.202, *Mass Adjustments,* for additional details regarding the application of the recalculated interim per diem rate.

Example

a. Hospital A ends its fiscal year June 30.

b. From the hospital's cost report for dates of service July 1, 2000, through June 30, 2001, Medicaid calculates un-audited cost at $648.23 per Medicaid-eligible inpatient day.

c. The Medicaid interim per diem rate for Hospital A for the period July 1, 2001, through June 30, 2002, is set at $648.00.

250.202 Mass Adjustments 10-13-03

A. If the new interim per diem rate differs from the previous interim rate, the Medicaid fiscal agent performs automated ("mass") adjustment transactions.

1. The automated adjustments ensure that all inpatient dates of service within the same cost reporting period are paid at the same interim per diem rate.
2. These adjustments apply to claims for inpatient services that have been:
   a. Provided since the beginning of the current cost reporting period and
   b. Paid before the implementation of the newly calculated per diem rate.

B. Continuing the example above in Section 250.201, Medicaid has scheduled implementation of the hospital's fiscal year 2002 per diem rate for check-write date January 4, 2002.

1. Concurrent with implementation of the new per diem rate, the Arkansas Medicaid fiscal agent performs mass adjustments for inpatient dates of service on and after July 1, 2001 that have been previously paid at the former rate.
2. Upon completion of the mass adjustments, all of Hospital A's inpatient dates of service in FY 2002 will have been paid at $648.00 per Medicaid-covered day.

C. For the purposes of this example let us say that the previous interim per diem rate was $646.00—two dollars less than the new rate—and that Medicaid has already paid claims for one hundred inpatient days with dates of service between July 1, 2001, and the date of the mass adjustments.

1. As a result of the mass adjustments Medicaid pays Hospital A an additional amount of two hundred dollars (two dollars multiplied by 100 Medicaid-paid inpatient days).
2. Arkansas Medicaid's fiscal accounting system reflects that each claim for service dates in fiscal year 2002 that was initially paid at $646.00 per day has been voided, reprocessed automatically and repaid at $648.00 per day.
3. The provider's Medicaid remittance advice reflects the above information on the scheduled check-write date.

250.203 Cost Settlement 11-15-12

A. The Division of Medical Services or its designee audits each hospital's cost report.

1. Allowable costs are determined and validated in accordance with CMS Publication 15-1 (costs and allowable costs) and CMS Publication 15-2 (cost reports).
2. Accounting exceptions specific to Title XIX or to the Arkansas Medicaid Program are noted in this section (Reimbursement, Section 250.000) of this provider manual.

B. With the exception of special payments and adjustments listed below in part C, Arkansas Medicaid limits total inpatient reimbursement to the lowest of three amounts. The amounts compared are as follows.

1. Allowable costs after application of the TEFRA rate of increase limit (The TEFRA rate of increase limit does not apply to Arkansas State Operated Teaching Hospitals for cost reporting periods ending on and after June 30, 2000.)
2. The hospital's customary charges to the general public for the services
3. An upper limit per Medicaid day

C. Special adjustments or payments apply to some hospitals.

1. In-state hospitals and certain qualifying out-of-state hospitals receive "disproportionate share hospital" payments. See Sections 250.300 through 250.500 for details.
2. Arkansas State Operated Teaching Hospitals receive direct graduate medical education (GME) payments. See Section 250.621 for details.

3. Arkansas State Operated Teaching Hospitals receive an adjustment based on the Medicare daily upper limit. See Section 250.622 for details.
4. Arkansas private, acute care, critical access, psychiatric and rehabilitative hospitals receive an adjustment based on the Medicaid upper payment limit. See Section 250.623 for details.
5. Arkansas non-state government-owned or operated acute care and critical access hospitals receive an adjustment based on the Medicare upper payment limit. See Section 250.624 for details.
6. Arkansas non-state owned government-owned or operated acute care/general hospitals within the state of Arkansas shall qualify for an annual upper payment limit, reimbursement adjustment. See Section 250.627 for details.
7. Arkansas private hospitals (excluding rehabilitative hospitals and specialty hospitals) will receive inpatient and outpatient hospital access payments based on the Medicaid upper payment limit. See Sections 250.628 and 250.269 for details.
8. All Arkansas private pediatric hospitals qualify for an inpatient rate adjustment. The amount of adjustment is determined annually by Arkansas Medicaid based on available funding. See Section 250.626 for details.

250.210 TEFRA Rate of Increase Limit 10-13-03

TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). This provision establishes a methodology by which to limit the amount of annual growth in reimbursement to hospitals. Arkansas Medicaid calculates and applies TEFRA reimbursement limits in accordance with Medicare TEFRA rules and regulations as found and/or amended in 42 CFR 413.40.

250.211 TEFRA Rate of Increase Limit Base Year Determination 10-13-03

CMS has established the base year for calculation of a hospital's initial cost per Medicaid discharge as the cost reporting period of at least 12 months that immediately precedes the hospital's first cost reporting period that is subject to the rate-of-increase limit.

A. For Arkansas and bordering city rural hospitals, the base year was each hospital's first full cost reporting period that began on or after January 1, 1989. See Section 250.301, part A, for the criteria determining a hospital's rural status.

B. For all other Arkansas and bordering city hospitals, except Arkansas State Operated Teaching Hospitals and new pediatric hospitals, the base year was each hospital's first full cost reporting period that began on or after July 1, 1991.

C. The base year for Arkansas State Operated Teaching Hospitals was the full cost report period *ending* on or before June 30, 1989.

D. The base year for new pediatric hospitals is the initial cost-reporting period when the hospital enrolled as a pediatric hospital in the Arkansas Medicaid Program. See Section 250.610 for detailed information.

250.212 TEFRA Exceptions 10-1-06

Waiver of the TEFRA limit and adjustment of the limit are permitted in particular circumstances.

A. A state may waive the TEFRA limit for a cost-reporting period in which extraordinary circumstances cause an unusual, temporary and substantial increase in costs.

1. If the hospital can demonstrate to the state that it incurred increased costs due to extraordinary circumstances over which it had no control, the state may waive the

TEFRA limit for the cost-reporting period in which the extraordinary circumstance occurred.

2. The TEFRA rate that, absent the waiver, would have applied is applied after the next cost reporting period in addition to the TEFRA rate due to be applied at that time. Waiving the TEFRA limit for one cost reporting period only suspends the application of that period's inflation factor until the next year, at which time the inflation factors for both years are applied.

B. Changes in the hospital's case mix or adding or discontinuing services or units may result in a distortion of the rate of costs increase, possibly justifying an adjustment in the TEFRA limit.

1. The hospital must demonstrate that such an event has occurred and the extent to which costs have been affected.

2. If the state finds cause for action, it may adjust the TEFRA limit for the year in which the cost distortion occurred.

C. New pediatric hospitals may request an exemption from the TEFRA rate-of-increase limit. See Section 250.610, part C.2.

D. Effective for discharge dates on and after September 1, 2006, the TEFRA rate of increase limit is not applied to in-state pediatric hospitals for covered transplant procedures other than corneal, renal, pancreas/kidney and bone marrow transplants.

250.220 Customary Charges 7-1-06

A. The lesser of allowable costs and charges is the amount to be compared to the upper limit amount.

1. The amount carried forward from the TEFRA rate-of-increase limitation calculations is compared to the hospital's charges for services furnished during the cost reporting period to Medicaid-eligible inpatients aged one year and older.

2. The lesser amount is carried forward for comparison to the upper limit amount.

B. Charges are obtained from the hospital's inpatient Medicaid claims for dates of service within the cost reporting period.

250.230 Daily Upper Limit 1-1-16

A daily upper limit to inpatient hospital reimbursement is established in the Title XIX State Plan.

A. A daily upper limit amount of $675.00 is effective for dates of service April 1, 1996 through June 30, 2006. The $675.00 daily upper limit for this period represents the 90th percentile of the cost-based per diems (per the cost settlements of their fiscal year-end 1994 cost reports) of all hospitals subject to the Arkansas Medicaid daily upper limit at the time of the computation.

B. For dates of service July 1, 2006 and after, DMS will review the hospital cost report data at least biennially and adjust the daily upper limit reimbursement amount if necessary.

C. A daily upper limit amount of $850.00 is effective for dates of service on and after January 1, 2007; effective October 1, 2014 inpatient days beyond 24 will be reimbursed at $400.00 per day. This is a prospective per diem rate and will not be included in the cost settlement.

D. The daily upper limit does not apply to the following.

1. Pediatric hospitals

2. Arkansas State Operated Teaching Hospitals, effective for cost reporting periods ending on or after June 30, 2000
3. Border City, University-affiliated, Pediatric Teaching hospitals
4. Inpatient services for children under the age of 1
5. Inpatient services for children, from their first birthday until their discharge date, who were admitted on or before their first birthday and were discharged after their first birthday

E. The daily upper limit is determined as follows.

1. The aggregate daily upper limit amount for a hospital is calculated by multiplying the hospital's cost-reporting period's covered days (excluding days subject to the $400 per diem prospective reimbursement amount) by the $850 upper cost per diem limit.
2. The aggregate daily upper limit amount is compared to the amount carried forward from the comparison of TEFRA-limited costs or charges.
3. The lesser of those two amounts becomes the new aggregate daily upper limit amount, subject to any additional payments or adjustments that may apply, such as direct graduate medical education (GME) costs or disproportionate share hospital (DSH) payments.
4. Effective for dates of service on or after July 1, 2006, Medicaid will review hospital cost report data at least biennially, in accordance with the methodology described above in subparts 1, 2, and 3 and adjust the daily upper limit amount if necessary.

250.240 Limited Acute Care Hospital Inpatient Quality Incentive Payment 11-15-12

A. Effective for claims with dates of service on or after July 1, 2006, all acute care hospitals with the exception of pediatric hospitals, Arkansas State operated teaching hospitals, rehabilitative hospitals, inpatient psychiatric hospitals, critical access hospitals and out-of-state hospitals (in both bordering and non-bordering states) may qualify for an Inpatient Quality Incentive Payment (IQIP).

B. Effective for claims with dates of service on and after January 1, 2007, Border City, University-Affiliated Pediatric Teaching Hospitals do not qualify for an Inpatient Quality Incentive Payment.

1. An IQIP is a per diem-based payment in addition to the hospital's cost-based interim per diem.
2. A qualifying hospital's IQIP is the lesser of $50 (per Medicaid-covered day during the subject cost-reporting period) or 5.9% (also per Medicaid-covered day) of the hospital's interim per diem.

C. Annually, Arkansas Medicaid will designate the quality measures to be reported and will establish a required compliance rate for each measure.

1. To the extent practicable, Medicaid will attempt to choose the quality measures that hospitals report to the Title XVIII (Medicare) Program.
2. To qualify for an IQIP, a hospital must meet or exceed Medicaid's required compliance rate on two-thirds (66.7%) of Arkansas Medicaid's designated quality measures for the most recently completed reporting period.
3. A hospital that meets or exceeds the compliance rate on 66.7% of a reporting period's specified quality measures will receive an IQIP for that year.

   If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

250.300 Disproportionate Share Payment Eligibility 10-13-03

A. Hospitals that serve, proportionate to their total inpatient population, a large number of uninsured, low-income, indigent or Medicaid-eligible individuals may be eligible to qualify for supplemental payments known as "disproportionate share hospital (DSH) payments," from an annual federal allotment designated for that purpose.

B. Acute care, inpatient psychiatric and rehabilitative hospitals may also qualify for DSH payments distributed by the state from the same federal allotment.

1. Only in-state hospital cost report inpatient statistics are used to determine the Medicaid inpatient utilization rates employed in the calculation of the qualifying criteria.

2. Bordering city acute care hospitals that Arkansas Medicaid has paid for more than 850 inpatient days (with dates of service within the qualifying cost report period) are eligible for disproportionate share payments distributed by Arkansas Medicaid. However, inpatient statistics from those hospitals are disregarded when determining Medicaid inpatient utilization rates for disproportionate share payment purposes.

C. The Department of Human Services or its designee determines eligibility for disproportionate share payments. Providers desiring consideration for DSH payment must submit a completed form DMS-628 with their cost report. **View or print form DMS-628.** Providers not submitting form DMS-628 by the state fiscal year end that coincides with or follows the provider's fiscal year end will not qualify for a disproportionate share payment in that cycle.

D. Cost report data from cost reporting periods ending within a given state fiscal year (July 1 through June 30) are used to calculate disproportionate share payments.

1. The calculations are performed during the state fiscal year following the one from which the cost report data derive.

2. The payments thus calculated are made by the end of the state fiscal year in which they are calculated.

EXAMPLE

a. Hospital D's first fiscal year and its first full 12-month cost reporting period run from April 1, 2002, through March 31, 2003.

b. Hospital D's fiscal year 2003 cost report must be submitted to the Division of Medical Services by August 31, 2003 (five-month deadline).

1.) Disproportionate share payments based on data from cost reporting periods ending between July 1, 2002, and June 30, 2003 (i.e., within state fiscal year 2003), comprise one cycle of disproportionate share payments.

2.) Between July 1, 2003, and June 30, 2004, Medicaid calculates the disproportionate share payments due for the cycle that ended June 30, 2003.

c. Hospital D and all other hospitals qualifying for a disproportionate share payment in the state fiscal year 2003 cycle will receive their payments before July 1, 2004.

d. The following table illustrates the disproportionate share payment timetable for all eligible hospitals.

Cost Reporting Periods Ending in state fiscal year:	2003 (7-1-02 through 6-30-03)

Data Compiled and Payments Calculated during state fiscal year:	2004 (7-1-03 through 6-30-04)
State Must Make Payment No Later Than:	6-30-04

E. The State uses the information submitted on the form DMS-628 and the most recent cost report data available (audited or un-audited) to calculate disproportionate share payments.

F. A hospital must meet each of five criteria to receive a disproportionate share payment. These are discussed in Sections 250.310 through 250.350. The first four of these criteria must be met during the qualifying fiscal year. One criterion must be met in the payment year.

250.301 Definitions of Important Terms 12-18-15

A. A hospital's **rural** or **urban** status determines which qualifying criteria to apply to a particular hospital's data.

1. A hospital located within a Metropolitan Statistical Area (MSA), as determined by the Executive Office of Management and Budget, is an **urban** hospital.
2. A hospital located outside an MSA is a **rural** hospital.

B. In the disproportionate share payment calculation to follow, the term "**Medicaid day(s)**" shall have one meaning only. Its meaning shall be in accordance with government regulators' interpretation of the following expression excerpted from Section 1923(b) of the Social Security Act in its instructions for calculating the Medicaid inpatient utilization rate and the low-income utilization rate: "**…eligible for medical assistance under (an approved Medicaid) State plan…**"

1. A **Medicaid day** is a day on which an individual receives inpatient services from a hospital and is "…eligible for medical assistance under (an approved Medicaid) State plan…"
   a. The individual's eligibility for Medicaid is concurrent with all or part of one or more inpatient stays and is on file with the state during the time of the individual's inpatient stay, or
   b. A retroactively determined period of Medicaid eligibility is concurrent with all or part of one or more inpatient stays.
2. Whether Medicaid makes any payment to the hospital is immaterial to whether the patient is eligible for Medicaid.
   a. The relationship of the individual's eligibility is solely to the days that the individual receives services from the hospital. (For example, if a patient is eligible for Medicaid, but all of the current stay is beyond his or her inpatient benefit limit, the patient is still "…eligible for medical assistance." Related charge or cost data is handled accordingly, per instructions.)
   b. Charges for inpatient services on days on which an individual has no Medicaid eligibility and no source of payment are included as charity care. (See part C, below, for the definition of **charity care**.)
3. Individuals dually eligible for Medicare Part A and Medicaid are considered not to be "…eligible for medical assistance under (an approved Medicaid) State plan…" for the purposes of these calculations.
4. Aid Categories 03 and 04 (listed on an eligibility verification transaction response after "AID CATEGORY CODE") are not Arkansas Medical Assistance categories of eligibility and are so noted on the eligibility verification response. Charges for

services for individuals who are on file with the State under Aid Categories 03 and 04 and who have no source of payment are entered under charity care.

C. **Charity care** is care provided to individuals who have no source of payment and are "not eligible for medical assistance under (an approved Medicaid) State plan."

1. Charges for services not covered by an individual's insurance and which the individual is unable to pay are included in charity care even if the individual's insurance has paid on other services that it does cover.
2. Charges for services on days on which the individual has no Medicaid eligibility and no source of payment are included as charity care.
3. Charges attributable to charity care do not include contractual allowances and discounts.
    a. The hospital may not add to charity-care charges the amounts discounted or written off as a result of arrangements made with payers such as HMOs, Medicare or indemnity plans.
    b. Charges unpaid due to Arkansas Medicaid policies that limit payments, such as benefit limits, caps on transplant reimbursement, upper limits on payments, etc., are ***not*** included in charity care. These amounts comprise "Medicaid shortfall" and are addressed later in the disproportionate share payment process.

D. A **standard deviation** is a common statistical tool. It is one of several indices of variability used to characterize dispersions among measures in a given population.

1. With respect to disproportionate share payments, the standard deviation is a number derived from the difference (or variance) among the rates at which the population of Medicaid-eligible inpatients uses the services of individual in-state hospitals.
2. The standard deviation is used to evaluate the difference between the utilization rate of a single hospital and the average utilization rate for all hospitals in the sample.

E. An **inpatient day**, in the context of disproportionate share payment eligibility, is any day "…in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere."

F. The **Medicaid inpatient utilization rate** represents service utilization by the Medicaid-eligible population in the form of a fraction of the total utilization of the hospital's services.

1. It is calculated by dividing the number of Medicaid days during the cost reporting period (as defined above in part B) by the total number of the hospital's inpatient days (as defined directly above in part E).
2. Hospital E has 4014 inpatient days in its fiscal year 2004. Of those inpatient days, Arkansas Medicaid covered 437.

    437 ÷ 4014 = 0.1089

3. Hospital E's Medicaid Inpatient Utilization Rate for fiscal year 2004 is 0.1089.

G. The **low-income utilization rate** is a fraction expressed as a percentage that is determined by adding together the following two calculated quotients:

1. Quotient 1 calculation:
    a. Total Medicaid inpatient receipts/income paid to the hospital **plus** total inpatient cash subsidies received directly from state and/or local governments **divided by**
    b. The total amount of receipts/income received for inpatient services.

2. Quotient 2 calculation:

   a. Total hospital inpatient charges attributable to charity care **less** total inpatient cash subsidies received directly from state and/or local government, **divided by**

   b. Total hospital inpatient charges.

   Calculation of low-income utilization rate

   Example:

   1.) For cost reporting year 2004, Hospital E has Medicaid income/receipts of $1,613,412, out of total hospital inpatient income/receipts of $5,413,891. The county has granted a $500,000 cash subsidy to Hospital E. Of this $500,000 subsidy, $300,000 is for inpatient services.

   2.) In the same cost reporting year Hospital E's total charges for all inpatient services are $9,222,117, of which $1,842,336 is attributable to charity care.

Medicaid revenue:	$1,613,412
Add inpatient cash subsidy:	+ 300,000
Total	$1,913,412
Divide by total inpatient income/receipts:	÷ $5,413,891
Quotient 1=	**0.3534**

Charity care charges:	$1,842,336
Less inpatient cash subsidy:	300,000
Total uncovered charity care:	$1,542,336
Divide by total inpatient charges:	÷ $9,222,117
Quotient 2=	**0.1672**

Quotient 1	0.3534
Quotient 2	+ 0.1672
Sum =	0.5206

Rounded, expressed as a percentage: 52%

   3.) Hospital E's low-income utilization rate for fiscal year 2004 is 52%.

250.310 Full 12-Month Cost Reporting Period 10-13-03

A. Hospitals with cost reporting periods of less than one year (e.g., new hospitals and hospitals under new ownership) are not eligible for disproportionate share payment. The first fiscal year for which a hospital may be considered for disproportionate share payment is its first 12-month fiscal year.

B. Hospital statistical information from cost reporting periods of less than one year is not included in the calculation of the mean Medicaid inpatient utilization rate.

   1. The mean Medicaid inpatient utilization rate is the average of the Medicaid inpatient utilization rates of all in-state hospitals submitting a full 12-month cost report.

2. See part F at Section 250.301 for detailed information regarding the Medicaid inpatient utilization rate.

250.320 A Qualifying Utilization Rate 10-13-03

A. To qualify for disproportionate share payments, a hospital's Medicaid inpatient utilization rate or its low-income utilization rate must be at a certain level.

1. The Medicaid inpatient utilization rate is a relative indicator because it must be at a certain level relative to the mean utilization level for the state.

2. The low-income utilization rate is not considered relative to other hospitals; an individual hospital's low-income utilization rate (see Section 250.301, part G) must exceed 25% of its total utilization.

B. Either indicator can qualify a hospital for disproportionate share payments.

1. Each indicator is linked to a formula for calculating the payment amount.

2. If a hospital qualifies by both indicators, the state calculates the payment amounts by both formulas and awards the higher payment to the hospital.

250.321 Minimum Qualifying Utilization Rates 10-13-03

A. Qualification by the Medicaid inpatient utilization rate:

1. Rural hospitals can qualify with a Medicaid inpatient utilization rate at least one-half standard deviation above the mean Medicaid inpatient utilization rate for all in-state hospitals.

2. Urban hospitals must have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for all in-state hospitals in order to qualify by means of this indicator.

B. Qualification by the low-income utilization rate:

1. Rural hospitals can qualify for disproportionate share payments with low-income utilization rates *exceeding 25%*.

2. Urban hospitals can qualify for DSH payments with low-income utilization rates *exceeding 25%*.

250.330 Minimum Obstetrical Staffing Requirement 10-13-03

A. The hospital must verify that at least two obstetricians have staff privileges at the hospital and have agreed to provide obstetric services to individuals entitled to such services under a Medicaid State Plan.

1. In a rural hospital, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

2. In an urban hospital, an obstetrician is defined as a board-certified obstetrician who has staff privileges and performs non-emergency obstetric procedures.

B. Hospitals are exempt from these staff requirements if:

1. The hospital's inpatients are predominately individuals under 18 years of age or

2. The hospital did not offer non-emergency obstetric services as of December 21, 1987.

C. Hospitals must notify the Arkansas Medicaid Program immediately of obstetrical physician staffing changes that affect their DSH eligibility with respect to the above criteria.

1. A hospital will not receive DSH payments for any period in which it does not meet the obstetrical physician criteria.
2. The Arkansas Medicaid Program periodically verifies hospitals' physician staffing.

250.340 Minimum Medicaid Inpatient Utilization Rate 10-13-03

To qualify for DSH payments, a hospital must have a minimum Medicaid inpatient utilization rate of one percent in the qualifying fiscal year. One percent in decimal form is 0.0100. The Medicaid inpatient utilization rate may not be a fraction less than 0.0100 that has been rounded up to 1%.

250.350 Minimum Payment Year Requirement 10-13-03

A hospital due to receive a disproportionate share payment must be licensed, operating and participating in the Arkansas Medicaid Program at the time of payment distribution in order to receive the payment.

250.400 Calculating Disproportionate Share Payments 10-13-03

A. Each hospital qualifying for a disproportionate share payment receives a $1000.00 minimum payment, plus a cost settlement adjustment in accordance with the appropriate formula from Sections 250.410 through 250.450.

B. The amounts resulting from these calculations are subject to the disproportionate share payment limit as well as to possible reduction due to the limited amount of the federal allotment.

250.410 Rural Hospitals Qualifying under the Medicaid Inpatient Utilization Rate 10-13-03

A. The disproportionate share payment to rural acute care hospitals qualifying under the Medicaid inpatient utilization rate is based on standard deviation increments above the mean Medicaid utilization rate for in-state hospitals.

B. For each of four established increments in the standard deviation, there is a corresponding DSH percentage payable.

Standard Deviation Above the Mean	DSH Percentage Payable	Allowable Costs Multiplier
$\geq$ 0.5 and < 1.0	7	1.07
$\geq$ 1.0 and < 2.0	8	1.08
$\geq$ 2.0 and < 3.0	9	1.09
$\geq$ 3.0	10	1.10

Example: Hospital F has a Medicaid inpatient utilization rate of 0.51, which is 1.4 standard deviations above the mean rate. The mean is 0.396. The standard deviation is 0.0813. According to the table above, Hospital F qualifies for a disproportionate share payment equal to 8% of its fiscal year Medicaid per diem reimbursement, plus $1000.00.

The expression "fiscal year Medicaid per diem reimbursement" is quoted exactly as it appears in the Social Security Act. It does not refer to the interim per diem. It means the allowable costs from the provider's cost report.

250.420 Urban Hospitals Qualifying under the Medicaid Inpatient Utilization Rate 10-13-03

A. Disproportionate share payment to urban hospitals qualifying under the Medicaid inpatient utilization rate is based on the percentage by which a hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate for in-state hospitals.

B. The written expression of the formula is as follows below in 1 and 2.

1. The disproportionate share payment to urban hospitals qualifying under the Medicaid inpatient utilization rate is a minimum payment of $1000.00, ***plus***
2. Ten percent (0.1) ***multiplied by*** the result of the following calculations:
   a. (The individual hospital's Medicaid inpatient utilization rate, ***minus*** one standard deviation above the mean Medicaid utilization rate), ***multiplied by***
   b. (The hospital's allowable inpatient cost identified on the cost report).

C. Example:

Hospital G's total inpatient reimbursement (excluding DSH) for its fiscal year 2001 is $6,468,414.00. Hospital G's Medicaid inpatient utilization rate is 0.5583. The mean Medicaid inpatient utilization rate is 0.2126 and the standard deviation is 0.0942.

1. Plugging these numbers into the formula above results in:

   $1000.00 + 0.1 **X (**0.5583 – (0.0942 + 0.2126)**) X** $6,468,414.00
2. Performing the calculations one at a time, beginning within the inside parentheses:

   $1000.00 + 0.1 **X** (0.5583 – 0.3068) **X** 6,468,414.00 =

   $1000.00 + 0.1 **X** 0.2515 **X** 6,468,414.00 =

   $1000.00 + 0.02515 **X** 6,468,414.00 =

   $1000.00 + $162,680.61 = $163,680.61
3. The DSH amount payable (subject to any other limits) to Hospital G is $163,680.61.

250.430 Hospitals Qualifying under the Low Income Utilization 10-13-03

A. Urban and rural acute care hospitals qualifying for disproportionate share payments based on their low income utilization rate receive an amount based on the difference between the hospital's low income utilization rate and the threshold rate of 25%. (A hospital's low-income utilization rate must exceed 25% to qualify the hospital for disproportionate share payments.)

B. The written expression of the formula is: Acute care hospitals qualifying for disproportionate share payments based on their low-income utilization rate receive $1000.00 plus

1. (0.04) *times* (the individual hospital's low-income utilization rate *minus* 25%) times
2. (the hospital's fiscal year Medicaid per diem reimbursement).

   The expression "fiscal year Medicaid per diem reimbursement" is quoted exactly as it appears in the Social Security Act. It does not refer to the interim per diem. It means the allowable costs from the provider's cost report.

C. Example:

Total reimbursement for Hospital H's allowable costs for fiscal year 2001 is $1,363,032.00. The hospital's low-income utilization rate is 39.3 percent.

1. Plugging the numbers into the formula, we get:

   $1000.00 + 0.04 **X** (0.393 – 0.25) **X** $1,363,032.00 **=**

   $1000.00 + (0.04 **X** 0.143) **X** 1,363,032.00 **=**

   $1000.00 + (.00572 **X** 1,363,032.00) **=**

   $1000.00 + $7796.54 = $8,796.54

2. Hospital H's DSH payment is $8796.54.

250.440 Hospitals Qualifying For Disproportionate Share Payments by Both Indicators 10-13-03

If a hospital qualifies for disproportionate share payments under both the Medicaid inpatient utilization rate and the low-income utilization rate, Arkansas Medicaid will use the method that results in the higher payment for the hospital.

250.450 Limitations to Disproportionate Share Payments 10-13-03

A. Section 1923(c)(1) of the Social Security Act—with additional clarification at Section 1923 (g)(1) of the Act—imposes a limit on individual DSH payments. Application of this limitation may result in retrospective adjustments to some DSH payments.

B. The DSH payment to a hospital during a given state fiscal year (SFY) must not exceed the hospital's costs for uncompensated care during the SFY in which the DSH payment is made.

1. The "uncompensated care" costs that constitute the DSH payment limit are determined by means of the formula and instructions to follow.

2. The uncompensated care costs comprise two sets of costs.

   a. The first set of costs is the Medicaid "shortfall."

      1.) The shortfall is the cost of services furnished to Medicaid patients, less the amount Medicaid has paid for services under the state plan.

      2.) Disproportionate share payments are not included in the amount Medicaid has paid.

   b. The second set of costs is:

      1.) The cost of services provided to uninsured patients during the year, less

      2.) The total of payments made by or on behalf of those patients.

      3.) The cost of services to "uninsured" patients includes the cost of services not covered by individual insurance policies or plans.

3. Calculation of the limit is as follows: Individual Hospital Disproportionate Share Payment Limit = **M + U**

   a. **M** = Cost of services to Medicaid patients, less the amount paid by the state under the non-disproportionate share payment provisions of the state plan.

   b. **U** = Cost of services to uninsured patients, less any cash payments made by them or in their behalf. (Includes cost of services to patients who have insurance that does not cover the service(s) they received.)

C. Example:

1. Hospital I reports costs of $3,643,912.00 for services furnished to Medicaid patients during the cost reporting period ending June 30, 2003.

2. Arkansas Medicaid has calculated a total reimbursement amount of $3,211,437.00 for the hospital's 2003 fiscal year, which runs exactly parallel to the Arkansas state fiscal year (SFY).

Cost of Services to Medicaid Patients =		$3,643,912.00
Less Medicaid Payment		3,211,437.00
	M =	$ 432,475.00
Cost of services to uninsured patients =		$800,311.00
Less payments by uninsured patients		106.00
	U =	$800,205.00
M		$432,475.00
+ U		+ 800,205.00
Disproportionate Share Payment Limit		$1,232,680.00

3. Hospital I's disproportionate share payment in SFY 2003 may not exceed $1,232,680.00.
4. If Arkansas Medicaid should determine later that the DSH amount initially paid to Hospital I during SFY 2003 exceeded $1,232,680.00, Hospital I must refund the amount in excess.
5. When a hospital's fiscal year does not run parallel to, but instead overlaps the SFY, final determination of the hospital's uncompensated costs during a given SFY must be made using portions of two cost reports.

D. In any given state fiscal year, if the total of a state's disproportionate share payments due should exceed the amount of the state's federal allotment (plus the corresponding state matching funds), the state Medicaid agency will proportionately reduce the amount of each payment until the sum of the payments equals the amount in the disproportionate share pool.

250.460 Annual Disproportionate Share Hospital (DSH) Audit 9-1-24

In addition to any other audits which may occur, independent certified audits of the Disproportionate Share Hospital (DSH) payments shall be conducted annually in accordance with 42 CFR 455.301 and 42 CFR 455.304. Reporting of the audit shall follow the requirements of 42 CFR 447.299. In accordance with 42 CFR 455.304(e), any overpayments of DSH funds shall be redistributed to other eligible hospitals within the state, provided each acute care hospital remains below their hospital specific DSH limit, in the following manner:

A. The amount of the DSH payment made to the acute care hospital will be recouped by the State of Arkansas to the extent necessary to reduce the DSH payment to an allowable amount.

B. Amounts recouped from acute care hospitals with payments in excess of the audited hospital specific DSH limits will be placed into an acute care hospital redistribution pool. Redistribution will be made to remaining acute care hospitals that do not exceed their hospital specific DSH limit. The allocation will be made based on these remaining acute care hospitals' available uncompensated care. No acute care hospital shall exceed its hospital specific DSH limit after redistribution.

C. Additionally, DSH funds not otherwise paid to qualifying acute hospitals shall be paid, subject to the uncompensated care cost limits and annual DSH allotment, to the Arkansas State Operated Teaching Hospital.

250.500 Disproportionate Share Payment and Rate Appeal Process 10-13-03

Participating hospitals are provided the following mechanism to appeal their disproportionate share eligibility and/or rate.

A. All hospitals will be notified of their eligibility status for the disproportionate share payment and of their disproportionate share rate, by certified mail. A hospital administrator may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following receipt of the certified letter, which notifies the hospital of their disproportionate eligibility status and/or rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference if needed.

Regardless of the program decision, the provider will be afforded the opportunity for a conference if he so wishes for a full explanation of the factors involved in the program decision. Following review of the appeal request, the Assistant Director will notify the hospital of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

B. If the decision of the Assistant Director, Division of Medical Services, is unsatisfactory, the facility may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the Arkansas Hospital Association and a member of the Department of Human Services (DHS) Management Staff who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question within 15 calendar days after receipt of a request for such appeal. The question will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services for approval. **View or print form DMS-628, Medicaid Low Income Utilization Schedule for Determination of Disproportionate Share Eligibility.**

250.600 In-State Hospital Class Groups

250.610 Pediatric Hospitals 7-1-06

A pediatric hospital is an acute care hospital that has in effect an agreement with the Division of Medical Services (DMS) to participate in Medicaid as a hospital and the majority of its patients are under 21. See Section 201.110 for participation requirements for pediatric hospitals.

A. Medicaid reimburses pediatric hospitals for inpatient services by means of an interim per diem with year-end cost settlement.

1. Unless supplemented by state law or rule, reasonable costs are determined in accordance with 42 U.S.C. § 1395x (v)(1)(A) and the implementing federal regulations.

2. Medicaid adjusts interim per diem rates annually upon receipt and review of initial cost reports.

B. Medicaid reimburses pediatric hospitals for outpatient services by a fee-for-service methodology, at the lesser of the billed charge or the Medicaid fee schedule maximum, with year-end cost settlement.

C. A new pediatric hospital is a pediatric hospital enrolling with Medicaid for the first time.

1. The TEFRA rate-of-increase limit base year for new pediatric hospitals is the first full 12-month cost reporting period beginning after the State grants approval for the hospital to operate under Medicaid as a pediatric hospital.

2. A new pediatric hospital may request an exemption from the TEFRA rate-of-increase limit.

a. The hospital must submit a written request at least 180 days before the end of the first full 12-month cost reporting period that began on or after the hospital's approved date of enrollment with Medicaid.

b. If a new pediatric hospital requests and receives an exemption to the TEFRA rate-of-increase limit, the hospital's base year will be the first full cost reporting period beginning at least two years after the effective date of the state's approval for the hospital to operate as a pediatric hospital.

D. Pediatric hospitals are exempt from limitation by the Arkansas Medicaid daily upper limit.

E. Pediatric hospitals are not eligible for Inpatient Quality Incentive Payments (IQIP). See Section 250.240 for information regarding IQIP.

250.620 Arkansas State Operated Teaching Hospitals 10-13-03

A hospital is an Arkansas State Operated Teaching Hospital if it has in effect an agreement to participate in Medicaid as an acute care hospital, is operated by the State of Arkansas and has current accreditation from the North Central Association of Colleges and Schools.

A. Arkansas State Operated Teaching Hospitals are reimbursed by interim per diem with year-end cost settlement.

1. With certain exceptions, Arkansas Medicaid follows Medicare's principles of cost reimbursement.

2. Medicaid adjusts interim per diem rates annually upon receipt of initial cost reports.

B. The TEFRA rate-of-increase limit is not applied to Arkansas State Operated Teaching Hospitals for cost reporting periods ending on or after June 30, 2000.

C. Medicaid reimburses Arkansas State Operated Teaching Hospitals for outpatient services by a fee-for-service methodology in accordance with an established fee schedule, with year-end cost settlement, effective for cost reporting periods ending on and after June 30, 2000.

250.621 Direct Graduate Medical Education (GME) Costs; Exclusion from Interim Per Diem 10-13-03

A. Effective for cost reporting periods beginning on or after January 1, 1997, Arkansas Medicaid excludes GME costs from the interim per diem rate for Arkansas State Operated Teaching Hospitals.

1. The State provides interim quarterly reimbursement for GME costs.

2. The amount of GME cost reimbursement is the number of inpatient days paid in the quarter multiplied by the GME cost per day derived from the hospital's cost report from its most recent full cost reporting period.

B. GME reimbursement is calculated in accordance with federal regulations at 42 CFR, 413.86.

1. The only exception to the referenced Medicare rules is the inclusion of nursery costs in the calculation of the cost per resident.

2. GME payments are not subject to the Arkansas Medicaid daily upper limit.

C. Graduate medical education (GME) costs are included in the final cost settlement.

250.622 Arkansas State Operated Teaching Hospital Adjustment 1-1-16

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

A. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit.

B. The adjustment is calculated as follows:

1. Using the most current audited data, Arkansas Medicaid determines each State Operated Teaching Hospital's base Medicare per discharge rate and base Medicaid per-discharge rate.
    a. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.
    b. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
    c. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the adjustment payments will be made.
2. The base per-discharge rates are trended forward to the current fiscal year using an annual Consumer Price Index inflation factor.
3. Once the per-discharge rates have been trended forward, the Medicare per-discharge rate is divided by the Medicare case mix index and the Medicaid per-discharge rate is divided by the Medicaid case mix index.
    a. The Medicare case mix index reflects the hospital's average diagnosis related group (DRG) weight for Medicare patients.
    b. The Medicaid case mix index reflects the hospital's average DRG weight for Medicaid patients using the Medicare DRGs.
4. The base Medicaid per-discharge rate is subtracted from the base Medicare per discharge rate.
5. The difference is multiplied by the hospital's Medicaid case mix index.
6. The adjusted difference is multiplied by the number of Medicaid discharges at the hospital for the most recent fiscal year.
7. The result is the amount of the annual State Operated Teaching Hospital Adjustment.
8. Payment is made on an annual basis before the end of the state fiscal year (June 30).
9. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.623 Private Hospital Inpatient Adjustment 10-1-14

Effective October 1, 2014, Arkansas Medicaid will remove the annual "Private Hospital Inpatient Adjustment" UPL $25.2 million methodology payments. The last quarterly "Private Hospital Inpatient Adjustment" reimbursement payments will be made within 15 days after September 30, 2014 for that quarter ending data.

250.624 Non-State Public Hospital Inpatient Adjustment 1-1-16

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

A. The adjustment shall result in total payments to each hospital that are equal to but not in excess of the individual facility's Medicare-related upper payment limit, as prescribed in 42 CFR § 447.272. The adjustment shall be calculated as follows.

1. Using data from the hospital's most recent audited cost report, Arkansas Medicaid shall determine each eligible non-state public hospital's base Medicare per discharge rate and its base Medicaid per discharge rate

a. Base Medicare and Medicaid per discharge rates will include respective Case Mix Index (CMI) adjustments in order to neutralize the impact of the differential between Medicare and Medicaid case mixes.

b. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.

c. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.

d. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the adjustment payments will be made.

2. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

3. For a hospital that, for the most recent audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine the hospital's rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year.

4. Hospitals with partial year cost reports which were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

B. The base Medicare per discharge rate shall be multiplied by the applicable upper payment limit (percentage) specified in 42 CFR § 447.272 for non-state government owned or operated hospitals.

1. For example, to the extent that such federal regulation permits Medicaid payments up to 150 percent of the amount that would be paid under Medicare reimbursement principles, the base Medicare per discharge rate shall be multiplied by 150 percent.

2. The result shall be the adjusted Medicare per discharge rate.

3. The base Medicaid per discharge rate shall then be subtracted from the adjusted Medicare per discharge rate.

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

C. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

D. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.625 Inpatient Adjustment for Non-State Public Hospitals Outside Arkansas 1-1-16

Effective April 1, 2006 through December 31, 2006, Arkansas may provide a public inpatient rate adjustment to non-state government owned or operated acute care regional medical center hospitals located outside of Arkansas (that is, acute care hospitals outside of Arkansas that are neither owned nor operated by any state) that: a) Provide level 1 trauma and burn care services; b) Provide level 3 neonatal care services; c) Are obligated to serve all patients, regardless of the patient's state of origin; d) Are located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 states, including Arkansas; e) Serve as a tertiary care provider for patients residing within a 125 mile radius; and f) Meet the criteria for disproportionate share hospital under Section 1923 of the Social Security Act in at least one state other than the state in which the hospital is located.

The adjustment shall result in total payments to each hospital that are equal to but not in excess of the individual facility's Medicare-related upper payment limit, as prescribed in 42 CFR § 447.272. The adjustment shall be calculated as follows.

A. Using data from the hospital's most recent audited cost report, Arkansas Medicaid shall determine each eligible non-state public hospital's base Medicare per discharge rate and its base Medicaid per discharge rate

1. Base Medicare and Medicaid per discharge rates will include respective Case Mix Index (CMI) adjustments in order to neutralize the impact of the differential between Medicare and Medicaid case mixes.
2. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.
3. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
4. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the adjustment payments will be made.
5. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.
6. For a hospital that, for the most recent audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine the hospital's rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year.
7. Hospitals with partial year cost reports which were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

B. The base Medicare per discharge rate shall be multiplied by the applicable upper payment limit (percentage) specified in 42 CFR § 447.272 for non-state government owned or operated hospitals.

1. For example, to the extent that such federal regulation permits Medicaid payments up to 150 percent of the amount that would be paid under Medicare reimbursement principles, the base Medicare per discharge rate shall be multiplied by 150 percent.

2. The result shall be the adjusted Medicare per discharge rate.

3. The base Medicaid per discharge rate shall then be subtracted from the adjusted Medicare per discharge rate.

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

C. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

D. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.626 In-State Private Pediatric Inpatient Adjustment 1-1-16

All Arkansas private pediatric hospitals qualify for a pediatric hospital inpatient rate adjustment. The amount of the adjustment shall be determined annually by Arkansas Medicaid based on available funding. Each qualifying hospital's adjustment amount shall be equal to their pro rata share of the total adjustment based on the hospital's Medicaid discharges for the most recent audited final year. In no case shall the pediatric hospital adjustment be in an amount that results in aggregate Medicaid inpatient payments to all private hospitals (including the private hospital inpatient rate adjustment) that are in excess of the applicable Medicare-related upper payment limit specified in 42 C.F.R § 447.727.

If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.627 Non-State Government Owned or Operated Outpatient UPL Reimbursement Adjustment 1-1-16

Arkansas non-state government-owned or operated acute care/general hospitals (that is, all acute care government hospitals within the state of Arkansas that are neither owned nor operated by the State of Arkansas) shall qualify for an annual upper payment limit (UPL) reimbursement adjustment. Psychiatric hospitals, pediatric hospitals, rehabilitative hospitals and critical access hospitals are not eligible for an adjustment. Payment shall be made before the end of the state fiscal year (SFY). The adjustment will be calculated and based on each hospital's previous SFY outpatient Medicare-related upper payment limit (UPL as specified in 42 CFR 447.321) for Medicaid reimbursed outpatient services. The adjustments will be calculated as follows:

A. For each qualifying hospital, Arkansas Medicaid will annually identify the total Medicaid outpatient expenditures during the most recent completed SFY.

B. For each qualifying hospital, the total Medicaid expenditures are determined in step A, and are divided by 80% to estimate the amount that would have been paid using Medicare reimbursement principles.

C. The difference between step A identified Medicaid expenditures and step B estimated Medicare amounts is the UPL annual adjustment amount that will be reimbursed.

Eligible hospitals that were not licensed and providing services throughout the most recent completed SFY shall receive a pro-rated adjustment based on the partial year data.

D. Payment for SH+FY 2003 shall be pro-rated proportional to the number of days between April 1, 2003 and June 30, 2003 to the total number of days in SFY 2003.

E. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

F. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.628 Inpatient Hospital Access Payments 1-1-16

All Arkansas private hospitals (that is, all hospitals within the state of Arkansas that are neither owned nor operated by state or local government), with the exception of private rehabilitative and specialty hospitals, qualify for a private hospital inpatient access payment.

The inpatient access payment shall be equal to each eligible hospital's pro rata share of a funding pool, based on the hospital's Medicaid discharges. The amount of the funding pool shall be determined annually by Arkansas Medicaid based on available funding.

The access payments shall be calculated as follows:

A. Arkansas Medicaid shall annually determine the amount of available funding for the private hospital access payment funding pool. The maximum allowable aggregate Medicaid inpatient hospital access payment for private hospitals will not exceed 97% of the difference between the Medicaid UPL and the Medicaid-based payments.

B. For each private hospital eligible for the access payment, Arkansas Medicaid shall determine the number of Medicaid discharges for the most recent audited fiscal period.

1. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period.
2. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
3. In order to be used to calculate the access payments, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the payments will be made.
4. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.
5. For hospitals that filed a partial year cost report for the most recently audited cost report year, such partial year cost report data shall be annualized to determine their access payment, provided that such hospital was licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report year shall receive pro-rated payments based on the partial year data.

C. To the extent that this private hospital access payment results in payments in excess of the upper payment limit, such payments shall be reduced on a pro rata basis according to each hospital's Medicaid discharges. Such reduction shall be no more than the amount necessary to ensure that aggregate Medicaid inpatient reimbursement to private hospitals is equal to but not in excess of the upper payment limit.

D. For each eligible private hospital, Arkansas Medicaid shall determine its pro rata percentage, which shall be a fraction equal to the number of the hospital's Medicaid discharges divided by the total number of Medicaid discharges of all eligible hospitals.

E. The amount of each eligible hospital's access payment shall be its pro rata percentage multiplied by the amount of available funding for the inpatient hospital access payment pool as determined by Arkansas Medicaid.

F. Inpatient hospital access payments shall be made on a quarterly basis.

G. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.629 Outpatient Hospital Access Payments 1-1-16

All Arkansas private hospitals (that is, all hospitals within the state of Arkansas that are neither owned nor operated by state or local government), with the exception of private rehabilitative and specialty hospitals, qualify for a private hospital outpatient access payment.

The outpatient access payment shall be equal to each eligible hospital's share of a funding pool, pro-rated based on the hospital's paid claims adjudicated for outpatient hospital services. The amount of the funding pool shall be determined annually by Arkansas Medicaid based on available funding.

The access payments shall be calculated as follows:

A. Arkansas Medicaid shall annually determine the amount of available funding for the private hospital access payment funding pool by using the Medicare cost principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals shall not exceed the difference between the results of Medicaid-based payments and the Medicaid outpatient hospital services cost.

B. For each private hospital eligible for the adjustment, Arkansas Medicaid shall determine the Medicaid paid claims adjudicated for outpatient hospital services for the most recent audited fiscal period.

1. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for access payment purposes.
2. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
3. In order to be used to calculate the access payment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1st of the state fiscal year (SFY) for which the payments will be made.
4. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.
5. For hospitals that filed a partial year cost report for the most recently audited cost report year, such partial year cost report data shall be annualized to determine their access payments, provided that such hospitals were licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report year shall receive pro-rated access payments based on the partial year data.

C. For each eligible private hospital, Arkansas Medicaid shall determine its pro rata percentage, which shall be a fraction equal to the hospital's Medicaid paid claims adjudicated for outpatient hospital services divided by the total Medicaid paid claims adjudicated for outpatient hospital services of all eligible hospitals.

D. Outpatient hospital access payments shall be paid on a quarterly basis.

E. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.630 Medicaid Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions 1-15-15

A. Arkansas Medicaid implemented 42 CFR 477.26; which requires that all state Medicaid plans prohibit payment for "provider-preventable conditions." The umbrella term "provider-preventable conditions" (PPCs) includes two separate categories: "healthcare-acquired conditions" (HCACs) and "other provider-preventable conditions" (OPPC). HCACs apply to Medicaid inpatient hospital settings and are generally defined to include the full list of Medicare's previous inpatient "hospital-acquired conditions" (HAC). Other provider preventable conditions that Arkansas Medicaid will be prohibiting payment for in any healthcare setting will be wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part or surgical or other invasive procedure performed on the wrong patient (See table below for detailed descriptions of healthcare-acquired conditions and other provider-preventable conditions.)

To be reportable, the adverse event must meet the following criteria:

1. The event must be reasonably preventable as determined by a root cause analysis.
2. The event must be within the control of the hospital.
3. The event must be clearly a result of a preventable mistake made from hospital procedures not being followed; otherwise the event would not have occurred.
4. The error or event resulted in significant harm which resulted in increased duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition.
5. All processes for identifying an event as non-payable will incorporate some element of case-by-case review and determination.
6. Pursuant to these guidelines, providers will not seek payments for additional days or services directly resulting from adverse events.

Health Acquired Conditions: **Inpatient Hospital Setting**	
Air Embolism	Vascular Catheter-Associated Infection
Blood Incompatibility	Manifestations of Poor Glycemic Control • Diabetic Ketoacidosis • Nonketotic Hypersmolar Coma • Secondary Diabetes with Ketoacidosis Secondary Diabetes with Hyperosmolarity

Health Acquired Conditions: **Inpatient Hospital Setting**	

Stage III and IV Pressure Ulcers	Surgical Site Infection
	• Orthopedic Procedures
	  ○ Spine
	  ○ Neck
	  ○ Shoulder
	  ○ Elbow
	• Coronary Artery Bypass Graft-Mediastinitis
	• Bariatric Surgery
	  ○ Laparoscopic Gastric Bypass
	  ○ Gastroenterostomy
	  ○ Laparoscopic Gastric Restrictive Surgery

Falls and Trauma • Fractures • Dislocations • Intracranial Injuries • Crushing Injuries • Burns • Electric Shock	Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement-*with pediatric and obstetric exceptions*
Catheter-Associated Urinary Tract Infection (UTI)	**Provider Preventable Conditions In any Health Care Setting:** • Wrong Surgical or other invasive procedure performed on a patient • Surgical or other invasive procedure performed on the wrong body part • Surgical or other invasive procedure performed on the wrong patient • Unintended retention of a foreign object

B. Reporting an Adverse Health Event:

Providers must use Form DMS-2704 (**View or print Form DMS-2704**.) Adverse Events Notification to report an Adverse Health Event. Adverse events must be reported to Arkansas Medicaid by faxing a completed Form DMS-2704 (**View or print Form DMS-2704.**) to the Division of Medical Services Reimbursement Unit. **View or print Provider**

Reimbursement Unit Contact Information. Reports will require the beneficiary first and last name, beneficiary date of birth, beneficiary ID number, type of event, date of event, facility name and contact information. (**See Form DMS-2704 on the Arkansas Medicaid website** or Section V of this provider manual.)

C. Prohibiting Payments for Adverse Events:

Arkansas Medicaid will continue to prohibit payment for events defined as preventable, serious adverse events that occurred under the care of the provider and that are included on the National Quality Forum's list of Serious Reportable Events as of December 15, 2008. Hospitals and ambulatory surgical centers must utilize the billing system and appropriate diagnosis codes to report conditions present on admission or provider-preventable conditions that occurred during the course of treatment. Arkansas Medicaid will determine, on a post-payment basis, whether to partially or fully recoup claims payment for Health-Acquired Conditions (HACs) or Provider-Preventable Conditions.

D. Appeals Processes:

Existing appeal processes are available for providers to contest whether the State has improperly identified the occurrence of a condition identified as a Provider Preventable Condition.

250.700 Allowable Costs 10-13-03

Except for graduate medical education costs the interim per diem rates are calculated in a manner consistent with the Medicare Program.

A. The State uses Medicare allowable costs as stated in the HIM-15.

B. The State uses the criteria referenced at 42 CFR, Section 413.80(e)—Criteria for allowable bad debt—to determine allowable bad debt.

C. Costs associated with administration, physicians and teachers are included in costs as recognized by Medicare reimbursement principles.

250.701 Costs Attributable to Private Room Accommodation 6-1-06

A. The cost of a private room is allowable when the patient's attending physician certifies that a private room is medically necessary.

B. When a Medicaid beneficiary is placed in a private room because no semi-private rooms are available, there is no difference in Medicaid cost settlement.

250.710 Organ Transplant Reimbursement 3-15-05

Effective for dates of service on and after December 3, 2004, Arkansas Medicaid reimburses hospitals for organ transplants in accordance with one of four methodologies.

A. Three of the reimbursement methodologies apply to all in-state acute care/general hospitals, all bordering city hospitals and all out-of-state hospitals, except for in-state pediatric hospitals and Arkansas state-operated teaching hospitals.

B. With the exception of inpatient stays for bone marrow transplants, inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

C. Organ transplant reimbursement methodologies are explained in Sections 250.711 through 250.717.

250.711 Bone Marrow Transplants 3-15-05

A. Interim reimbursement for bone marrow transplants is 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed.

1. Total reimbursement for all covered transplant-related services (except any services specifically exempted in this section) may not exceed $150,000.00.

2. Medicaid's remittance includes reimbursement for all covered inpatient hospital services related to the transplant procedure (unless excluded in this section) from the date of admission for the bone marrow transplant procedure to the date of discharge.

B. The hospital claims and the physician claims are manually priced simultaneously after all participating providers have filed their claims.

C. When the combined total of 80% of all participating providers' billed charges exceeds the $150,000.00 maximum allowed reimbursement, each provider's reimbursement is decreased by an equal percentage until the combined total does not exceed the $150,000.00 limit.

D. Medicaid's reimbursement of the medical expenses of a bone marrow donor is not included in the $150,000.00 maximum reimbursement. Providers may submit charges for services related to the donor's participation as those services occur.

E. Medicaid reimbursement for outpatient donor tissue typing is not included in the $150,000.00 maximum reimbursement allowed for bone marrow transplants. Providers may submit charges for outpatient donor tissue typing services as the services occur.

F. Medicaid reimbursement for donor medical transportation related to a bone marrow transplant is not included in the $150,000.00 maximum reimbursement allowed for bone marrow transplants.

250.712 Corneal, Kidney and Pancreas/Kidney Transplants 3-15-05

The Arkansas Medicaid Program reimburses each hospital for inpatient services related to corneal, kidney and pancreas/kidney transplants in accordance with the same methodology that the Program employs to reimburse the hospital for any other inpatient service.

250.713 Other Covered Transplants in all Hospitals Except In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals 8-1-21

A. Hospital services (not including organ acquisition) related to other covered transplant procedures (i.e., all but bone marrow, corneal, kidney and pancreas/kidney) are reimbursed at 45% of submitted charges.

1. Reimbursement includes all medical services related to the covered transplant procedure from the date of the transplant procedure to the date of discharge.

   a. Transplant hospitalization days in excess of transplant length-of-stay averages must be approved through DHS or its designated vendor's medical review.

   b. Transplant length-of-stay averages for each transplant type will be determined from the most current written Medicare National Coverage Decisions.

2. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

B. Medically necessary readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same methodology as the initial transplant service at 45% of submitted charges.

250.714 Other Covered Transplants in In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals 8-1-21

A. Hospital services provided by in-state pediatric hospitals and Arkansas state-operated teaching hospitals related to other covered transplant procedures (does not include bone marrow, corneal, kidney or pancreas/kidney) are reimbursed in the same manner as other inpatient hospital services with interim reimbursement and final cost settlement.

B. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

C. Medically necessary readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same reimbursement methodology as the initial transplant service.

D. The TEFRA rate of increase limit is not applied to in-state pediatric hospitals for covered transplant procedures other than corneal, renal, pancreas/kidney and bone marrow transplants.

250.715 Organ Acquisition Related to "Other Covered Transplants" 10-1-06

Organ transplants other than bone marrow, corneal, kidney and pancreas/kidney are considered "other covered transplants" for the purposes of this rule.

A. Reimbursement for the acquisition of the organ to be transplanted is at:

1. 100% of the submitted organ invoice amount from a third-party organ provider organization or
2. The hospital's reasonable cost with interim reimbursement and year-end cost settlement.

B. The hospital may choose either of the two methods.

1. Under the invoice method, Medicaid will reimburse the hospital 100% of the invoice amount, with no additional reimbursement.
2. Under the interim reimbursement method, Medicaid will remit an interim payment and calculate a year-end cost settlement in a manner consistent with the method used by the Medicare Program for organ acquisition costs.

250.716 Beneficiary Financial Responsibility 3-15-05

The beneficiary may not be billed for Medicaid-covered charges in excess of the State's reimbursement.

250.717 Transportation Related to Transplants 3-15-05

A. Transportation is available for the Medicaid beneficiary through the Arkansas Medicaid Program.

B. Transportation costs are not included in the $150,000.00 maximum reimbursement for bone marrow transplant services.

250.720 Costs Associated with Children under the Age of One 10-13-03

Operating costs related to medically necessary inpatient services for children under the age of one year, and for children admitted before their first birthday and discharged on or after their first

birthday, are cost-settled separately from costs related to inpatient services for all other Medicaid-eligible individuals. No dollar limits are applied and the costs are not considered in the TEFRA rate of increase limit computation.

250.721 Newborn Physiological Bilateral Hearing Screen 11-1-17

A. Additional Payment for Newborn Bilateral Physiological Hearing Screens

Arkansas Medicaid remits to birthing hospitals, in addition to the per diem reimbursement for a newborn admission, a separate amount for providing newborn bilateral physiological hearing screens.

B. Billing Instructions

1. Providers may bill Medicaid for a newborn bilateral physiological hearing screen only on a claim for an inpatient newborn admission.
    a. Use revenue code 471 to identify the charges for the newborn bilateral physiological hearing screen.
        1.) Revenue code 471 is also used for diagnostic audiology for patients other than newborns.
        2.) Other data elements present on the newborn claim will ensure that the revenue code is processed correctly in each circumstance.
    b. When the fiscal agent adjudicates for payment an inpatient CMS-1450 claim on which:
        1.) The date of admission is the patient's date of birth,
        2.) Condition code 81 is present and
        3.) The type of bill code is 111 or 112; then
    c. Medicaid will remit payment for the newborn bilateral physiological hearing screen separately (though on the same Remittance and Status Report) from the per diem payment remitted to the hospital for the admission.
2. Remittance and Status Reports (RAs) for paid inpatient claims will display an additional line of text for each inpatient newborn admission that is billed to Medicaid with revenue code 471.
    a. The additional line of text will explain that the check includes a payment of $96.00 for a newborn bilateral physiological hearing screen and that the payment is in addition to the regular interim per diem payment for the admission.
    b. This payment amount of $96.00 is equal to the amount paid to providers furnishing this hearing screen as an outpatient service.

251.000 Out-of-State Hospital Reimbursement 10-13-03

A. Arkansas Medicaid follows a prospective payment system methodology to reimburse out-of-state hospitals for inpatient services.

1. Out-of-state hospitals are class-grouped as follows according to the number of licensed acute care beds:

Group Number	Acute Care Beds
1	Over 300
2	151 to 300
3	101 to 150

4	51 to 100
5	1 to 50

2. Within each of the five class groups there are four subgroups as follows:
   a. Teaching hospitals excluding allowance for indigent care
   b. Non-teaching hospitals excluding allowance for indigent care
   c. Non-teaching hospitals including allowance for indigent care
   d. Teaching hospitals including allowance for indigent care

B. Hospitals in bordering cities (see Section 250.200 for definition of bordering cities) are reimbursed by means of interim per diem and cost settlement.

1. Certain exemptions granted to some in-state hospitals do not apply to bordering city hospitals. See the appropriate section regarding each exemption for information regarding its application or non-application to bordering city hospitals.
2. Costs associated with inpatient stays of children under the age of one are cost settled with bordering city hospitals in the same manner as are costs associated with all Medicaid-eligible individuals under the age of 21 in the Child Health Services (EPSDT) Program.

251.010 Border City, University-Affiliated, Pediatric Teaching Hospitals 7-1-07

Special consideration is given to border city, university-affiliated, pediatric teaching hospitals because of the higher costs typically associated with such hospitals.

A. A Border City, University-affiliated, Pediatric Teaching Hospital is an Arkansas Medicaid-enrolled acute care/general hospital located within a bordering city (see Attachment 4.19-A page 3b), that complies with all of the following requirements.

1. The provider submits and maintains (in its Arkansas Medicaid Program provider file) a copy of the current and effective affiliation agreement with an accredited university, as well as any additional documentation necessary to further establish that the hospital is university-affiliated.
2. The provider is licensed and credentialed as a pediatric hospital or a pediatric primary hospital in its home state.
3. The provider maintains at least five different, pediatric specialty, intern training programs.
4. The provider maintains and operates at least one hundred (100) beds dedicated exclusively to the care and treatment of patients under the age of 21.

B. Arkansas Medicaid cost settles on a per diem basis with Border city, University-affiliated, Pediatric Teaching hospitals, for inpatient services the hospitals provide to Arkansas Medicaid beneficiaries aged 1 to 21, inclusive.

1. The Arkansas Medicaid per diem of this type hospital comprises all Medicaid-allowable per diem costs that it incurred, within its most recent *completed* cost reporting period, for the aggregated inpatient days of Arkansas Medicaid beneficiaries older than one year.
2. A condition of this cost settlement arrangement is that the provider shall certify the number of patient days that it provided to patients aged 1 to 21, inclusive, during the cost settlement period.

251.100 Reimbursement by Class Group 10-13-03

Prospective payment rates for all class groups are set at the 40th percentile of all in-state hospitals' interim per diem rates with the same bed size group, with no cost settlement.

A. The rates and Medicaid days associated with in-state university-affiliated teaching hospitals are excluded when calculating the base rate for out-of-state hospitals.

B. Reimbursement rates for out-of-state hospital inpatient services (except those in bordering cities) are calculated annually.

1. The rate year is the calendar year, meaning that calculated rates apply for dates of service from January 1 through December 31.

2. The rates becoming effective for each January 1 are derived from the in-state interim rates (except for those of Arkansas State Operated Teaching Hospitals) calculated during the initial review of cost reports received through September 30 of the calendar year immediately preceding the calendar year in which the rates take effect.

251.110 University-affiliated Teaching Hospitals 10-13-03

Special consideration is given to university-affiliated teaching hospitals due to the higher costs associated with such hospitals.

A. The rates for out-of-state, university-affiliated teaching hospitals are established at 105 percent of the 40th percentile rate of all in-state hospitals' per diem rates within the same bed-size group, with no cost settlement.

B. In order to qualify as a university-affiliated teaching hospital, a hospital must submit documentation to the Arkansas Medicaid Program substantiating that the hospital is university-affiliated and maintains at least three different intern specialty-training programs.

251.120 Hospitals Serving a Disproportionate Number of Medicaid Eligibles (Indigent Care Allowance Eligibility) 10-13-03

Special consideration is given to hospitals serving a disproportionate number of Medicaid eligibles.

A. Rates for hospitals serving a disproportionate number of Medicaid eligibles are established at 150 percent of the 40th percentile rate of all in-state hospitals' interim per diem rates within the same bed size group, with no cost settlement.

B. In order to qualify as a hospital serving a disproportionate number of Medicaid eligibles, a hospital must submit documentation (e.g., cost report data) verifying that Medicaid days exceed 20 percent of the total inpatient days.

C. See Section 250.301, parts B and E respectively, for definitions of "Medicaid days" and "inpatient days."

252.000 Reimbursement for Outpatient Hospital Services in Acute Care Hospitals 10-13-03

Reimbursement for outpatient hospital services in acute care hospitals is by fee schedule and is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Arkansas Medicaid cost settles only with in-state pediatric hospitals and Arkansas State Operated Teaching Hospitals for outpatient hospital services.

252.100 Outpatient Fee Schedule Reimbursement 10-13-03

A. The Medicaid schedule of maximum allowable charges (outpatient hospital fee schedule) was initially established (effective for dates of service on and after July 1, 1991) by one of the following methods:

1. Maximum allowable charges for procedures listed in the Blue Shield fee schedule published 10/90, were set at 80% of the Blue Shield customary charge.
2. Maximum allowable charges for procedures that had no comparable Blue Shield code were set at 135% the Medicaid maximum charge in effect for service date June 30, 1991.

B. Effective for dates of service on and after July 1, 1992, Medicaid maximum allowable fees were reduced by 20%.

C. Maximum allowable fees for new procedures and newly coded procedures are based on their comparability with procedures with established rates.

D. Some procedures must be reviewed and priced by appropriate medical professionals each time they are billed.

252.110 Reimbursement of Outpatient Surgery in Acute Care Hospitals 10-13-03

A. Covered surgical procedures have been assigned to one of four outpatient surgical groups for reimbursement purposes.

1. See Sections 252.111 through 252.114 of this manual for outpatient surgical procedures by group.
2. Outpatient surgical procedures not listed in an outpatient surgical group are reviewed and priced by appropriate medical professionals. Some may require an operative report for reimbursement determination.

B. Medicaid reimburses outpatient surgical procedures at the lesser of the billed charge or the Medicaid maximum allowable fee established for the procedure's corresponding outpatient surgical group.

C. The maximum allowable fees in effect for service date June 30, 1991, were increased by 35%, effective for dates of service on or after July 1, 1991.

D. Effective for dates of service on and after July 1, 1992, the Medicaid maximum allowable fees were reduced by 20%.

252.111 Billing Instructions for Unlisted CPT© and HCPCS Procedure Codes 1-15-15

For consideration of any claims with CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by that unlisted code on the claim form. Documentation that further describes the service provided must be attached and must support medical necessity. All other billing requirements must be met in order payment to be approved.

252.112 Reserved 1-15-15

252.113 Reserved 1-15-15

252.114 Reserved 1-15-15

252.115 Reimbursement of Laboratory and Radiology Services in Acute Care Hospitals 10-13-03

A. Laboratory and X-ray procedures, other than clinical laboratory services, are reimbursed by a fee schedule established in accordance with the methodology described at Section 252.100.

B. Clinical laboratory services are also reimbursed by fee schedule, and the Medicaid fee schedule maximum amounts are recalculated periodically at 62% of the Medicare fee.

C. Tests that are components of laboratory panels are not covered individually. Arkansas Medicaid employs **ClaimsXten™** software to "rebundle" fragmented billings.

1. Chemistries billed individually are rebundled into the appropriate multi-channel test grouping.
2. The **ClaimsXten™** software assigns the correct procedure code to the multi-channel test grouping and displays it on the remittance advice.
3. The software allows the procedure codes billed to be displayed on the remittance advice along with the correct procedure code and a message explaining the rebundling.

D. Fragmented radiology billings are rebundled or denied as appropriate.

252.116 Reimbursement of End-Stage Renal Disease (ESRD) Services in ESRD Facilities and Acute Care Hospitals 10-13-03

A. Reimbursement of ESRD services is made at the lower of the provider's actual charge for the service or the allowable fee from the State's ESRD fee schedule based on reasonable charge.

B. The Medicaid maximum is based on the 50th percentile of the Arkansas Medicare facility rates in effect March 1, 1988.

C. Effective for dates of service on and after July 1, 1992, the Title XIX (Medicaid) maximum rates were decreased by 20%.

D. See Section 272.400 for special billing instructions.

252.117 Reimbursement of Burn Dressing Changes in Outpatient Hospitals 2-1-22

A. The CPT procedure codes for burn dressing changes are in the range of surgical procedures, but the Arkansas Medicaid Program has deemed them therapy procedures for reimbursement purposes. They are not listed in the outpatient surgical groupings.

B. Burn dressing changes are reimbursed at a global fee. The global fee includes:

1. All medication, pre-medication, I.V. fluids, dressing solutions and topical applications,
2. All dressings and necessary supplies and
3. All room charges.

C. Conform to the following procedure code definitions when billing for burn dressing changes:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

D. Medicaid allows reimbursement for only one burn dressing change procedure per day.

E. Physical therapy charges are not included in the global fee.

1. Physical therapy requires a written prescription by the attending physician.
2. Physical therapy requires a PCP referral.
3. A copy of the attending physician's order reflecting the frequency of dressing changes and the mode(s) of therapy to be administered must be maintained in the patient's chart and must be available upon request by any authorized representative of Arkansas Division of Medical Services.

252.118 Extracorporeal Shock Wave Lithotripsy (E.S.W.L.) 10-13-03

Extracorporeal shock wave lithotripsy is not reimbursed at a surgical group rate. Medicaid does not cover a second treatment if the patient is treated again for the same kidney within 60 days. Reimbursement is a global rate and includes the use of the machine.

252.119 Reimbursement for Hyperbaric Oxygen Therapy (HBOT) 10-1-09

Arkansas Medicaid reimburses hospitals at the outpatient surgery Group I rate for hyperbaric oxygen therapy. Refer to Sections 217.130, 242.000, 244.000, 245.030 and 272.404 for additional information on HBOT.

252.120 Outpatient Reimbursement for Pediatric Hospitals 10-13-03

Effective for dates of service on and after April 1, 1992, outpatient hospital services provided at a pediatric hospital are reimbursed based on reasonable costs with interim payments and a year-end cost settlement.

A. Interim payment is by fee-for-service reimbursement in accordance with the outpatient hospital fee schedule.

B. Arkansas Medicaid cost settles with pediatric hospitals at the lesser of reasonable costs or customary charges.

C. With the exception of graduate medical education costs, cost settlements are calculated using the methods and standards of the Medicare Program. Graduate medical education costs are reimbursed based on Medicare cost rules in effect before the September 29, 1989, rule change.

252.130 Outpatient Reimbursement for Arkansas State Operated Teaching Hospitals 10-13-03

A. Effective for cost-reporting periods ending on and after June 30, 2000, outpatient hospital services provided at an Arkansas State Operated Teaching Hospital are reimbursed based on reasonable costs, with interim payments and year-end cost settlement.

1. Interim payments are in the form of fee-for-service reimbursement, in accordance with the methodology described in Section 252.100 of this manual.
2. Arkansas Medicaid establishes cost reimbursement for outpatient services at the lesser of reasonable costs or customary charges.
    a. Except for graduate medical education costs, cost settlements are calculated using the methods and standards followed by the Medicare Program.
    b. Reimbursement of graduate medical education costs is in accordance with the methodology described in Section 250.621 of this manual.

B. Effective May 18, 2000, Arkansas State Operated Teaching Hospitals receive an annual outpatient reimbursement adjustment.

1. This adjustment is calculated from and based on the previous state fiscal year's (SFY) outpatient Medicare-related upper payment limit (UPL) for "as identified Medicaid reimbursed" outpatient services.
2. The calculations use a single SFY's payment data for "as identified" services that were furnished in hospital outpatient departments and from payments made to non-hospital providers for services that could have been furnished in hospital outpatient departments if the non-hospital providers had not existed or had not been available to furnish those services.
3. The adjustment amount designated for a particular SFY is determined from the payment data of the previous SFY.
    a. Payment of the adjustment amount begins in the following SFY.
    b. Remittance is four equal quarterly payments, the first of which must be made no later than fifteen days after the end of the second quarter of the payment SFY.

252.200 Critical Access Hospital (CAH) Reimbursement

252.210 CAH Inpatient Reimbursement 10-13-03

A. CAH inpatient reimbursement is by interim per diem rates with year-end cost settlement.

1. Allowable costs and cost settlements are determined in accordance with Title XVIII (Medicare) CAH cost principles and applicable cost settlement procedures and calculations.
2. A CAHs initial interim per diem rate will be the most recent interim per diem rate it received under its prior enrollment in the Arkansas Medicaid Hospital Program, or the interim per diem calculated from the most recent full year's cost report it submitted under its prior enrollment in the Arkansas Medicaid Hospital Program.
3. In the event that a hospital enrolled in the Arkansas Medicaid Hospital Program converts to a CAH before it has had an interim per diem rate in effect for a full cost reporting period, the State will set the facility's CAH interim per diem rate at the mathematical mean of established CAHs' per diem rates in effect on the date Medicaid establishes as the facility's date of enrollment in the Arkansas Medicaid Critical Access Hospital Program.
4. A hospital that converts to a CAH, and whose effective date of Medicaid enrollment as a CAH is a date other than the day following the last day of the facility's established cost reporting period under its enrollment in the Arkansas Medicaid Hospital Program, must submit partial-year cost reports under each program in which it maintained enrollment during the cost reporting period.

B. Interim per diem rates are calculated annually in the same manner as are the interim per diem rates of hospitals enrolled in the Arkansas Medicaid Hospital Program.

252.220 CAH Outpatient Reimbursement 10-13-03

A. CAH outpatient reimbursement consists of interim fee-for-service payment in accordance with the Arkansas Medicaid Program outpatient hospital fee schedule (at the lesser of the billed charge or the fee schedule maximum) with year-end cost settlements.

B. Allowable costs and cost settlements are determined in accordance with Title XVIII (Medicare) CAH cost principles and applicable cost settlement procedures and calculations.

253.000 Change of Ownership 10-13-03

A. A letter containing all of the following information must be received by the Division of Medical Services at least 30 calendar days before the effective date of the change of ownership:

1. Name(s), mailing address(es), telephone number(s) of the previous owner(s) and of their contact person(s).
2. Name(s), mailing address(es), telephone number(s) of the new owner(s) and of their contact person(s).
3. The individual or entity that has accepted the liabilities of the former owner(s) and the effective date of the assumption of those liabilities if it is different from the date of the change of ownership.
4. The individual or entity that has accepted the assets of the former owner(s) and the effective date of assumption of those assets if it is different from the date of the change of ownership.
5. Signatures of both the previous and new owners or of the authorized agents of the corporations.
6. A copy of the lease or purchase agreement between the two parties.
7. A new enrollment contract and application completed by the new owner.

B. Upon receipt of the copy of the lease or purchase agreements and supporting letter, these documents will be referred to the Department of Human Services, Office of Chief Counsel, for review and advice. The Arkansas Medicaid Program accepts no responsibility for the division of assets and liabilities related to any changes of ownership.

C. If this information is not received by the specified deadline, all payments to the hospital will be suspended. Suspension will allow claims to be processed, but a check will not be issued to the provider.

254.000 Medicaid Credit Balances 10-13-03

A condition of participation in the Arkansas Medicaid Program is the timely identification and refunding of credit balances owed to the Program.

Each provider must establish and maintain bookkeeping procedures by which Medicaid credit balances are refunded within 30 days of identification. The Centers for Medicare and Medicaid Services and the Arkansas Department of Human Services audit provider records to monitor compliance with this requirement.

255.000 Filing a Cost Report 10-13-03

A. Certified cost reports are due on or before the last day of the fifth month following the close of the period covered by the report.

1. When a cost reporting period ends on a day other than the last day of the month, the certified cost report is due within 150 days after the last day of the cost reporting period.
2. A certified cost report is a cost report that has been signed by the appropriate hospital official(s), certifying the accuracy of the costs indicated in the report.

B. A provider that voluntarily or involuntarily ceases to participate in the Arkansas Medicaid Program, or that experiences a change of ownership, must file a certified cost report for the period under the Program that begins on the first day not included in a previous cost report and that ends on the effective date of termination of its provider agreement or of the change of ownership.

C. If the Division of Medical Services does not receive a cost report within the specified time, the agency will suspend payments until the cost report is received.

1. Suspension of payments allows claims to be processed with no check issued to the provider.

a. The provider's remittance advice indicates a statement number rather than an internal check number.

b. The suspension remains in effect until the certified cost report is received.

2. Continued failure to file a cost report will result in termination of the provider's participation in the Program.

D. Extensions may be requested when extraordinary circumstances have significantly and adversely affected the provider's operations. Extension requests must be submitted in writing and received by the Arkansas Division of Medical Services at least 15 calendar days before the five-month (or 150-day) deadline.

256.000 Access to Subcontractor's Records 10-13-03

When a facility has a contract with a subcontractor (e.g., a pharmacy, doctor, hospital, etc.) for services costing or valued at $10,000 or more over a 12-month period, the contract must contain a clause giving the Department of Human Services (DHS) access to the subcontractor's records. The subcontractor must also require *its* subcontractors that provide *any* amount of service reimbursed by Medicaid funds to furnish to DHS any requested records relevant to those Medicaid-funded services. Contract provisions delineating this record-access requirement shall further require that records of Medicaid-covered services shall be maintained until 5 years have expired after the dates of service or until any pending audits or legal proceedings are complete, whichever period is longer.

257.000 Rate Appeal and/or Cost Settlement Appeal Process 10-13-03

Participating hospitals are provided the following mechanism to appeal a reimbursement rate.

A Medical facility administrator may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the facility of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the facility to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference if he or she so wishes for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the facility of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services, is unsatisfactory, the facility may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the Arkansas Hospital Association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

257.100 Cost Settlement Reopening Process 11-1-24

The state will compute interim payments for providers and subsequently reconcile the interim payments with final payments for which providers are eligible based on billed claims. The interim payment methodology is not a prepayment prior to services being furnished but represents interim payments for services furnished that are subject to final reconciliation.

A medical facility administrator or an identified facility representative such as the cost report preparer, DHS representative, a Medicare Administrative Contractors (MAC) representative, or another relevant contract representative may request a hospital cost report reopening by writing to the **Reimbursement Unit of the Division of Medical Services**. The request must be received no later than three (3) years after the date of the determination (Notice of Program Reimbursement ("NPR") or Revised NPR) or the decision that is the subject of the reopening. The request must reflect a reimbursement impact that totals a cumulative amount of at least $10,000 increase due to new and material issues within the individual cost report. Each issue cited must be reviewed and determined as new and material to be counted in the cumulative total.

260.000 HOSPITAL/PHYSICIAN REFERRAL PROGRAM

261.000 Introduction 10-13-03

The intent of the Hospital/Physician Referral Program is four-fold.

First, if the hospital/physician elects to participate in the Hospital/Physician Referral Program, it provides the hospital/physician with a means to identify needy individuals to Arkansas Department of Human Services through written referral and assures the hospital/physician of follow-up contact with interested individuals by Arkansas Department of Human Services.

Second, it provides Arkansas Department of Human Services with a means of reaching needy individuals who might not otherwise be aware of or apply for Medicaid benefits.

Third, it informs needy individuals of possible Medicaid coverage that would help defray their medical expense.

Fourth, it enables the hospital/physician to know if application is made and whether or not the patient is Medicaid eligible.

262.000 Hospital/Physician Responsibility 10-13-03

The hospital/physician should inform needy individuals of possible medical assistance available under the Medicaid Program. The hospital/physician should refer all interested individuals to Arkansas Department of Human Services by means of Form DMS-630, Referral for Medical Assistance. **View or print form DMS-630.**

The hospital/physician should be prepared to provide itemized statements on all individuals referred to Arkansas Department of Human Services for potential use in the eligibility determination. The hospital's/physician's representative is responsible for the accurate completion of the Referral Form (DMS-630). After the required information has been entered on the form, the hospital/physician representative will read and explain the authorization section to the client before securing the client's signature. Once the signature is obtained, the hospital/physician representative will sign and date the form and forward it to the local county Human Services office in the client's county of residence.

The County Human Services Office addresses are available from the Arkansas Division of Medical Services. **View or print the Division of Medical Services contact information.**

263.000 County Human Services Office Responsibility 10-13-03

Upon receipt of the referral form DMS-630, the local county Human Services Office will contact the client. Action must be completed within forty-five (45) days on all applications taken during follow-up. Once a determination has been made, the local county Human Services office will notify the hospital/physician by completing Section 2 of Form DMS-630. **View or print form DMS-630.** The three (3) types of dispositions are:

A. Did Not Respond or No Longer Interested - Client failed to respond to follow-up contact or client stated he or she was no longer interested.

B. Denied - Application taken; client was determined ineligible or eligibility could not be determined.

C. Approved - Application taken; client was determined eligible effective month/day/year.

The client's Medicaid identification card should be issued within thirty (30) days of eligibility determination.

The client is responsible for presenting his or her Medicaid identification card to the hospital/physician for billing purposes each time he or she receives a service.

264.000 Completion of Referral for Medical Assistance Form

264.100 Purpose of Form 10-13-03

Section 1 of Form DMS-630 is used by hospital/physicians to refer to the Arkansas Department of Human Services any needy individuals who might not otherwise be aware of or apply for medical assistance under the Medicaid Program. Section 2 of Form DMS-630 is used by the Arkansas Department of Human Services to notify the hospital/physician of the disposition of the referral on the patient.

264.200 Hospital/Physician Completion - Section 1 10-13-03

Enter, in sequence: hospital/physician name and address; patient account number; local county Human Services office name and address; client's first name, middle initial and last name; client's last name; signature of hospital/physician representative; date signed; name of hospital/physician; signature of client, address and date signed.

264.300 County Human Services Office Completion - Section 2 10-13-03

Leave blank. Section 2 will be completed by the local county Human Services office.

265.000 Hospital/Physician Referral for Newborns 10-13-03

Federal law mandates Medicaid coverage of infants born to Medicaid beneficiaries for a period of up to 12 months, as long as the mother remains Medicaid eligible and as long as the infant resides with the mother.

A new Hospital/Physician Referral Form for Newborns (DCO-645) must be completed to report the birth of a Medicaid eligible infant. The referring providers must complete and mail the form to the DHS County Office of the mother's resident county within 5 days of the infant's birth, when possible. The form will serve the Division of County Operations as verification of the birth date of the infant as well as documentation of relationship.

If all vital information and signatures are on the form when received, if it is verified that the mother was a certified Arkansas Medicaid beneficiary at time of delivery and if the DHS County Office has verified by collateral that the child lives with its mother, a newborn certification will be made within 5 working days from receipt of the completed form DCO-645. The DHS County Office service representative must then complete Part III of the form and return it to the provider

within the 5-day period. A DCO-700 will be mailed to the infant's mother to notify her of the application's approval or denial.

View or print form DCO-645 and instructions for completion.

270.000 BILLING PROCEDURES

271.000 Introduction to Billing 7-1-20

Hospital providers who submit paper claims must use the CMS-1450 claim form, which also is known as the UB-04 claim form.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

Section III of every Arkansas Medicaid provider manual contains information about available electronic claim options.

272.000 Inpatient and Outpatient Hospital CMS-1450 (UB-04) Billing Procedures 11-1-17

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements, and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) **View or print NUBC contact information.**

The committee develops, maintains, and distributes to its subscribers the Official UB-04 Data Specifications Manual (UB-04 Manual) and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Manual, a CMS-1450 (UB-04) claim form.

Please forward the original of the completed form to the Claims Department. **View or print the Claims Department contact information.** One copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

272.100 HCPCS and CPT Procedure Codes

272.101 Reserved 5-17-10

272.102 Drug Procedure Codes and National Drug Codes (NDC) 1-1-23

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on or after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A "covered labeler" is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the **DHS contracted Pharmacy vendor website**.

A complete listing of **"Covered Labelers"** is located on the website. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*. For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA-assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 1 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 1

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 2 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 2

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

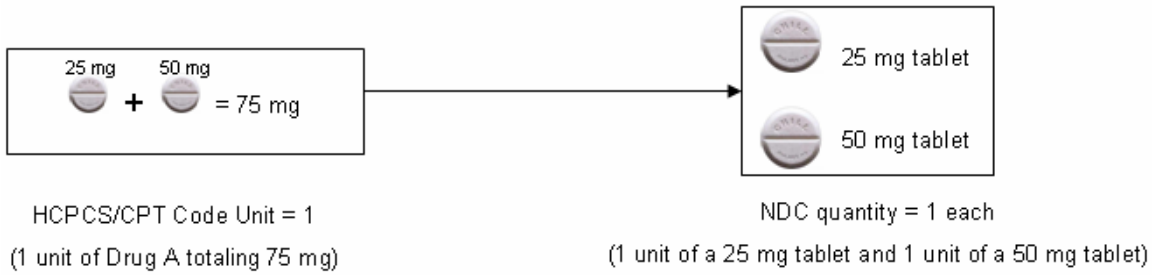
Exception: There is no requirement for an NDC when billing for vaccines.

C. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

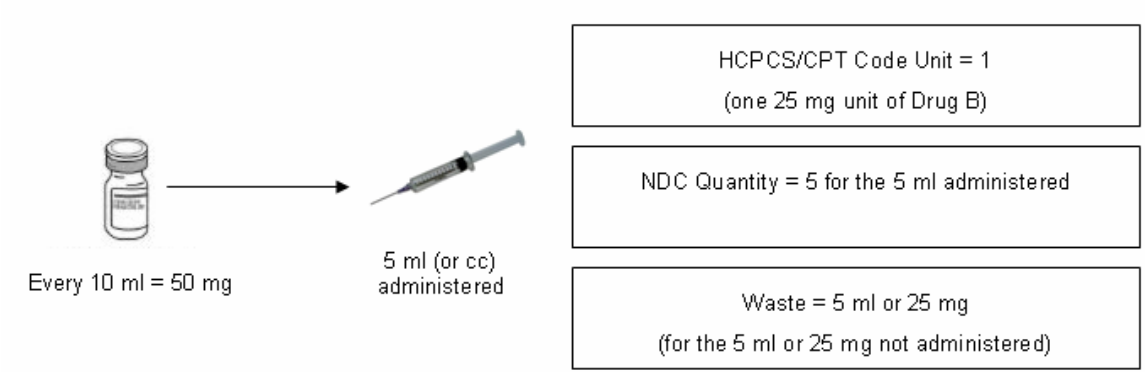
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug, whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example, whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 3.

Diagram 3



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. For billing wastage, see bullets D (Electronic Claims Filing) and E (Paper Claims Filing) below.

Diagram 4



D. Electronic Claims Filing 837I (Outpatient)

Providers are instructed to bill as follows:

- o 1 NDC for a procedure – 1st/only detail shall be billed with no modifier
- o 2 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- o 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- o 4 or more NDCs for same procedure – submit via paper claim
- o Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: The NDCs listed above are not the same (unless with a JW modifier). Same NDCs shall be billed on a single line with appropriate units.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

E. Paper Claims Filing CMS-1450 (UB-04)

Providers are instructed to bill as follows:

- o 1 NDC for a procedure – 1st/only detail shall be billed with no modifier
- o 2 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- o 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- o 4 or more NDCs for same procedure – 1st detail shall be billed with a KP and 2nd and subsequent details shall be billed with a KQ modifier
- o Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

Diagram 5

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0636	N4 12345678912 UN 1.00	Z1234 KP	01/01/22	1	2500		
2	0636	N4 01111222233 UN 1.00	Z1234 KQ	01/01/22	1	2500		
3	0636	N4 44444455506 ML 3.00	Z1234 KQ	01/01/22	3	7500		
4	0636	N4 44444455506 ML 2.00	Z1234 JW	01/01/22	2	5000		
5								

F. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

G. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, disputes or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing the purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.

See Section 272.510 for additional information regarding National Drug Code (NDC) billing.

272.103 Instructions for Prior Approval Letter Acquisition for Special Pharmacy, Therapeutic Agents and Treatments 1-15-15

Providers must obtain prior approval, in accordance with the following procedures, for special pharmacy, therapeutic agents and treatments. Approval letters may be obtained by the ordering physician and a copy provided to the hospital; however the billing provider is ultimately responsible for meeting the documentation requirements for payment.

A. Before treatment begins, the Division of Medical Services (DMS), Medical Director for Clinical Affairs must approve any drug, therapeutic agent or treatment not listed as covered in this provider manual or in official DMS correspondence.

This requirement also applies to any drug, therapeutic agent or treatment with special instructions regarding coverage in the provider manual or in official DMS correspondence.

B. The Medical Director for Clinical Affairs' prior approval is required to ensure approval for medical necessity. Additionally, all other requirements must be met for reimbursement.

1. The provider must submit a history and physical examination with the treatment protocol before beginning the treatment.

2. The provider will be notified by mail of the DMS Medical Director for Clinical Affairs' decision. No prior authorization number is assigned if the request is approved, but a prior approval letter is issued and must be attached to each claim. Any changes in treatment require resubmission and a new approval letter.

Send requests for a prior approval letter for pharmacy and therapeutic agents to the attention of the **Division of Medical Services, Medical Director of Clinical Affairs**.

272.104 Reserved 1-15-15

272.109 Reserved 1-15-15

272.110 Reserved 5-17-10

272.111 Reserved 5-17-10

272.112 Reserved 5-17-10

272.113 Reserved 5-17-10

272.114 Reserved 5-17-10

272.115 Observation Bed Billing Information 2-1-22

Use code 760* to bill for Observation Bed. One unit of service on the CMS-1450 (UB-04) outpatient claim equals 1 hour of service. Medicaid will cover up to 8 hours of hospital observation per date of service.

When a physician admits a patient to observation subsequent to providing emergency or non-emergency services in the emergency department, the hospital may bill the observation bed code 760* and the appropriate procedure code for emergency room 450* or non-emergency room 459*. Condition code 88 must be billed to indicate an emergency claim.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

You may not bill 622* or 250*:

A. Alone or in conjunction with only one another.

B. With the non-emergency room procedure code 459*.

C. With an outpatient surgical procedure.

D. Without code 450*.

*Revenue code

272.116 Observation Bed Policy Illustration 10-13-03

The following table gives examples of appropriate billing for hospital services involving patients in observation bed status. The billing instructions in the third and fourth columns do not necessarily include all services for which the hospital may bill. For instance, they do not state that you may bill for lab, X-ray, emergency room, etc. The purpose of this table is to illustrate Arkansas Medicaid observation bed policy and Medicaid criteria determining inpatient and outpatient status.

OBSERVATION BED STATUS POLICY ILLUSTRATION			
PATIENT IS ADMITTED TO OBSERVATION	**PATIENT IS**	**FOR TUESDAY SERVICES, THE HOSPITAL:**	**FOR WEDNESDAY SERVICES, THE HOSPITAL:**
Tuesday, 3:00 PM	Still in Observation Wednesday, 3:00 PM	May bill Medicaid for up to 8 hours of medically necessary Observation Bed Status.	Must admit the patient to inpatient status at 3:00 PM.
Tuesday, 3:00 PM	Discharged Wednesday 12:00 PM (noon)	May bill Medicaid for up to 8 hours of medically necessary Observation Bed Status.	May bill Medicaid for up to 8 hours of medically necessary Observation Bed Status.
Tuesday, 3:00 PM	Discharged Wednesday 4:00 PM	May bill Medicaid for up to 8 hours of medically necessary Observation Bed Status.	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM, after outpatient surgery	Discharged Wednesday 10:00 AM	Must bill Medicaid for outpatient surgery.	May bill Medicaid for up to 8 hours of medically necessary Observation Bed Status.

272.120 Reserved 5-17-10

272.130 Outpatient – Emergency, Non-Emergency and Related Charges 11-1-17

National Code	Revenue Code Description
450*	Emergency Room Coverage. Condition code 88 required.
459*	Non-emergency Service Room Charge. This Service Room Charge includes supplies, drugs and injections.
622*	Outpatient Hospital Supplies - emergency only.
250*	Outpatient Hospital drugs and injection; emergency only.

*Revenue code

272.131 Non-Emergency Charges 2-1-22

The following procedure codes may be billed in conjunction with procedure code 459* ("Other non-emergency service", which includes room charge). See Section 272.510 for billing requirements.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

*Refer to Section 272.510 for additional criteria.

NOTE: Arkansas Medicaid reimburses for medically necessary vaccines, laboratory services, X-Rays and machine tests in addition to standalone revenue code 0459.

272.132 Procedure Codes Requiring Modifiers 2-1-22

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

272.140 Inpatient / Outpatient Dental Procedures 11-1-17

These codes may only be billed once per claim.

National Code	Revenue Code Description
361*	Outpatient hospitalization-up to 30 minutes
360*	Outpatient hospitalization-31 to 60 minutes
369*	Outpatient hospitalization-60 to 90 minutes
509*	Outpatient hospitalization-91 minutes or more

*Revenue code

272.150 Reserved 1-15-15

272.151 Reserved 1-15-15

272.152 Reserved 1-15-15

272.153 Reserved 1-15-15

272.154 Reserved 1-15-15

272.155 Reserved 1-15-15

272.156 Reserved 1-15-15

272.157 Reserved 1-15-15

272.160 Outpatient Surgery 10-13-03

The procedure codes for outpatient surgical procedures are global codes which include all related non-physician services. Separate charges should not be billed for drugs, injection, supplies, room charges, etc. Laboratory, radiology and machine tests charges may be billed separately. If more than one procedure is done, the more complex procedure should be coded.

Do not use more than one surgical code per date of service. If the procedure is an emergency and a procedure is performed within the surgical code range, the type of bill code must be 101.

272.200 Place of Service and Type of Service Codes 10-13-03

Not applicable for Hospital, CAH or ESRD claims.

272.300 Hospital Billing Instructions – Paper Only 4-1-14

Field #	Field name	Description
1.	(blank)	*Inpatient and Outpatient:* Enter the provider's name, (physical address – service location) city, state, zip code, and telephone number.
2.	(blank)	The address that the provider submitting the bill intends payment to be sent if different from FL 01. (Use this address for provider's return address for returned mail.)
3a.	PAT CNTL #	*Inpatient and Outpatient:* The provider may use this optional field for accounting purposes. It appears on the RA beside the letters "MRN." Up to 16 alphanumeric characters are accepted.
3b.	MED REC #	*Inpatient and Outpatient:* Required. Enter up to 15 alphanumeric characters.
4.	TYPE OF BILL	*Inpatient and Outpatient:* See the UB-04 manual. Four-digit code with a leading zero that indicates the type of bill.
5.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
6.	STATEMENT COVERS PERIOD	Enter the covered beginning and ending service dates. Format: MMDDYY. *Inpatient:* Enter the dates of the first and last covered days in the FROM and THROUGH fields. The FROM and THROUGH dates cannot span the State's fiscal year end (June 30) or the provider's fiscal year end. To file correctly for covered inpatient days that span a fiscal year end: 1. Submit one interim claim (a first claim or a continuing claim, as applicable) on which the THROUGH date is the last day of the fiscal year that ended during the stay. On a first claim or a continuing claim, the patient status code in field 17 must indicate that the beneficiary is still a patient on the indicated THROUGH date. 2. Submit a second interim claim (a continuing claim or a last claim, as applicable) on which the FROM date

Field #	Field name	Description
		is the first day of the new fiscal year. When the discharge date is the first day of the provider's fiscal year or the state's fiscal year, only one (bill type: admission through discharge) claim is necessary, because Medicaid does not reimburse a hospital for a discharge day unless the discharge day is also the first covered day of the inpatient stay. When an inpatient is discharged on the same date he or she is admitted, the day is covered when the TYPE OF BILL code indicates that the claim is for admission through discharge, the STAT (patient status) code indicates discharge or transfer, and the FROM and THROUGH dates are identical. *Outpatient:* To bill on a single claim for outpatient services occurring on multiple dates, enter the beginning and ending service dates in the FROM and THROUGH fields of this field. The dates in this locator must fall within the same fiscal year – the state's fiscal year and the hospital's fiscal year. When billing for multiple dates of service on a single claim, a date of service is required in field 45 for each HCPCS code in field 44 and/or each revenue code in field 42 .
7.	Not used	Reserved for assignment by the NUBC.
8a.	PATIENT NAME	*Inpatient and Outpatient:* Enter the patient's last name and first name. Middle initial is optional.
8b.	(blank)	Not required.
9.	PATIENT ADDRESS	*Inpatient and Outpatient:* Enter the patient's full mailing address. Optional.
10.	BIRTH DATE	*Inpatient and Outpatient:* Enter the patient's date of birth. Format: MMDDYYYY.
11.	SEX	*Inpatient and Outpatient:* Enter M for male, F for female, or U for unknown.
12.	ADMISSION DATE	*Inpatient:* Enter the inpatient admission date. Format: MMDDYY. *Outpatient:* Not required.
13.	ADMISSION HR	*Inpatient and Outpatient:* Enter the national code that corresponds to the hour during which the patient was admitted for inpatient care.
14.	ADMISSION TYPE	*Inpatient:* Enter the code from the Uniform Billing Manual that indicates the priority of this inpatient admission. *Outpatient:* Not required.

Field #	Field name	Description
15.	ADMISSION SRC	*Inpatient and Outpatient:* Admission source. Required. Code 1, 2, 3, or 4 is required when the code in field 14 is 4.
16.	DHR	*Inpatient:* See the UB-04 Manual. Required except for type of bill 021x. Enter the hour the patient was discharged from inpatient care.
17.	STAT	*Inpatient:* Enter the national code indicating the patient's status on the Statement Covers Period THROUGH date (field 6). *Outpatient:* Not applicable.
18.-28.	CONDITION CODES	*Inpatient and Outpatient:* Required when applicable. See the UB-04 Manual for requirements and for the codes used to identify conditions or events relating to this bill.
29.	ACDT STATE	Not required.
30.	(blank)	Unassigned data field.
31.-34.	OCCURRENCE CODES AND DATES	*Inpatient and Outpatient:* Required when applicable. See the UB-04 Manual.
35.-36.	OCCURRENCE SPAN CODES AND DATES	*Inpatient:* Enter the dates of the first and last days approved, per the facility's PSRO/UR plan, in the FROM and THROUGH fields. See the UB-04 Manual. Format: MMDDYY. *Outpatient:* See the UB-04 Manual.
37.	Not used	Reserved for assignment by the NUBC.
38.	Responsible Party Name and Address	See the UB-04 Manual.
39.	VALUE CODES	*Outpatient:* Not required. *Inpatient:*
a.	CODE	Enter 80.
	AMOUNT	Enter number of covered days. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeros (00) to the right of the vertical dotted line.
b.	CODE	Enter 81.
	AMOUNT	Enter number of non-covered days. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeros (00) to the right of the vertical dotted line.
40.	VALUE CODES	Not required.
41.	VALUE CODES	Not required.
42.	REV CD	*Inpatient and Outpatient:* See the UB-04 Manual.
43.	DESCRIPTION	See the UB-04 Manual.

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

Field #	Field name	Description
64. A, B, C	DOCUMENT CONTROL NUMBER	Field used internally by Arkansas Medicaid. No provider input.
65. A, B, C	EMPLOYER NAME	*Inpatient and Outpatient:* When applicable, based upon fields 51 through 62, enter the name(s) of the individuals and entities that provide health care coverage for the patient (or may be liable). When submitting a paper claim for an Arkansas Medicaid beneficiary who is incarcerated, enter LEA Code 3599 in field 65.
66.	DX	Diagnosis Version Qualifier. See the UB-04 Manual. Qualifier Code “9” designating ICD-9-CM diagnosis required on claims. Qualifier Code “0” designating ICD-10-CM diagnosis required on claims. Comply with the UB-04 Manual’s instructions on claims processing requirements.
67. A-H	(blank)	*Inpatient and Outpatient:* Enter the ICD-9-CM or ICD-10-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Fields are available for up to 8 codes.
68.	Not used	Reserved for assignment by the NUBC.
69.	ADMIT DX	Required for inpatient. See the UB-04 Manual.
70.	PATIENT REASON DX	See the UB-04 Manual.
71.	PPS CODE	Not required.
72	ECI	See the UB-04 Manual. Required when applicable (for example, TPL and torts).
73.	Not used	Reserved for assignment by the NUBC.
74.	PRINCIPAL PROCEDURE	*Inpatient:* Required on inpatient claims when a procedure was performed. On all interim claims, enter the codes for all procedures during the hospital stay. *Outpatient:* Not applicable.
	CODE	Principal procedure code.
	DATE	Format: MMDDYY.
74a-74e	OTHER PROCEDURE	*Inpatient:* Required on inpatient claims when a procedure was performed. On all interim claims, enter the codes for all procedures during the hospital stay. *Outpatient:* Not applicable.
	CODE	Inpatient claims only. Other procedure code(s).
	DATE	Inpatient claims only. Format: MMDDYY.
75.	Not used	Reserved for assignment by the NUBC.

Field #	Field name	Description
76.	ATTENDING NPI	Enter NPI of the primary attending physician or enter the Medicaid ID.
	QUAL	Not required.
	LAST	Enter the last name of the primary attending physician.
	FIRST	Enter the first name of the primary attending physician.
77.	OPERATING NPI	Enter NPI of the operating physician or enter the Medicaid ID.
	QUAL	Not required.
	LAST	Enter the last name of the operating physician.
	FIRST	Enter the first name of the operating physician.
78.	OTHER NPI	Enter NPI of primary care physician.
	QUAL	Not required.
	LAST	Enter the last name of the primary care physician.
	FIRST	Enter the first name of the primary care physician.
79.	OTHER NPI/QUAL/LAST/FIRS	Not used.
80.	REMARKS	For provider's use.
81.	Not used	Reserved for assignment by the NUBC.

272.400 Special Billing Instructions

272.401 Interim Billing 10-13-03

Interim billings are required at the end of a hospital's fiscal year as well as at the Medicaid fiscal year end. It is not necessary, however, to submit interim bills if the patient is discharged on the first day of the new fiscal year since the day of discharge is not counted as a hospital day for reimbursement purposes.

272.402 Newborn 10-13-03

All newborn services including nursery charges must be billed under the newborn's own Medicaid identification number.

272.403 Burn Dressing 7-1-07

All claims submitted for burn dressing changes must reflect the date of occurrence of the injury. The applicable occurrence code and the date of the injury are required in the first available of fields 31-34 of the CMS-1450 (UB-04) claim form. If this information is omitted, the claim will be denied. **View a CMS-1450 sample form.**

272.404 Hyperbaric Oxygen Therapy (HBOT) Procedures 2-1-22

A. **Facilities may bill for only one unit of service per day.** The facility's charge for each service date must include all its hyperbaric oxygen therapy charges, regardless of how many treatment sessions per day are administered.

B. Facilities may bill for laboratory, X-ray, machine tests and outpatient surgery in addition to procedure code.

C. Hospitals and ambulatory surgical centers may bill electronically or file paper claims for procedure code with the prior authorization number placed on the claim in the proper field. If multiple prior authorizations are required, enter the prior authorization number that corresponds to the date of service billed.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Refer to Sections 217.130, 242.000, 244.000, 245.030, and 252.119 for additional information on HBOT.

272.405 Billing of Gastrointestinal Tract Imaging with Endoscopy Capsule 2-1-22

Gastrointestinal Tract Imaging with Endoscopy Capsule, billed as, is payable for all ages and must be billed by using the primary diagnosis of (**View ICD Codes**.).

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

This procedure code should be billed with no modifiers when performed in the outpatient hospital place of service.

CPT code is payable on electronic and paper claims. For coverage policy, see Section 217.113.

272.406 Billing for Inpatient Hospital Services When a Beneficiary Turns Age 21 10-22-10

A. The benefit limit for acute care/general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged 21 and older.

B. When a beneficiary turns 21 during an inpatient hospital stay, the dates of service on or after his/her 21st birthday must be billed separately.

C. Arkansas Medicaid covers up to 4 days of inpatient services with no certification requirement. If a beneficiary is not discharged before or during the fifth day, additional days are covered only if certified. The Medicaid Utilization Management Program (MUMP) determines covered inpatient lengths of stay in general and rehabilitative hospitals, in and out of state. See Sections 212.510 for MUMP applicability and 212.520 for MUMP certification request procedures.

272.407 Billing for Inpatient Hospital Services When a Beneficiary is Incarcerated 2-28-14

When an Arkansas Medicaid beneficiary is incarcerated by the Arkansas Department of Corrections, it must be indicated on the claim.

NOTE: When submitting a paper claim, enter LEA Code 3599 in field 65 of form CMS-1450 (UB-04). See Section 272.300 for claim form instructions.

272.420 Dialysis

272.421 Dialysis Procedure Codes 2-1-22

The facility providing the hemodialysis and peritoneal dialysis service must use the following HCPCS procedure codes when billing for the dialysis treatment:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

The codes listed in CPT-4 must not be used.

National Code	Revenue Code Description
820*	Facility Fee-Hemodialysis (maximum - 3 treatments per week)
830*	Facility Fee - Peritoneal Dialysis (10-19 hours per week)
839*	Facility Fee - Peritoneal Dialysis (20-29 hours per week)
831*	Facility Fee - Peritoneal Dialysis (Weekly - Over 29 hours)

*Revenue code

272.422 Hemodialysis 11-1-17

National Code	Revenue Code Description
820*	Facility Fee-Hemodialysis (maximum - 3 treatments per week)

*Revenue code

272.423 Peritoneal Dialysis 11-1-17

National Code	Revenue Code Description
830*	Facility Fee - Peritoneal Dialysis (10-19 hours per week)
839*	Facility Fee - Peritoneal Dialysis (20-29 hours per week)
831*	Facility Fee – Peritoneal Dialysis (Weekly – Over 29 hours)

*Revenue code

Each procedure code for peritoneal dialysis must cover a 7-day period, Sunday through Saturday. Each procedure code represents 1 unit of service. One unit of service equals one 7-day period.

In field 43 of the CMS-1450 (UB-04) claim form, enter the procedure code, description and the dates of service for each treatment during the 7-day period, Sunday through Saturday. The initial date of the treatment for the 7-day period must be entered to the right of the dotted line in field 43.

In field 46 of the CMS-1450 claim form, one unit of service must be entered for each procedure code that represents a 7-day period. The units must always reflect 1. Providers may bill multiple procedure codes per claim but each procedure code represents a 7-day time period.

In field 47 of the CMS-1450 claim form, enter the charges for each procedure code. Total charges must be entered at the bottom of field 47. **View a CMS-1450 sample form.**

272.424 Reserved 11-1-17

272.430 Billing for Organ Transplants 3-15-05

A. All associated claims for a transplant evaluation (e.g., physician, lab and X-ray, dental, etc.) must be forwarded to the Arkansas Medicaid fiscal agent. **View or print the Claims Department contact information.**

B. All claims associated with a transplant procedure must be submitted to the Division of Medical Services, Utilization Review (UR) Section. **View or print Utilization Review contact information.** A copy of any third-party payer Explanation of Benefits must be attached to the claim when applicable.

272.431 Billing for Bone Marrow Transplants 3-15-05

All claims associated with a bone marrow transplant must be filed for payment within 60 calendar days from the discharge date of the inpatient stay for the transplant procedure.

A. No claims will be considered for payment after the 60 calendar days have elapsed.

B. If an HIPAA Explanation of Benefits (HEOB) is received from a third-party payer after the 60 calendar days have elapsed, you must forward a copy of the HEOB to the UR Transplant Coordinator.

272.432 Billing for a Living Bone Marrow Donor 10-1-15

You must file a separate claim for the inpatient hospital stay of a living bone marrow donor.

A. If the donor is not an eligible Medicaid beneficiary, file the claim under the eligible Medicaid beneficiary's name and Medicaid ID number.

1. Use the following ICD diagnosis code (**View ICD Codes**.) (Donors, bone marrow) for the bone marrow donor.
2. Use the following ICD diagnosis code (**View ICD Codes**.) (Other specified general medical examination–examination of potential donor of organ or tissue) for the tissue typing of the donor.

B. If the donor is an eligible Medicaid beneficiary, file the claim under the donor's Medicaid ID number and use the same diagnosis codes listed above.

272.433 Billing for a Living Kidney Donor 10-1-15

You must file a separate claim for the inpatient hospital stay of a living kidney donor.

A. If the donor is not an eligible Medicaid beneficiary, file the claim under the eligible Medicaid beneficiary's name and Medicaid ID number.

1. Use the following ICD diagnosis code: (**View ICD Codes**.) (Donors, kidney) for the renal donor.
2. Use the following ICD diagnosis code: (**View ICD Codes**.) (Other specified general medical examination–examination of potential donor of organ or tissue) for the tissue typing of the donor.

B. If the donor is an eligible Medicaid beneficiary, file the claim under the donor's Medicaid ID number and use the same diagnosis codes listed above.

272.434 Billing for a Living Partial-Liver Donor 10-1-15

You must file a separate claim for the transplant-related inpatient hospital stay of a living donor of a partial liver.

A. If the donor is not an eligible Medicaid beneficiary, file the claim under the eligible Medicaid beneficiary's name and Medicaid ID number.

1. Use the following ICD diagnosis code: (**View ICD Codes.**) (Donors, kidney) for the renal donor.

2. Use the following ICD diagnosis code: (**View ICD Codes.**) (Other specified general medical examination–examination of potential donor of organ or tissue) for the tissue typing of the donor.

B. If the donor is an eligible Medicaid beneficiary, file the claim under the donor's Medicaid ID number and use the same diagnosis codes listed above.

272.435 Tissue Typing 7-1-22

A. Authorized procedure codes are payable for the tissue typing for both the donor and the receiver.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

B. The tissue typing is subject to the following benefit limits:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30);

2. Extensions will be considered for beneficiaries who exceed the five-hundred-dollar benefit limit for diagnostic laboratory services; and

3. Providers must request an extension.

C. Medicaid will authorize up to ten (10) tissue-typing diagnostic laboratory procedures to determine a match for an unrelated bone marrow donor.

D. A separate claim must be filed for the tissue typing.

E. Claims for the donor must be forwarded to the Transplant Coordinator.

272.436 Billing for Corneal Transplant 2-1-22

For processing, preserving and transporting corneal tissue, use procedure code

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.h

Requires paper billing and a manufacturer's invoice attached to the claim. See Section 217.062 for coverage information.

272.437 Vascular Embolization and Occlusion 2-1-22

The following procedure codes require paper billing and documentation attached that describes the procedure code and supports medical necessity:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

272.440 Factor VIIa 2-1-22

Arkansas Medicaid covers Factor VIIa (coagulation factor, recombinant) for treatment of bleeding episodes in hemophilia A or B patients with inhibitors to Factor VIII or Factor IX. Factor VIIa coverage is restricted to diagnosis codes: (**View ICD Codes**.).

Providers must bill Medicaid for Factor VIIa with HCPCS procedure code. One unit equals 1.2 milligrams.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

272.441 Factor VIII 2-1-22

HCPCS procedure code must be used when billing for all anti-hemophiliac Factor VIII, including Monoclate.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital setting, physician's office or beneficiary's home. When billing for this procedure, enter the brand name and the dosage in the description area of the claim form. The provider must bill the cost per unit and the number of units administered. The number of units administered must be entered in the units column of the claim form.

272.442 Factor IX 2-1-22

HCPCS procedure code must be used when billing for Factor IX Complex (Human).

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Factor IX Complex (Human) is covered by the Arkansas Medicaid Program when administered in the outpatient hospital setting, physician's office or beneficiary's home. When billing for this procedure, enter the brand name and the dosage in the description area of the claim form. The provider must bill the cost per unit and the number of units administered. The number of units administered must be entered in the units column of the claim form.

272.443 Factor VIII and Factor IX 2-1-22

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital, physician's office or in the patient's home. The following procedure codes must be used:

Factor VIII [antihemophilic factor (porcine)], per IU

Factor VIII [antihemophilic factor (recombinant)], per IU

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

The provider must bill his/her cost per unit and the number of units administered.

HCPCS procedure code must be used when billing for Factor IX Complex (human). Factor IX Complex (human) is covered by Medicaid when administered in the physician's office or the patient's home (residence). The provider must bill his/her cost per unit and the number of units administered.

For the purposes of Factor VIII and Factor IX coverage, the patient's home is defined as where the patient resides. Institutions, such as a hospital or nursing facility, are not considered a patient's residence.

272.444 Reserved 1-15-15

272.445 Reserved 11-1-17

272.446 Therapeutic Leave 7-1-07

Hospital providers billing for therapeutic leave must enter revenue code 183 in field 42 on the CMS-1450 (UB-04) claim form and the number of units in field 46. One unit equals one day. Therapeutic leave must be indicated on the claim form as described. The day the patient leaves the hospital on approved therapeutic leave is a covered day and the provider will receive full per diem. If the patient does not return to the hospital within 24 hours, therapeutic leave must be billed for the day following the patient's departure from the hospital. The day the patient returns to the hospital, regardless of the hour, is considered a day of therapeutic leave. For example, a beneficiary leaves the hospital at 10:00 a.m. on 3-1-92 on therapeutic leave and returns to the hospital at 5:00 p.m. on 3-13-92. The provider must enter revenue code 183 in field 42 and must enter two units in field 46. This indicates two days of hospitalization included therapeutic leave time. The number of covered days in field 7 must equal the number of units entered in field 46. The hospital provider is eligible to receive 50% of the actual cost per day involving therapeutic leave. The established per diem rate of reimbursement for the hospital will be initially paid to the provider, and the 50% calculation will be computed at the time of the cost settlement process.

272.447 Bone Stimulation 2-1-22

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Procedure codes are payable when provided in the physician's office, ambulatory surgical center or outpatient hospital setting to Medicaid beneficiaries of all ages. Procedure codes will require prior authorization and are payable only for non-union of bone. When provided in the outpatient setting, the provider must submit an invoice with the claim if providing the device.

272.448 Vascular Injection Procedures 2-1-22

Effective for claims with dates of service on or after December 1, 1993, in accordance with Medicare guidelines, the Arkansas Medicaid Program implemented the following policy regarding vascular injection procedures:

If a provider bills procedure code and one or all of the following procedure codes on the same date of service, the Medicaid Program will reimburse for procedure code and the other codes will be denied.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

272.449 Molecular Pathology 8-1-21

Molecular Pathology procedure codes require prior authorization (PA). Providers must receive prior authorization before a claim for molecular pathology is filed for payment. Providers may request the PA from DHS or its designated vendor before or after the procedure is performed as long as it is acquired in time to receive approval and file a clean claim within the 365-day claims filing deadline. **View or print contact information to obtain the DHS or designated vendor step-by-step process to request prior authorization.**

Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory Services **(form DMS-841**) and all pertinent clinical documentation needed to justify the procedure. Reconsideration of denied requests is allowed if new or additional information is received within thirty (30) days of the initial denial. **View or print form DMS-841**. This form may be found in Section V of the provider manual. **Do not complete the form unless you are submitting a Molecular Pathology PA request.**

Molecular Pathology procedure codes must be submitted on a red line paper claim form with the PA number listed on the claim and the itemized invoice attached that supports the charges for the test billed. See Section 244.000 for Molecular Pathology procedure codes.

272.450 Special Billing Requirements for Laboratory and X-Ray Services 2-1-22

The following codes have special billing requirements for laboratory and X-Ray procedures.

A. CPT and HCPCS Lab Procedure Codes with Diagnosis Restrictions

The following CPT procedure codes will be payable with a primary diagnosis as is indicated below.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

B. Genetic Testing

C. Arkansas Code §20-15-302 states that all newborn infants shall be tested for certain metabolic diseases. Arkansas Medicaid shall reimburse the enrolled Arkansas Medicaid hospital provider that performs the tests required for the cost of the tests. Newborn Metabolic Screenings performed inpatient are included in the interim per diem reimbursement rate and facility cost settlement. For Newborn Metabolic Screenings performed in the outpatient setting (due to retesting or as an initial screening), Arkansas Medicaid will reimburse the hospital directly. For the screenings performed in the outpatient hospital setting, the provider will submit a claim using procedure code. All positive test results shall be sent immediately to the Arkansas Department of Health.

The list of metabolic diseases for which providers can bill under can be found within the **Arkansas Department of Health (ADH) rules pertaining to testing of newborn infants**.

272.451 Reserved 1-15-15

272.452 Abortion Procedure Codes 1-15-15

Refer to Section 217.010 through 217.012 of this manual for abortion coverage procedures.

272.453 Hysterectomy for Cancer or Dysplasia 2-1-22

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Hospitals may use procedure code when billing for a total hysterectomy procedure when the diagnosis is cancer or severe dysplasia.

Procedure code does not require prior authorization (PA). All hysterectomies require paper billing using claim form CMS-1450. Form DMS-2606 must be properly signed and attached to the claim form.

Procedure code is covered for emergency hysterectomy **immediately** following C-section. It requires no PA but does require form DMS-2606 and an operative report/discharge summary to confirm the emergency status.

272.454 Reserved 11-1-17

272.460 Reserved 10-1-18

272.461 Verteporfin (Visudyne) 2-1-22

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

A. Verteporfin administration may be billed separately from the related surgical procedure.

B. Claims for Verteporfin administration must include one of the following ICD diagnosis codes: (**View ICD Codes**.)

C. Use anatomical modifiers to identify the eye(s) being treated.

D. May be billed electronically or on a paper claim

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

272.462 Billing Protocol for Computed Tomographic Colonography (CT) 2-1-22

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For coverage policy information, see Section 217.141 of this manual.

272.470 Reserved 10-1-18

272.500 Influenza Virus Vaccines 2-1-22

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

A. Procedure code, influenza virus vaccine, split virus, preservative free, for children 6 to 35 months of age, is covered through the Vaccines for Children (VFC) program.

1. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **SL**.
3. ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or Print the Department of Health contact information.**

B. Effective for dates of service on and after October 1, 2005, Medicaid covers procedure code, influenza virus vaccine, split virus, preservative free, for ages 3 years and older.

1. For children under 19 years of age, claims must be filed using modifiers **EP** and **TJ**.
2. For ARKids First-B participants, claims must be filed using modifier **SL**.
3. For individuals aged 19 and older, no modifier is necessary.

C. Effective for dates of service on and after October 1, 2005, procedure code, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals ages 5 through 49 who are not pregnant.

1. When filing claims for children 5 through18 years of age, use modifiers **EP** and **TJ**.

2. For ARKids First-B participants, the procedure code must be billed using modifier **SL**.

3. No modifier is required for filing claims for beneficiaries ages 19 through 49.

D. Procedure code, influenza virus vaccine, split virus, for children ages 6 through 35 months, is covered.

1. Modifiers **EP** and **TJ** are required.

2. For ARKids First-B beneficiaries, use modifier **SL**.

E. Procedure code, influenza virus vaccine, split virus, for use in individuals aged 3 years and older, will continue to be covered.

1. When filing paper claims for Medicaid beneficiaries under age 19, use modifiers **EP** and **TJ**.

2. For ARKids First-B participants, use modifier **SL**.

3. No modifier is required for filing claims for beneficiaries aged 19 and older.

272.501 Medication Assisted Treatment and Opioid or Alcohol Use Disorder Treatment Drugs 2-1-24

Medication Assisted Treatment for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2023**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

272.502 Drug Treatment for Pediatric PANS and PANDAS 6-1-22

A. Effective for dates of service on and after 6/1/2022 drug treatment will be available to all qualifying Arkansas Medicaid beneficiaries when specified conditions are met for one (1) or both of the following conditions:

1. Pediatric acute-onset neuropsychiatric syndrome (PANS),

2. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).

B. The drug treatments include off-label drug treatments, including without limitation intravenous immunoglobulin (IVIG).

C. Medicaid will cover drug treatment for PANS or PANDAS under the following conditions:

1. The drug treatment must be authorized under a Treatment Plan; and

2. The Treatment Plan must be established by the approved PANS/PANDAS provider.

D. A Prior Authorization (PA) must be obtained for each treatment. Providers must submit the current Treatment Plan to the **Quality Improvement Organization (QIO)** along with the request for Prior Authorization. (Add link to AFMC.)

E. The authorized procedure codes and required modifiers are found in the following link:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services, including PANS and PANDAS procedure codes.

272.510 Injections, Radiopharmaceuticals and Therapeutic Agents 1-1-23

1. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

272.520 Vagus Nerve Stimulation Therapy, Device and Procedure Billing Protocol 6-1-22

The Arkansas Medicaid Program covers vagus nerve stimulation therapy, device, and procedure. When filing a claim, providers will bill the cost for both the device and procedure under the single billing code.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.