SECTION II - NURSE PRACTITIONER

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200.000 NURSE PRACTITIONER GENERAL INFORMATION

201.000 Arkansas Medicaid Requirements for Participation in the Nurse Practitioner Program — 11-1-09

The Arkansas Medicaid Program enrolls registered nurse practitioners or advanced practice nurses for participation in the Nurse Practitioner Program. Nurse Practitioner Program providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. The provider must be licensed by the state authority in the state in which services are furnished.

B. The following documents must be submitted with the provider application and Medicaid contract:

1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the specialty to be practiced. (See Section 201.300 of this manual.)
2. Providers have the option of enrolling in the Title XVIII (Medicare) Program. If enrolled in Title XVIII, the provider must inform the Medicaid Provider Enrollment Unit of his or her Medicare number. Out-of-state providers must submit a copy of their Title XVIII (Medicare) certification.
3. Providers who have prescriptive authority must furnish documentation of their prescriptive authority certification. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.

201.001 Electronic Signatures 10-8-10

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

201.100 Group Providers 5-1-09

Group providers of Nurse Practitioner services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a nurse practitioner is a member of a group, each individual nurse practitioner and the group must both enroll according to the following criteria:

A. Each individual nurse practitioner within the group must enroll following the criteria established in Section 201.000.

B. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled, registered nurse practitioner or advanced practice nurse within the group.

201.200 Providers in Arkansas and Bordering States 5-1-09

Providers in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) that satisfy Arkansas Medicaid participation requirements may be enrolled as **routine services providers**.

Routine services providers may furnish and claim reimbursement for services covered by Arkansas Medicaid, subject to benefit limitations and coverage restrictions set forth in this manual.

201.210 Providers in Non-Bordering States 3-1-11

A. Providers 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 with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid 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 the 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 Certification for Registered Nurse Practitioner/Advanced Practice Nurse 5-1-09

The registered nurse practitioner must be certified as a registered nurse practitioner by the state in which services are furnished.

Advanced practice nurses must hold certification from a nationally recognized certifying body approved by the state in which services are furnished. Certification must be in the category and the specialty for which the advanced practice nurse is educationally prepared.

202.000 Medical Records Nurse Practitioners are Required to Keep 11-1-09

A. Nurse practitioners are required to keep the following records and, upon request, to furnish the records to authorized representatives of the Arkansas Division of Medical Services and the state Medicaid Fraud Unit and to representatives of the Centers for Medicare and Medicaid Services (CMS):

1. History and physical examinations.
2. Chief complaint on each visit.
3. Tests and results.
4. Diagnoses.
5. Service or treatment, including prescriptions, or a referral to a physician for prescriptions, and record of physician referral or consultation.
6. Signature or initials of the nurse practitioner after each visit.
7. Copies of records pertinent to any and all services delivered by the nurse practitioner and billed to Medicaid.
8. Records must include the service date of each service billed to Medicaid.

B. Patient records must support the levels of service billed to Medicaid, in accordance with the American Medical Association's Common Procedural Terminology (CPT) standards.

C. All required records must be kept for a period of five (5) years from the ending date of service; or, until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.

D. Furnishing patient medical records on request to authorized individuals and agencies listed above in part A is a contractual obligation of providers enrolled in the Medicaid Program. Failure to furnish medical records upon request may result in the imposition of sanctions. (See Section 142.300 for additional information regarding record keeping requirements).

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

203.000 The Nurse Practitioner's Role in Home Health Services 7-1-17

203.010 Home Health and the Primary Care Physician (PCP) Case Management Program (ConnectCare) 7-1-17

A. Home health care requires a PCP referral except in the following circumstances:

1. Medicaid does not require Medicare beneficiaries to enroll with PCPs; therefore, a PCP referral is not required for home health services for Medicare/Medicaid dual-eligibles.
2. Obstetrician/gynecologists may authorize and direct medically-necessary home health care for postpartum complications without obtaining a PCP referral.

B. A PCP may refer a beneficiary to a specific home health agency only if he or she ensures the beneficiary's freedom of choice by naming at least one alternative agency.

1. PCPs, authorized attending physicians and home health agencies must maintain all required PCP referral documentation in the beneficiary's clinical records.
2. PCP referrals must be renewed when specified by the PCP or every 60 days, whichever period is shorter.

C. PCP referral is not required to revise a plan of care during a period covered by a current referral, but the agency must forward copies of the signed and dated assessment and the revision to the PCP.

203.020 Documentation of Services 7-1-17

Home Health providers must maintain the following records for patients of all ages:

A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans, when applicable.

B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapists and physical therapy assistants.

C. Signed and dated documentation of *pro re nata* (PRN) visits, which must include the following:

1. The medical justification for each such unscheduled visit.
2. The patient's vital signs and symptoms.
3. The observations of and measures taken by agency staff and reported to the physician.
4. The physician's comments, observations and instructions.

D. Verification, by means of physician or approved non-physician practitioner documentation that there was a face-to-face encounter with the beneficiary that meets the following requirements:

1. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the 90 days before or the 30 days after the start of services.
2. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than 6 months prior to the start of services.
3. The face-to-face encounter may be conducted by one of the following practitioners:

a. The primary care physician;

b. A nurse practitioner working in collaboration with the primary care physician;

c. A certified nurse midwife by the scope of practice;

d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility. The service is not considered to be separate from the physician's service.

e. For beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

4. The allowed non-physician practitioner performing the face-to-face encounter must communicate the clinical findings of that encounter to the ordering physician. These clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the physician ordering the services must:

a. Document that the face-to-face encounter which is related to the primary reason the patient requires home health services occurred within the required timeframes prior to the start of home health services.

b. Indicate the practitioner who conducted the encounter, and the date of the encounter.

6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter.

E. No payment may be made for medical equipment, supplies, or appliances to the extent that a face-to-face encounter requirement would apply as durable medical equipment (DME) under the Medicare program unless the primary care physician or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in D.3. with the exception of nurse-midwives.

F. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications.

G. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention.

H. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.

I. The registered nurse's (or physical therapist's when applicable) notes from supervisory visits.

203.030 Plan of Care Review 7-1-17

A. All home health services are at the direction of the patient's PCP or authorized attending physician.

B. The physician, in consultation with the patient and professional staff, is responsible for establishing the plan of care, specifying the type(s), frequency and duration of services.

C. Medicaid requires the PCP or authorized attending physician to review the patient's plan of care as often as necessary to address changes in the patient's condition, but no less often than every 60 days.

1. The physician establishes the start date of each new, renewed or revised plan of care. A "renewed" plan of care is a plan of care that has been reviewed in accordance with the 60-day requirement and has been authorized by the PCP or authorized attending physician to continue, either with or without revision. A "revised" plan of care is a plan of care developed in response to a change in the patient's condition that necessitates prompt review by the physician and reassessment by the case nurse.

2. The PCP or authorized attending physician must have performed a comprehensive (see Physician's Common Procedural Terminology for guidelines regarding comprehensive evaluation and management procedures) physical examination with medical history or history update within the 12 months preceding the start date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

203.040 Program Criteria for Home Health Services 7-1-17

A. A Medicaid beneficiary is eligible for home health services only if he or she has had a comprehensive physical examination and a medical history or history update by his or her PCP or authorized attending physician within the twelve months preceding the beginning date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

B. The appropriateness of home health services is determined by the beneficiary's PCP or authorized attending physician.

1. An individual's PCP or authorized attending physician determines whether the patient needs home health services, the scope and frequency of those services and the duration of the services.

2. The PCP or authorized attending physician is responsible for coordination of the patient's care, both in-home and outside the home.

C. Some examples of individuals for whom home health services may be suitable are those who need the following:

1. Specialized nursing procedures with regard to catheters or feeding tubes.

2. Detailed instructions regarding self-care or diet.

3. Rehabilitative services administered by a physical therapist.

D. Some beneficiaries may require home health services of very short duration while they or their caregivers receive training enabling them to provide for particular medical needs with little or no assistance from the home health agency.

E. Some individuals may need only intermittent monitoring or skilled care. When an individual's skilled care is so infrequent that more than 60 days elapse between services, that individual requires a new assessment and a new plan of care for each episode of care, unless the physician documents that the interval without such care is no detriment and appropriate to the treatment of the beneficiary's illness or injury.

203.050 Home Health Place of Service 7-1-17

Home health services may be provided in any normal setting in which normal life activities take place, other than a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) or any setting in which payment is or could be made under

Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound. The single exception to this policy permits Medicaid to reimburse a home health agency for providing nursing services to an ICF/IID resident on a short-term basis if the only alternative to home health services is inpatient admission to a hospital or a skilled nursing facility. Medicaid supplies, equipment and appliances suitable for use may be provided in any setting in which normal life activities take place.

203.060 Intravenous Therapy in a Patient's Home (Home IV Therapy) 7-1-17

Home IV therapy is a skilled nursing service that is included in coverage of LPN and RN home health visits. Home IV therapy is available to a Medicaid-eligible individual who is stabilized on a course of treatment and requires continued IV therapies in the home for several days or weeks. Medicaid requirements for establishing and maintaining home IV therapy are:

A. A Medicaid-eligible individual may qualify for home IV therapy only if he or she has had a face-to-face encounter with their physician or the allowed non-physician practitioner.

B. The registered nurse employed by the Home Health provider must assess the patient and the patient's need for home IV therapy.

C. The PCP or authorized attending physician, in consultation with the Home Health provider, establishes and authorizes a home health plan of care that includes the physician's instructions for IV therapy.

D. The physician prescribes the IV drug(s).

1. Prescriptions for IV drugs are subject to applicable Medicaid Pharmacy program policy and Medicaid program benefit limits.
2. The client, the client's representative or the Home Health provider may obtain the drug(s) under the client's prescription drug benefit.
3. The pharmacy bills Medicaid or the patient, in accordance with Medicaid program policy, for the IV drugs.

E. The plan of care must include the following:

1. Details regarding the patient training that will occur, describing the type, the amount and the frequency of self-care the patient will learn and perform.
2. Realistic training goals.
3. The projected date by which skilled nursing care will end or decrease because the client will be capable of self-care or of a designated portion of her or his self-care.
    a. The registered nurse must visit and reassess the client before the projected date that the complete or partial self-care is to commence.
    b. The home health agency in consultation with the PCP or authorized attending physician must terminate or revise the plan of care, basing its determination on the degree of self-care of which the client has become capable.

F. The Home Health provider or a provider enrolled in the Arkansas Medicaid Prosthetics program may furnish the IV therapy supplies. Regardless of the source of the supplies, the Home Health provider is responsible for the deployment and management of the IV therapy supplies and for the documentation of their medical deployment and management.

G. The Home Health provider must report the patient's status to the PCP or authorized attending physician in accordance with the physician's prescribed schedule in the plan of care.

203.070 Registered Nurse Supervision of Home Health Aide Services 7-1-17

A. The supervising registered nurse must issue written instructions to the home health aide.

1. The instructions must specify the aide's specific duties at each visit.
2. The aide must note that he or she has performed each task and note, with written justification of the omission, which tasks he or she did not perform.

B. If a beneficiary is receiving home health aide services only, the registered nurse must visit the beneficiary at least once every 60 days to assess his or her condition and to evaluate the quality of service provided by the home health aide.

C. If a beneficiary is receiving only physical therapy and home health aide services, with no skilled nursing services, either the registered nurse or the qualified physical therapist may make this required supervisory visit.

203.080 Medical Supplies and Diapers/Underpads 7-1-17

When billing for these services, which are benefit-limited to a maximum number of dollars per month, providers must bill according to the **calendar** month. **Providers may not span calendar months when billing for medical supplies and diapers and underpads.** The date of delivery is the date of service. Providers may not enter different dates for "from" and "through" dates of service.

Supplies are healthcare-related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, and are required to address an individual medical disability, illness or injury.

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in the absence of a disability, illness or injury; can withstand repeated use; and can be reusable or removable. Medical coverage of equipment and appliances is not restricted to items covered as durable medical equipment in the Medicare program.

Arkansas has a list of preapproved medical equipment, supplies and appliances for administrative ease, but the state is prohibited from having absolute exclusions of coverage on medical equipment, supplies or appliances. Items not available on the preapproval list may be requested on a case-by-case basis. When denying a request, the state must inform the beneficiary of the right to a fair hearing.

203.100 The Nurse Practitioner's Role in the Pharmacy Program 8-1-21

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) which was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the Arkansas Division of Medical Services (DMS) Pharmacy website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes**. Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

An advanced nurse practitioner with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances

identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

Prescribers must obtain the latest information regarding prescription drug coverage at the website listed in the contact information for DHS or its designated Pharmacy Vendor. **View or print contact information for the DHS designated Pharmacy Vendor.**

203.101 Tamper Resistant Prescription Applications 2-6-17

Section 7002(b), which amends section 1903(i) of the Social Security Act (the Act) (42 U.S.C. section 1936b(i)) by adding new paragraph (23), states that payment shall not be made for ". . . amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." This provision becomes effective on October 1, 2007. The tamper-resistant pad requirement of section 7002(b) applies to all outpatient drugs, including over-the-counter drugs in States that reimburse for prescriptions for such items. Section 1927(k)(3) of the Act provides exceptions to section 1927(k)(2) for drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and other specified institutional and clinical settings. Such drugs in these settings (to the extent that they are not separately reimbursed) are exceptions to section 1927(k)(2), and, therefore, are not subject to the tamper-resistant pad requirement of section 7002(b). Section 7002(b) is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

See the CMS website for technical information:

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/TRP.html

Regardless of whether Medicaid is the primary or secondary payer of the prescription being filled, this rule applies to all non-electronic Medicaid-covered outpatient drugs except:

1. Emergency fills of non-controlled or controlled dangerous substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic or compliant written prescription within 72 hours after the date on which the prescription was filled;

2. Drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities and other federally-specified institutional and clinical settings so long as those drugs are not billed separately to Medicaid, for example, those billed by an individual pharmacy provider.

For purposes of this rule, "electronic prescriptions" include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber.

203.200 The Nurse Practitioner's Role in the Child Health Services (EPSDT) Program 5-1-06

The Child Health Services (EPSDT) program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth until their 21st birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with periodic screening, as well as diagnostic and treatment services delivered.

A primary care physician (PCP) may refer a child to a nurse practitioner to administer an EPSDT screen. A provider of nurse practitioner services may recommend to the PCP that an EPSDT screen could be necessary for any child that is thought to need one. If a nurse practitioner discovers a problem as a result of an EPSDT screen, or receives a referral as a result of an

EPSDT screen, nurse practitioner services may be provided after consulting with the child's PCP.

A. Treatment means physician, hearing, visual, dental, nurse practitioner services and any other type of medical care and services recognized under State law to prevent or correct disease or abnormalities detected by screening or by diagnostic procedures.

B. Nurse practitioners and other health professionals who do Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment.

C.. If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires a treatment service not normally covered under the Arkansas Medicaid Program, the service will also be considered for reimbursement if it is medically necessary and permitted under federal Medicaid regulations.

D. Effective for dates of service on and after May 1, 2006, nurse practitioners may bill a sick visit and a periodic Child Health Services (EPSDT) screening for a patient on the same date of service. This visit must be billed electronically, or on paper using form CMS-1500. **View a form CMS-1500 sample form.**

Refer to Section I of this manual for additional information. Providers of Child Health Services (EPSDT) should refer to the Child Health Services (EPSDT) provider manual.

203.300 The Nurse Practitioner's Role in the ARKids First-B Program 10-13-03

The ARKids First-B Program, established by Arkansas Act 407 of 1997, extends health care coverage to Arkansas' uninsured children. The health care delivery network for ARKids First-B Program is ConnectCare. ConnectCare is the Primary Care Physician (PCP) Managed Care Program utilized by the Arkansas Medicaid Program.

Preventive health screens are covered in the ARKids First–B Program for ARKids First-B eligible children from birth through age 18. Preventive health screens are similar to EPSDT screens. With the exception of routine newborn care, preventive health screens must be performed by the primary care physician (PCP) or referred by the PCP to an appropriate provider for screening. If a nurse practitioner receives a referral from the child's PCP for a screen and a problem is discovered, treatment may be provided with consultation from the PCP.

Nurse practitioners enrolled as a Medicaid provider may request an ARKids First-B provider manual for participation in the ARKids First-B Program. Providers should refer to their ARKids First-B provider manual for more information.

203.400 Nurse Practitioner's Role in Early Intervention Reporting for Children from Birth to Three Years of Age 10-13-03

Part C of the Individuals with Disabilities Education Act (IDEA '97) mandates the provision of early intervention services to infants and toddlers, ages birth to thirty-six months of age. Health care providers offering any early intervention services to an eligible child must refer the child to the Division of Developmental Disabilities Services for possible enrollment in First Connections, the Part C Early Intervention Program in Arkansas. Federal regulations at 34 CFR 303.321.d.2.ii require health care professionals to refer potentially eligible children within two days of identifying them as candidates for early intervention.

A. A child must be referred if he or she is age birth to three years and meets one or more of the following criteria:

1. Developmental delay – a delay of 25% or greater in one of the following areas of development:

a. Physical (gross/fine motor).

b. Cognitive.

c. Communication.

d. Social/emotional.

e. Adaptive and self-help skills.

2. Diagnosed physical or mental condition – examples of such conditions include but are not limited to:

a. Down's Syndrome and chromosomal abnormalities associated with mental condition.

b. Congenital syndromes associated with delays such as Fetal Alcohol Syndrome, intra-uterine drug exposure, prenatal rubella, severe microcephaly and macrocephaly.

c. Maternal Acquired Immune Deficiency Syndrome (AIDS).

d. Sensory impairments such as visual or hearing disorders.

B. The Division of Developmental Disabilities Services (DDS) within the Department of Human Services is the lead agency for early intervention as required in Part C of IDEA in Arkansas. Referrals to First Connections may be made either through the DDS Service Coordinator for the child's county of residence or directly to a DDS licensed community program.

203.500 The Nurse Practitioner's Role in Family Planning Services 1-1-23

Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services provided by nurse practitioners and other providers. Medicaid clients' family planning services are in addition to their other medical benefits. Family planning services do not require PCP referral.

A. Refer to Sections 214.321 through 214.333 of the manual for family planning coverage information.

B. Refer to Sections 252.430 and 252.431 of the manual for family planning services special billing instructions and procedure codes.

203.600 The Nurse Practitioner's Role in Hospital Services 8-1-21

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)

B. The care and treatment of a patient must be under the direction of a licensed physician, a licensed nurse practitioner, a certified nurse-midwife or dentist with hospital staff affiliation.

C. DHS or its designated vendor reviews all inpatient hospital transfers and all inpatient stays longer than four (4) days for the Medicaid Utilization Management Program (MUMP).

DHS or its designated vendor also completes post-payment reviews of hospital stays for medical necessity determinations. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.**

D. Hospital claims are also subject to review by the Medicaid Peer Review Committee or the Medical Director for the Medicaid Program.

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to nurse practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.

2. Nurse practitioners and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.

3. Nurse practitioners and hospitals may not bill inpatient services previously denied for lack of medical necessity as outpatient services.

203.700 The Nurse Practitioner's Role in Preventing Program Abuse 1-15-16

A. The Arkansas Medicaid Program has the responsibility for assuring quality medical care for its beneficiaries along with protecting the integrity of the funds supporting the program. The Division of Medical Services is committed to this goal by providing staff and resources to the prevention, detection and correction of abuse. However, this task can only be accomplished through the cooperation and support of the provider community. The nurse practitioner is many times in a position to detect certain program abuses.

B. A nurse practitioner who has reason to suspect either beneficiary or provider abuse or unacceptable quality of care should contact the Utilization Review Section of Arkansas Division of Medical Services. An investigation will then be made. **View or print the Arkansas Division of Medical Services Utilization Review Section contact information**.

C. Examples of the types of abuse you may detect include:

1. Beneficiary over-utilization of services
2. Beneficiary misuse or inappropriate utilization of services
3. Beneficiary misuse of I.D. card
4. Poor quality of service
5. Provider over-utilization or abuse

203.800 The Nurse Practitioner's Role in Children's Advocacy Centers 7-1-24

Children's Advocacy Centers (CACs) provide a comprehensive interdisciplinary evaluation, assessment, and treatment of sexually and physically abused children under twenty-one (21) years of age. A team of professionals representing a variety of medical, social, and legal disciplines and advocates assesses the child and coordinates needed services. Sexual abuse, neglect, and physical abuse examinations are available to children under twenty-one (21) years of age through Medicaid providers who deliver and bill for the separate components of the service (physical examination). Medicaid coverage of services provided by CACs is limited to sexual abuse or neglect and physical abuse medical examinations, or both. The nurse practitioner's role in CACs includes the following:

A. Serve as the medical director of the CAC;

B. Perform medical examination for neglect and physical abuse of individuals under twenty-one (21) years of age; and

C. Perform medical examination for sexual assault of individuals under twenty-one (21) years of age.

203.801 Sexual Assault Nurse Examiner Pediatric (SANE-P) Certification and Enrollment as a Provider for Arkansas Medicaid 7-1-24

Registered Nurse Certified as a Sexual Assault Nurse Examiner-Pediatric (SANE-P)

A. Registered Nurses (RNs) must have specialized training in the evaluation and treatment of neglect and abuse of children;

B. Registered Nurses must have specialized training on the use of a colposcope;

C. Registered Nurses must be certified as Sexual Assault Nurse Examiners- Pediatric (SANE-P) by the International Association of Forensic Nurses; and

D. Enrolled as a provider with Arkansas Medicaid.

204.000 Role of Quality Improvement Organization (QIO) 10-13-03

The Quality Improvement Organization (QIO) reviews all federally and state funded hospital inpatient services. The purpose of such review is the promotion of effective, efficient and economical delivery of health care services of proper quality and assurance that such services conform to appropriate professional standards. QIO reviews are mandated to assure that federal payment for such services will take place only when they are determined to be medically necessary, consistent with professionally recognized health care standards and provided in the most appropriate setting and location.

A pattern of aberrant practice may result in a nurse practitioner having his or her waiver of liability revoked. Once a nurse practitioner has lost his or her waiver of liability, 100% of his or her admissions are reviewed by QIO. After the appeal process, QIO forwards any denials to the state agency for recoupment of funds.

210.000 PROGRAM COVERAGE

211.000 Introduction 1-15-16

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

212.000 Advanced Nurse Practitioner 10-13-03

A nurse practitioner, as applicable to this program, is a licensed professional nurse who meets the participation requirements and enrollment criteria for advanced practice nursing as defined by the state licensing authority.

The nurse practitioner provides direct care to individuals, families and other groups in a variety of settings including homes, hospitals, nursing homes, offices, industries, schools and other institutions and health care settings. The service provided by the nurse practitioner is directed toward the delivery of primary, secondary and tertiary care that focuses on the achievement and maintenance of optimal functions in the population.

The nurse practitioner engages in independent decision-making about the health care needs of clients and collaborates with health professionals and others in making decisions about other health care needs. The nurse practitioner plans and initiates health care programs as a member of the health care team. The nurse practitioner is directly accountable and responsible for the quality of care provided.

213.000 Scope 10-13-03

The scope of the Nurse Practitioner Program includes Medicaid covered services provided by pediatric, family, obstetric-gynecologic (women’s health care) and gerontological nurse practitioners in accordance with state and federal regulations.

Services provided through the Nurse Practitioner Program include:

A. Assessment and diagnostic services.

B. Development and implementation of treatment plans.

C. Evaluation of client outcomes.

D. Referrals to appropriate providers when the health status of the Medicaid-eligible individual requires additional diagnostic and treatment services based on the health status of the individual.

214.000 Coverage 1-15-16

Many nurse practitioner services covered by the Arkansas Medicaid Program have coverage restrictions or are benefit limited. Coverage restrictions are the circumstances under which certain services will be covered. Benefit limits are the limits on the quantity of covered services Medicaid-eligible individuals may receive. Benefit limits for some services may be extended if medically necessary. See Sections 214.000 through 214.800 and Section 252.484 for information about covered nurse practitioner services with restrictions and/or benefit limits.

214.100 Exclusions 10-13-03

Exclusions are those services not covered in Arkansas Medicaid Nurse Practitioner Program and any covered services furnished by a nurse practitioner that are not within the scope of practice of the advanced nurse practitioner as defined by the state licensing authority and by the national certifying body. Services are not covered when provided by an employed or contracted nurse practitioner who is not enrolled as a participant in the Nurse Practitioner Program.

Medicaid does not cover services that are not medically necessary or are not generally accepted by the medical profession. Medicaid does not cover services that are not properly documented by diagnoses that certify medical necessity.

214.200 General Nurse Practitioner Services 10-13-03

A. Services provided by a nurse practitioner include initial visits and established patient visits for:

1. Diagnosis and evaluation.
2. Treatment services.
3. Health management services for prevention and early intervention.
4. Appropriate referrals to other health care providers for diagnostic and treatment services.

B. Some services (pelvic exams, prostate massages, removal of sutures, etc.) are not considered a separate service from an office visit.

214.210 Advanced Practice Registered Nurse (APRN) Services Benefit Limits 7-1-25

A. For clients twenty-one (21) years of age or older, APRN services provided in a physician office, an APRN office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30).

The following services are counted toward the Service Benefit Limits established for the state fiscal year:

1. APRN services in the office, patient's home, or nursing facility
2. Physician services in the office, patient's home, or nursing facility
3. Rural health clinic (RHC) encounters
4. Medical services furnished by a dentist

5. Medical services furnished by an optometrist
6. Certified nurse-midwife services
7. Federally qualified health center (FQHC) encounters

The established benefit limit does not apply to clients under age twenty-one (21).

Office visits coded with obstetrical visit procedure codes are not counted toward the visit limit. All other office visits count toward the established sixteen (16) visit limit.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

214.300 Reserved 1-15-16

214.310 Reserved 1-15-16

214.320 Reserved 1-15-16

214.321 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 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.

214.330 Family Planning Coverage Information 1-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing nurse practitioners 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. Family planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information.

C. Nurse practitioners desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 214.321 through 241.333 to Medicaid beneficiaries of childbearing age.

D. Nurse practitioners preferring not to provide family planning services may refer their patients to other providers. 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. Physicians

4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physicians
8. Certified Nurse-Midwives

E. 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:

1. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).
2. 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.
3. 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**.
4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

F. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

214.331 Nurse Practitioner Basic Family Planning Visit 1-15-16

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

D. Laboratory services, including, as necessary:

1. Pregnancy test.
2. Hemoglobin and hematocrit.
3. Sickle cell screening.
4. Urinalysis testing for albumin and glucose.
5. Papanicolaou (PAP) smears for cervical cancer.
6. Testing for sexually transmitted diseases.

214.332 Nurse Practitioner Periodic Family Planning Visit 1-15-16

Medicaid covers three periodic family planning visits per beneficiary per Arkansas state fiscal year (July 1 through June 30). The periodic visit includes follow-up medical history, weight, blood pressure and counseling regarding contraceptives and possible complications of contraceptives. The purpose of the periodic visit 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.

214.333 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.
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 physicians that supply the IUD at the time of insertion.
3. Medicaid pays physicians for IUD insertion and removal.

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 252.430.
3. Refer to Sections 252.430 through 252.431 of this manual for family planning procedure codes and billing instructions for family planning services.

214.400 Reserved 1-15-16

214.500 Laboratory and X-Ray Services Referral Requirements 2-1-22

A nurse practitioner referring a Medicaid beneficiary for laboratory, radiology or machine testing services must specify an ICD diagnosis code for each test ordered, *and include in the order,* pertinent supplemental diagnosis supporting the need for the test(s).

A. Diagnostic facilities, hospital labs and outpatient departments performing reference diagnostics rely on the referring nurse practitioner to establish medical necessity.

B. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities performing the tests.

C. Nurse practitioners must follow the Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.

D. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD volume concurrent with the referral dates and the claim dates of service.

E. The following ICD diagnosis codes may not be utilized (**View ICD Codes.**).

Medicaid regulations regarding collection, handling and/or conveyance of specimens are as follows:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen); or, (2) collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

View or print the procedure codes for Nurse Practitioner services.

NOTE: The P codes listed are the Urinary Collection Codes.

Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. If laboratory procedures requiring a venous blood specimen are performed in the office and other laboratory procedures are sent to a reference laboratory on the same date of service, no collection fee may be billed.

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

214.510 Diagnostic Laboratory and Radiology/Other Services Benefit Limits 7-1-22

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

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
2. All the benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).
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.

View or print the essential health benefit procedure codes.

B. Medicaid established a maximum amount (benefit limit) of five hundred dollar ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services for beneficiaries twenty-one (21) years of age and older. Exceptions are listed below:

1. There is no diagnostic laboratory services benefit limit or radiology/other services benefit limit for beneficiaries under twenty-one (21) years of age.
2. There is no benefit limit on diagnostic laboratory services related to family planning. (Refer to Section 252.431 of this manual for the family planning-related clinical laboratory procedures.)
3. There are no benefit limits on diagnostic laboratory services or radiology/other services that are performed as emergency services and approved by DHS or its designated vendor for payment as emergency services.

   View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.
4. Claims with the following primary diagnoses are exempt from diagnostic laboratory services or radiology/other services benefit limits:
   a. Malignant Neoplasm (**View ICD Codes**);
   b. HIV disease and AIDS (**View ICD Codes**);
   c. Renal failure (**View ICD Codes**);
   d. Pregnancy* (**View ICD Codes**); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes.**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes.**)

C. *Obstetric (OB) ultrasounds and fetal non-stress tests have benefit limits and are not exempt from Extension of Benefits request requirements. (See Section 214.630 for additional coverage information.)

D. Extension of benefit requests are considered for clients who require supportive treatment, such as dialysis, radiation therapy, or chemotherapy for maintaining life.

E. Benefits may be extended for other conditions documented as medically necessary.

214.600 Obstetrical Services 7-1-25

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible clients in *full* coverage aid categories with a medically verified pregnancy.

Aid category 61, PW clients are eligible for full range Medicaid coverage. Aid category 61, PW pregnant women's eligibility ends on the last day of the month in which the 60th postpartum day falls.

Medicaid provides temporary Aid Category 62, Presumptive Eligibility Pregnant Woman (PE-PW). Coverage is restricted to prenatal services and services for conditions that may complicate the pregnancy. These services are further limited to the outpatient setting only.

214.610 Covered Nurse Practitioner Obstetrical Services 10-13-03

Covered nurse practitioner obstetrical services may be provided when medically necessary and are *limited* to antepartum and postpartum care. Appropriate referrals will be made to a physician and/or a certified nurse-midwife for complete obstetrical services to include delivery.

214.620 Risk Management Services for High Risk Pregnancy 2-1-22

A nurse practitioner may provide risk management services if he or she employs the professional staff indicated in service descriptions below. If a nurse practitioner does not choose to provide high-risk pregnancy services but believes the patient would benefit from such services, he or she may refer the patient to a clinic that offers the services.

Covered risk management services described in parts A through E below are considered as one service with a benefit limit of 32 cumulative units. The early discharge home visit described in part F is considered as a separate service.

A. Risk Assessment

Risk assessment is defined as a medical, nutritional and psychosocial assessment by a nurse practitioner or a registered nurse on the nurse practitioner's staff, to designate patients as high or low risk.

1. Medical assessment using the Hollister Maternal and/or Newborn Record System or equivalent form includes:
    a. Medical history
    b. Menstrual history
    c. Pregnancy history
2. Nutritional assessment includes:
    a. 24 hour diet recall
    b. Screening for anemia
    c. Weight history
3. Psychosocial assessment includes criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: 2 units per pregnancy

B. Case Management Services

Case management services are provided by a nurse practitioner, a licensed social worker or registered nurse to assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational and other services (e.g., locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver a newborn, following up to verify that the patient kept her appointment, rescheduling the appointment).

Maximum: 1 unit per month. A minimum of two contacts per month must be provided. A case management contact may be with the patient, other professionals, family and/or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (physician, public health nurse, nutritionist or health educator) include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health
4. Postpartum care
5. Nutrition in pregnancy
6. Maximum: 6 classes (units) per pregnancy

D. Nutrition Consultation — Individual

Nutrition consultation services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration must include at least one of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan
2. Nutritional care plan follow-up and reassessment as indicated

Maximum: 9 units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker must include at least one of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan
2. Social work plan follow-up, appropriate intervention and referrals

Maximum: 6 units per pregnancy

F. Early Discharge Home Visit

If a physician or certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours after delivery), the physician or certified nurse-midwife may provide a home visit to the mother and baby within 72 hours of the hospital discharge. The physician or certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by the physician or certified nurse-midwife's order (includes a hospital discharge order).

A home visit may be ordered for the mother and/or infant discharged later than 24 hours if there is specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in **Section 252.450**.

214.630 Fetal Non-Stress Test 2-1-22

The fetal non-stress test is *limited to 2 per pregnancy per beneficiary*. If it is necessary to exceed this limit, the nurse practitioner must request an extension of benefits and submit documentation that establishes medical necessity. Refer to Section 214.900 of this manual for procedures to request extension of benefits. Refer to **Section 252.451** of this manual for billing instructions and the procedure code.

The post-procedural visits are covered within the 10-day period following the fetal non-stress test.

214.700 Reserved 1-15-16

214.710 Inpatient Services 10-13-03

Nurse practitioner inpatient services must meet the Medicaid requirement of medical necessity. The Quality Improvement Organization (QIO) will deny payments for inpatient admissions and subsequent inpatient services when they determine that inpatient care was not necessary. Inpatient services are subject to QIO review for medical necessity whether the nurse practitioner admitted the patient, or whether Medicaid deemed the inpatient status criteria in Section 214.711.

The attending nurse practitioner must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent. Nurse practitioner and hospital claims for hospital observation services are subject to post-payment review to verify medical necessity.

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

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care and/or general hospitals, in state and out of state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age one (1), are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday. Refer to item "E" below for the procedure to follow when a child's first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

A. Medicaid will reimburse hospitals for up to four (4) days of inpatient service with no pre-certification requirement, except for admissions by transfer from another hospital.

B. If the attending nurse practitioner determines the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact DHS or its designated vendor and request an extension of inpatient days.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.

C. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines.

D. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day (inclusive) of the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.

E. Additional extensions may be requested as needed.

F. Reconsideration reviews of denied extensions may be requested by sending the medical record to AFMC through regular mail, or expedited by overnight express. The hospital will be notified by the next working day of the decision.

G. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However, the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable. All calls will be limited to ten (10) minutes to allow equal access to all providers.

H. Inpatient stays for bone marrow, liver, heart, lung, skin and pancreas and/or kidney transplant procedures are excluded from this review program.

I. A retrospective or post-payment random sample review will be conducted for all admissions, including inpatient stays of four (4) days or less, to ensure that medical necessity for the services is substantiated.

J. Admissions of retroactive eligible beneficiary: If eligibility is identified while the patient is still an inpatient, the hospital may request retrospective review of those days already used

past the original four for a determination of post-authorization and concurrent evaluation of future extended days.

If the retroactive eligible beneficiary is not identified until after discharge, and the hospital files a claim and receives a denial for any days past the original four allowed, the hospital may request post-extension evaluation approval of the denied days. If granted, the claim may be refiled. If the length of stay is more than thirty (30) days, the provider shall submit the entire medical record to DHS or its designated vendor for review.

K. Claims submitted without an extension will result in automatic denials of any days billed beyond the fourth day. The only exceptions are for claims reflecting third party liability and patients with retroactive Medicaid eligibility described in items G and J above.

L. If a patient is transferred from one facility to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours of admitting the patient to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider may contact DHS or its designated vendor on the first working day following the weekend or holiday.

M. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure code in order to be reimbursed.

N. If a provider fails to contact DHS or its designated vendor for an extension of inpatient days due to the patient's having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, etc., post-certification of days past the original four days may be obtained by the following procedures:

1. Send a copy of the denial notice received from the third-party payer to DHS or its designated vendor.
2. Include a note requesting post-certification and the full name of the requester and a phone number where the requester may be reached.

   Upon receipt of the denial copy and the provider request, a coordinator will call the provider and obtain certification information.

O. If a third-party insurer pays for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

214.712 Evaluation and Management 10-13-03

A. Medicaid covers nurse practitioner evaluation and management services for hospital inpatients on Medicaid-covered inpatient days only. The single exception to this policy is that Medicaid will cover discharge day management. Medicaid does not remit the hospitals per diem for the day of discharge unless it is also the admission day. Medicaid reimburses nurse practitioners for medically necessary discharge day management unless the nurse practitioner evaluation and management services for that day are included in another service, or unless the nurse practitioner does not customarily bill private-pay patients for discharge day management.

B. The Medicaid Program covers only one evaluation and management service per day, regardless of how many times the nurse practitioner sees the patient.

C. The Medicaid Program covers standby or detention services when requested by a physician that involves prolonged attendance without direct (face-to-face) patient contact. When providing standby services, the nurse practitioner must not be providing care or services to other patients during this period. Service is covered when provided in the inpatient hospital setting and is limited to one unit per date of service.

D. The Medicaid Program will recover payments to nurse practitioners for inpatient evaluation and management services on days for which the hospital's inpatient claims are denied (or would be denied, if filed) for:

1. Exceeding benefit limits,
2. Failure to pre-certify inpatient days, when applicable, or
3. Lack of medical necessity.

214.713 Professional Components of Diagnostic and Therapeutic Procedures 10-13-03

Medicaid reimbursement to hospitals for inpatient services includes the non-professional components (technical components) such as machine tests, laboratory tests and radiology procedures provided to inpatients.

Reimbursement to nurse practitioners and independent laboratories for laboratory and radiology services for inpatients is solely for the professional component of machine tests, radiology services and anatomical laboratory services.

Medicaid does not pay for technical components of diagnostic procedures (or complete procedures that include a technical component) or for clinical laboratory procedures performed in the course of diagnosing and treating a hospital inpatient. Hospitals must furnish or purchase those ancillary services.

214.714 Inpatient Hospital Benefit Limits 1-15-16

A. There is an annual benefit limit of 24 medically necessary days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries ages 21 and older.

B. There is no inpatient hospital benefit limit for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

214.720 Outpatient Hospital Services 10-13-03

For the purpose of coverage and reimbursement determination, outpatient hospital nurse practitioner services are divided into two types of service.

214.721 Emergency Services 1-15-16

Nurse practitioner outpatient hospital visits are covered as an emergency when the beneficiary's medical condition constitutes an emergency medical condition. (Refer to the Glossary of this manual for the definition of emergency services.)

Services not considered as emergency services are covered with primary care physician approval, or the beneficiary may be billed for the services.

214.722 Non-Emergency Services 10-13-03

Coverage of non-emergency nurse practitioner services in an outpatient hospital setting is restricted to a visit charge and the professional component for machine tests, radiology and anatomical laboratory procedures.

214.800 Occupational, Physical, and Speech-Language Therapy 1-1-21

A. Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries under age 21 in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. Therapy services are not

covered as nurse practitioner services. The following is provided for the nurse practitioner's information.

B. Occupational, Physical, and Speech-Language therapies are covered for beneficiaries in the ARKids A and ARKids -B program benefits.

C. Therapy services for individuals age 21 and older are only covered when provided through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT), Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.

D. All therapy services for beneficiaries under age 21 require a referral for evaluation utilizing the form DMS-640 and a separate form DMS-640 for the written prescription from the patient's primary care physician (PCP) or attending physician if the beneficiary is exempt from PCP Managed Care Program requirements. A referral for therapy services must be renewed every twelve (12) months. After the initial referral using the form DMS-640 and initial prescription, utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640. The prescription for treatment is valid for one year unless the prescribing physician specifies a shorter period.

E. The PCP or attending physician must complete and sign the DMS-640 for beneficiaries under age 21. The PCP or attending physician must initiate a referral and prescription for beneficiaries over age 21. An original signature is required when making a referral or prescribing a therapy service. An electronic signature is acceptable on either document, provided it is in compliance with Arkansas Code 25-31-103. A copy of the prescription must be maintained in the beneficiary's records. The original prescription is to be maintained by the physician. **View or print form DMS-640** (for beneficiaries under age 21)

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

Extended therapy services may be provided based on medical necessity, for Medicaid beneficiaries under age 21.

Occupational, physical, and speech-language therapies are subject to the benefit limit of 12 outpatient hospital visits per state fiscal year (SFY) for beneficiaries age 21 and over. Benefit Extensions may be provided for therapy services, based on medical necessity, for Medicaid beneficiaries 21 years of age and over when provided within a covered program.

214.810 Occupational, Physical and Speech Therapy Guidelines for Retrospective Review 11-1-10

Though nurse practitioners are not reimbursed for occupational, physical and speech therapy services, it is important for the nurse practitioner to be aware of Medicaid's guidelines to document medical necessity. For Arkansas Medicaid guidelines applicable to therapy services, please refer to the Occupational, Physical and Speech Therapy Services provider manual.

214.811 Occupational and Physical Therapy Guidelines 3-1-05

Occupational, physical and speech therapists must adhere to the specific guidelines for retrospective review.

A. Therapy services for individuals must be medically necessary to the treatment of the individual's medical condition as prescribed by the individual's PCP. Nurse practitioners are not reimbursed for occupational or physical therapy services.

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 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 medical necessity definition in the Glossary of this manual).

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Frequency, Intensity and Duration of Physical Therapy Services:

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 therapy services. These services can be provided to the child as part of a home program that can be implemented by the child's caregivers and do not necessarily require the skilled services of a physical therapist to perform safely and effectively.
3. Duration of Services: Therapy services should be provided as long as 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.

C. 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.
8. Graduate students must have the supervising physical therapist co-sign progress notes.

214.812 Speech-Language Therapy Retrospective Review Guidelines 8-1-09

A. Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. 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 reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See medical necessity in glossary of the Arkansas Medicaid manual.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

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 12 months of age or younger, gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (when less than 37 weeks gestation) if the child is 12 months of age or younger this should be noted in the evaluation.
6. An assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
7. The child should be tested in their native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

The mental measurement yearbook is the standard reference to determine good reliability/validity of the test(s) administered in the evaluation.

C. Birth to Three:

1. — (minus) 1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive) or a — (minus) 2.0 SD (standard score of 70) below the mean in one area to qualify for language therapy.
2. Two language tests must be reported with at least one of these being a global norm-referenced standardized test with good reliability/validity. The second test may be criterion referenced.

214.900 Procedures for Obtaining Extension of Benefits 7-1-22

A. Nurse practitioners who perform diagnostic laboratory services or radiology/other services within their scope of practice may request extension of benefits for those services if the patient has exhausted the benefit limit.

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. To request an extension of benefits for diagnostic laboratory services or radiology/other services, use the following procedures.

214.910 Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each 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).

B. Requests for extension of benefits for diagnostic laboratory services or radiology/other services 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 extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's five-hundred-dollar benefit limit for either diagnostic laboratory services or radiology/other services is exhausted.

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

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.

C. A request for extension of benefits must be received within ninety (90) calendar days of the date of benefit limit denial.

D. 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.

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

214.920 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology/Other Services." 7-1-22

A. The Medicaid Program's diagnostic laboratory services limit and radiology/other services benefit limit each 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 for extension of benefits for clinical services (such as physician's visits or Nurse Practitioner visits), outpatient services (meaning, hospital outpatient visits), diagnostic laboratory services (meaning, laboratory tests) and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Consideration of requests for extension of benefits requires correct completion of all fields on 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.**

2. Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each provider manual.

214.930 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each 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. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records *must:*

   a. Be legible and include records supporting the specific request;

   b. Be signed by the performing provider;

   c. Include clinical, outpatient, and emergency room records for dates of service in chronological order;

   d. Include related diabetic and blood pressure flow sheets;

   e. Include a current medication list for the date of service;

   f. Include the obstetrical record related to a current pregnancy when applicable; and

   g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician

2. Diagnostic laboratory and radiology/other reports *must* include:

a. Clinical indication for diagnostic laboratory and radiology/other services ordered;

b. Signed orders for diagnostic laboratory and radiology/other services;

c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable.

214.940 Administrative Reconsideration and Appeals 6-1-25

A. 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.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal 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.

214.950 Reserved 6-1-25

214.951 Reserved 6-1-25

214.952 Reserved 6-1-25

215.000 Fluoride Varnish Treatment 2-1-22

Arkansas Medicaid covers fluoride varnish application, ADA code, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

View or print the procedure codes for Nurse Practitioner services.

Eligible physicians may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. The online training course can be accessed at **http://ar.train.org**. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate of completion to Provider Enrollment.

220.000 PRIOR AUTHORIZATION

221.000 Procedure for Obtaining Prior Authorization 8-1-21

A. Certain medical and surgical procedures are not covered without prior authorization, because of federal requirements or because of the elective nature of the surgery.

B. DHS or its designated vendor issues prior authorizations for restricted medical and surgical procedures covered by the Arkansas Medicaid Program. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.**

1. Prior authorization determinations are in accordance with established medical or administrative criteria combined with the professional judgment of physician advisors.

2. Payment for prior-authorized services is in accordance with federal regulations.

C. Prior authorization of service does not guarantee eligibility for a beneficiary. Payment is subject to verification that the beneficiary is Medicaid-eligible at the time services are provided.

221.100 Post-Procedural Authorization 8-1-21

Post-procedural authorization will be granted only for emergency procedures for beneficiaries age twenty-one (21) and older. Requests for post-authorization of an emergency procedure must be applied for on the first working day after the procedure is performed.

In cases of retroactive eligibility, the provider must contact DHS or its designated vendor for post-authorization within sixty (60) days of the eligibility authorization date displayed in the electronic eligibility verification response.

221.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 8-1-21

A. Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain a prior authorization number if the beneficiary is under age twenty-one (21).

B. The following post-procedural authorization process must be followed when obtaining an authorization number.

1. All requests for post-procedural authorizations for eligible beneficiaries are to be made to 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.**
2. Out-of-state providers and others without electronic capability may call DHS or its designated vendor to obtain the dates of eligibility. **View or print contact information to obtain dates of eligibility**.
3. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.
4. Consultants are responsible for DHS or its designated vendor to have their required and/or restricted procedures added to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

Providers must obtain prior authorization for procedures requiring authorization in order to prevent risk of denial due to lack of medical necessity.

221.200 Prescription Prior Authorization 8-1-21

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a nurse practitioner with prescriptive authority. Certain prescription drugs may require prior authorization. It is the responsibility of the prescriber to request and obtain the prior authorization. Information may be obtained from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor prescription drug information.**

The following information is available:

A. Prescription drugs requiring prior authorization.

B. Criteria for drugs requiring prior authorization.

C. Forms to be competed for prior authorization.

D. Procedures required of the prescriber to request and obtain prior authorization.

221.300 Procedures that Require Prior Authorization 10-13-03

Medical and/or surgical procedures that are generally restricted to the outpatient setting no longer require prior authorization for inpatient services.

222.000 Reserved 6-1-25

230.000 REIMBURSEMENT

231.000 Method of Reimbursement 10-13-03

Medicaid reimbursement for nurse practitioner services is based on the lesser of the amount billed or the Title XIX maximum allowable.

231.010 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.

232.000 Rate Appeal Process 10-13-03

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he 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 provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (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.

250.000 BILLING PROCEDURES

252.000 Introduction to Billing 7-1-20

Nurse Practitioner providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

252.000 CMS-1500 Billing Procedures

252.100 Reserved 1-15-16

252.110 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 Nurse Practitioner services.

B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For the Nurse Practitioner, the above listed procedure codes are only payable for the technical component.

See Section 252.442 for additional information about the technical component.

252.120 Reserved 1-15-16

252.130 Special Billing Instructions 2-1-22

A. Use the following procedure codes for billing.

View or print the procedure codes for Nurse Practitioner services.

B. For consideration of any claims with payable 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 include justification for medical necessity.

All other billing requirements must be met in order for payment to be approved.

252.131 Molecular Pathology 2-1-22

The following Molecular Pathology codes require prior authorization from the Arkansas Foundation for Medical Care. See Sections 221.000 through 221.300 for prior authorization procedures.

View or print the procedure codes for Nurse Practitioner services.

252.132 Special Billing Requirements for Lab and X-Ray Services 2-1-22

For consideration of payable unlisted CPT/HCPCS drug procedure codes:

A. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.

B. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.

C. All other billing requirements must be met in order for payment to be approved.

View or print the procedure codes for Nurse Practitioner services.

252.200 Reserved 1-15-16

252.210 National Place of Service (POS) Codes 7-1-07

Electronic and paper claims now require the same National Place of Service code.

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Office	11
Patient's Home	12
Day Care Facility	99
Nursing Facility	32
Skilled Nursing Facility	31
Ambulance	41
Other Locations	99

252.300 Billing Instructions – Paper Claims Only 11-1-17

Bill Medicaid for nurse practitioner services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

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

252.310 Completion of CMS-1500 Claim Form 1-15-16

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.

Field Name and Number		Instructions for Completion
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.

Field Name and Number	Instructions for Completion
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Some providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Enter the appropriate place of service code. See Section 252.200 for codes.
C. EMG	Check “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 252.100 through 252.132.
MODIFIER	Modifier(s) if applicable.

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider’s services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail. .
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider’s Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT’S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as “MRN.”
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	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.
30.	RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

252.400 Special Billing Procedures

252.410 Clinic or Group Billing 2-1-22

Providers who wish to have payment made to a group practice or clinic must enroll as a group practice. When billing, enter the Clinic/Group pay-to Provider Identification Number in Field 33 after "GRP#." Enter the performing provider identification number in Field 24K. If more than one nurse practitioner in a group practice provides services for a beneficiary, the clinic may bill for all their services on the same claim limited only by the size of the claim format.

Procedure code is payable when provided in the inpatient hospital setting by a nurse practitioner.

View or print the procedure codes for Nurse Practitioner services.

252.420 Evaluations and Management

252.421 Initial Visit 1-15-16

The American Medical Association's *Current Procedures Terminology* (CPT) codes should be used only for the first visit of a new patient. Each subsequent visit should be billed using an established patient code. A distinction is made in CPT codes for new or established patients for office visits, home visits, nursing facility visits and emergency room visits. Refer to the latest edition of the CPT.

Providers are allowed to bill one new patient visit procedure code per beneficiary, per attending provider in a three (3) year period.

252.422 Detention Time (Standby Service) 2-1-22

View or print the procedure codes for Nurse Practitioner services.

Procedure code must be used by nurse practitioners when billing for detention time.

One unit equals 30 minutes. A maximum of 1 unit per date of service may be billed.

Procedure code is payable when provided in the inpatient hospital setting by a nurse practitioner.

252.423 Inpatient Hospital Visits 10-13-03

Each nurse practitioner is limited to billing one day of care for each inpatient hospital covered days, regardless of the number of hospital visits rendered.

252.424 Hospital Discharge Day Management 2-1-22

View or print the procedure codes for Nurse Practitioner services.

Procedure code, hospital discharge day management, may not be billed by providers on the same date of service as an initial or subsequent hospital care code, procedures. Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

252.425 Nursing Home Visits 10-13-03

The appropriate CPT procedure codes should be used when billing for nurse practitioner visits in a nursing facility.

252.426 Specimen Collections 2-1-22

The policy in regard to collection, handling and/or conveyance of specimens is:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen); or (2) collecting a urine sample by catheterization.

The following codes should be used when billing for specimen collection:

View or print the procedure codes for Nurse Practitioner services.

252.428 Services Not Considered a Separate Service from an Office Visit 2-1-22

Some services (e.g., pelvic examinations, prostatic massages, removal of sutures, etc.) are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Procedure code should never be used for billing routine pelvic examinations, but should be used only when a pelvic examination is done under general anesthesia.

View or print the procedure codes for Nurse Practitioner services.

252.429 Health Examinations for ARKids First B Beneficiaries and Medicaid Beneficiaries Under Age 21 1-15-16

Providers should refer to the Child Health Services (EPSDT) Provider manual and the ARKids First-B Provider manual for covered services and billing procedures.

252.430 Family Planning Services Program Procedure Codes 2-1-22

A. Family planning services are covered for beneficiaries in full coverage aid categories or Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section

124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail**. **Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in **Section 252.431**.

B. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization 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**.

C. The following procedure code table explains the family planning visit services payable to nurse practitioners.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

View or print the procedure codes for Nurse Practitioner services.

D. The following procedure code table explains family planning codes payable to nurse practitioners. Use the FP modifier for family planning services.

*Bill using modifiers FP, SA.

**Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. Use modifier FP for family planning services.

E. The following procedure codes are payable to Nurse Practitioners:

F. The following procedure code table explains the pathology procedure code payable to nurse practitioners.

NOTE: The procedure code with the modifiers indicated below denotes the Arkansas Medicaid description.

Family planning laboratory codes are found in **Section 252.431**.

252.431 Family Planning Laboratory Procedure Codes 2-1-22

Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

A. The following procedure code table contains family planning laboratory procedure codes.

View or print the procedure codes for Nurse Practitioner services.

*Procedure codes are limited to one unit per beneficiary per state fiscal year.

**Payable only to pathologists and independent labs.

***Requires FP modifier only.

¤See points B and C below for information regarding this procedure code.

B. Laboratory codes payable to **non-hospital-based nurse practitioners.**

The following procedure code table contains laboratory services payable to non-hospital-based nurse practitioners.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

C. Laboratory codes payable to **hospital-based nurse practitioners.**

The following procedure code table describes the laboratory services payable to hospital-based nurse practitioners.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

252.438 National Drug Codes (NDCs) 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. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and 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. See Diagram 1 for an example of this screen. 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*.

Diagram 1

Labeler ID	Labeler Name	Contract Begin Date	Contract End Date
00002	ELI LILLY AND COMPANY	01/01/1991	01/01/3000
00003	E.R. SQUIBB & SONS, LLC.	01/01/1991	01/01/3000
00004	GENENTECH, INC.	01/01/1991	01/01/3000
00006	MERCK SHARP & DOHME CORP.	01/01/1991	01/01/3000
00007	GLAXOSMITHKLINE LLC	01/01/1991	01/01/3000
00008	WYETH PHARMACEUTICALS LLC,	01/01/1991	01/01/3000
00009	PHARMACIA AND UPJOHN COMPANY LLC	01/01/1991	01/01/3000
00013	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00014	PFIZER, INC	01/01/1991	01/01/3000
00015	MEAD JOHNSON AND COMPANY	01/01/1991	01/01/3000
00023	ALLERGAN INC	01/01/1991	01/01/3000
00024	SANOFI-AVENTIS, US LLC	01/01/1991	01/01/3000
00025	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00026	BAYER HEALTHCARE LLC	01/01/1991	01/01/3000
00032	ABBVIE INC.	01/01/1991	01/01/3000

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 2 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 2

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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	**Required 11-digit NDC (5-4-2) Billing Format**
12345 6789 1	1234567890**0**1
1111-2222-33	**0**1111222233
01111 456 71	01111**0**45671

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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

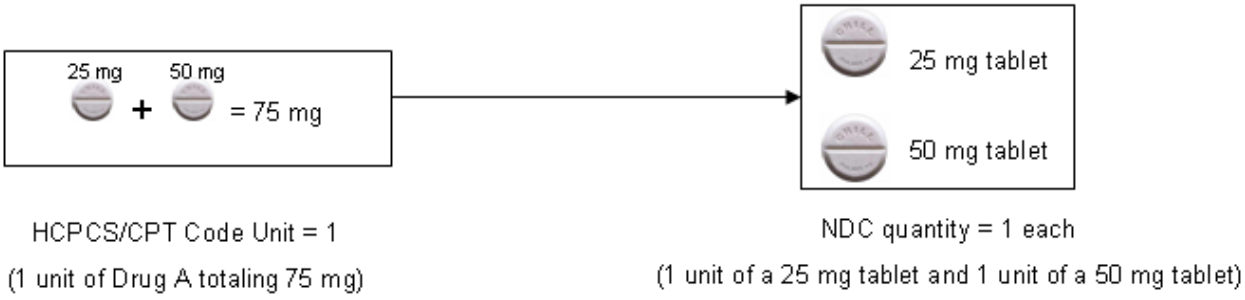
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

I. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

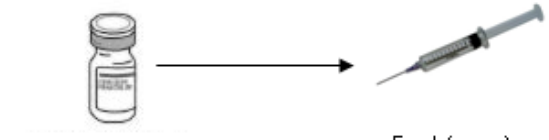
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



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. See Diagram 5. For billing wastage, see bullets A (Electronic Claims Filing) and B (Paper Claims Filing) below.

Diagram 5



Every 10 ml = 50 mg

5 ml (or cc) administered

HCPCS/CPT Code Unit = 1
(one 25 mg unit of Drug B)

NDC Quantity = 5 for the 5 ml administered

Waste = 5 ml or 25 mg
(for the 5 ml or 25 mg not administered)

A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Providers are instructed to bill as follows:

- 1 NDC for a procedure – 1st/only detail shall be billed with no modifier
- 2 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- 4 or more NDCs for same procedure – submit via paper claim
- 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

B. Paper Claims Filing – CMS-1500

Providers are instructed to bill as follows:

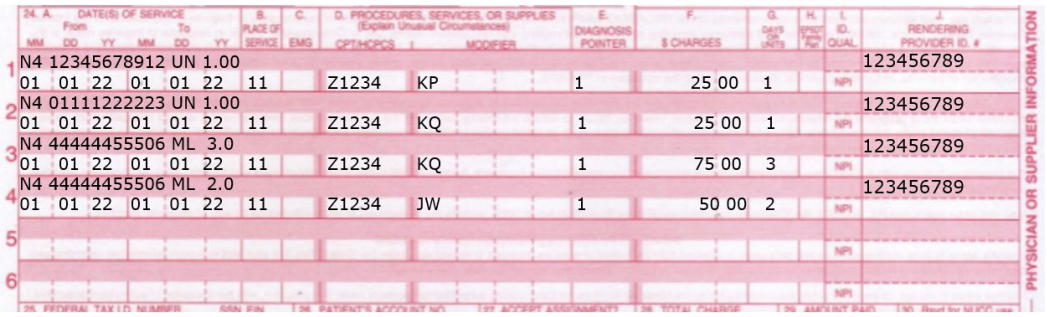
- 1 NDC for a procedure – 1st/only detail shall be billed with no modifier
- 2 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- 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
- 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 6



24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 N4 12345678912 UN 1.00											123456789
01 01 22	01 01 22	11		Z1234	KP	1	25 00	1		NPI	
2 N4 01111222223 UN 1.00											123456789
01 01 22	01 01 22	11		Z1234	KQ	1	25 00	1		NPI	
3 N4 44444455506 ML 3.0											123456789
01 01 22	01 01 22	11		Z1234	KQ	1	75 00	3		NPI	
4 N4 44444455506 ML 2.0											123456789
01 01 22	01 01 22	11		Z1234	JW	1	50 00	2		NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

II. 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.

III. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

252.439 Billing of Multi-Use and Single-Use Vials 1-1-23

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.

View or print the procedure codes for Nurse Practitioner services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.

2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.

3. **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.

252.440 Reserved 1-15-16

252.441 Family/Group Psychotherapy 2-1-22

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family/group psychotherapy:

View or print the procedure codes for Nurse Practitioner services.

Procedure codes are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure code is payable only when the patient is present during the treatment. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

252.442 Radiology and Laboratory Procedure Codes 1-15-16

The technical component radiology procedure codes listed on the Nurse Practitioner fee schedule are payable when performed in the office place of service (11) if the nurse practitioner provider owns the equipment. The technical component must be billed on the claim with modifier TC added to the procedure code on the claim detail.

The payment for laboratory codes listed on the Nurse Practitioner fee schedule is based on Clinical Laboratory Improvement Amendments (CLIA) certification. CLIA-certified providers are not the only providers who may bill for lab procedures performed in the office place of service (11). Nurse practitioner providers that bill CLIA-required laboratory procedure codes must have the current CLIA certification on file with the Provider Enrollment Unit.

252.443 Other Covered Injections 2-1-22

Nurse practitioners billing the Arkansas Medicaid Program for injections for treatment or immunization purposes should bill the appropriate CPT or HCPCS procedure code for the specific injection provided. The immunization procedure codes and descriptions may be found in the CPT coding book and in this section of this manual.

Providers may bill the immunization procedure codes on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 form.

If the patient is scheduled for immunization only, the provider will not be permitted to bill for an office visit, but for the immunization only.

The following is an alphabetized list of injections with special instructions for coverage and billing.

View or print the procedure codes for Nurse Practitioner services.

* Procedure code requires paper billing.

NOTE: Where both a national code and a local code ("Z code") are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after

October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a national code is available, it can be used indefinitely for both electronic and paper claims.

252.444 Billing Procedures for Rabies Immune Globulin and Rabies Vaccine 2-1-22

The following CPT procedure codes are covered for all ages without diagnosis restrictions.

View or print the procedure codes for Nurse Practitioner services.

These procedure codes require billing on a paper claim with the dosage entered in the units column of the claim form for each date of service. The manufacturer's invoice must be attached to each claim. Reimbursement for each of these procedure codes includes an administrations fee. Medical policy and billing procedures have not changed for these procedure codes.

252.445 Reserved 1-15-16

252.446 Reserved 1-15-16

252.447 Reserved 1-15-16

252.448 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 Nurse Practitioner 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**.

252.449 Influenza Virus Vaccine 2-1-22

View or print the procedure codes for Nurse Practitioner services.

A. Procedure code, influenza virus vaccine, split virus, preservative free, for children 6 to 35 months, is currently covered through the VFC program. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.

   For ARKids First-B beneficiaries, use modifier **TJ**.

B. Effective for dates of service on and after October 1, 2005, Medicaid will cover procedure code, influenza virus vaccine, split virus, preservative free, for ages 3 years and older.

   1. For individuals under 19 years of age, claims must be filed using modifiers **EP** and **TJ**.
   2. For ARKids First-B beneficiaries, use modifier **TJ**.
   3. For individuals ages 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 beneficiaries, the procedure code must be billed using modifier **TJ**.
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. Modifiers **EP** and **TJ** are required.

For ARKids First-B beneficiaries, use modifier **TJ**.

E. Procedure code, influenza virus vaccine, split virus, for use in individuals ages 3 years and older, will continue to be covered.

1. When filing paper claims for individuals under age 19, use modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **TJ**.
3. No modifier is required for filing claims for beneficiaries aged 19 and older.

252.450 Obstetrical Care and Risk Management Services for Pregnancy 2-1-22

Covered nurse practitioner obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A nurse practitioner may provide risk management services listed below if he or she receives a referral from the patient's physician or certified nurse-midwife and if the nurse practitioner employs the professional staff required. Complete service descriptions and coverage information may be found in Section 214.620 of this manual. The services in the list below are considered to be one service and are limited to 32 cumulative units.

View or print the procedure codes for Nurse Practitioner services.

For an early discharge home visit, use one of the applicable CPT procedure codes.

252.451 Fetal Non-Stress Test 2-1-22

The Fetal Non-Stress Test (procedure code) is limited to 2 per pregnancy. If it is necessary to exceed this limit, the nurse practitioner must request an extension of benefits and submit documentation that establishes medical necessity.

View or print the procedure codes for Nurse Practitioner services.

252.452 Newborn Care 2-1-22

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn will be responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

View or print the procedure codes for Nurse Practitioner services.

For routine newborn care following a vaginal delivery or C-section, procedure codes must be used one time to cover all newborn care visits by the attending physician, certified nurse-midwife or, if applicable, a nurse practitioner.

The newborn care procedure codes represent the initial Child Health Services (EPSDT) newborn care/screen. This screening includes the physical exam of the baby and the conference(s) with the newborn's parent(s). Payment of these codes is considered a global rate, and subsequent visits may not be billed in addition to these codes.

Procedure codes may be billed on the EPSDT screening paper form DMS-694 or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically. For information on the Child Health Service (EPSDT) Program, call the Provider Assistance Center. **View or print Provider Assistance Center contact information.**

For illness care (e.g., neonatal jaundice), use procedure codes. Do not use procedure codes in addition to these codes.

Note the descriptions, modifiers and required diagnosis range. The newborn care procedure codes require a modifier and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

ARKids A (EPSDT) requires an EPSDT claim form or CMS-1500 claim form and may be billed electronically or on paper.

ARKids First B requires a CMS-1500 claim form and may be billed electronically or on paper.

252.453 Fluoride Varnish Treatment 2-1-22

View or print the procedure codes for Nurse Practitioner services.

The American Dental Association (ADA) procedure code is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under the age of twenty-one (21). Topical fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under age twenty-one (21).

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to DHS or its designated vendor before the specialty code will be added to their file in the MMIS. **View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.** After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)). View a form CMS-1500 sample form.

252.454 Tobacco Cessation Products and Counseling Services 2-1-22

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria.**

View or print the procedure codes for Nurse Practitioner services.

*Exempt from PCP referral requirements.

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent/legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counselling sessions limit described in section C above.

The provider must complete the counseling checklist and place in the patient records for audit. A copy of the checklist is available at **View or Print Be Well Arkansas Referral Form**.

252.455 Physical Therapy Services Billing 2-1-22

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Physical therapy evaluations are payable to the nurse practitioner. Physical therapy may be payable to the physician when directly provided in accordance with the Occupational, Physical, Speech Therapy Services Manual. The following procedure codes must be used when filing claims for physician provided therapy services. See Glossary - Section IV - for definitions of "group" and "individual" as they relate to therapy services.

View or print the procedure codes for Nurse Practitioner services.

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for physical and speech therapy, if medically necessary, for eligible Medicaid beneficiaries of all ages.

252.456 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) 2-1-22

The following CPT procedure codes are covered for Medicaid beneficiaries.

View or print the procedure codes for Nurse Practitioner services.

252.457 Procedures That Require Prior Authorization 2-1-22

A. The following procedure code requires prior authorization by the Arkansas Foundation for Medical Care (AFMC). (See Section 220.000 of this manual for prior authorization instructions.)

B. The following Molecular Pathology codes require prior authorization from AFMC.

View or print the procedure codes for Nurse Practitioner services.

252.458 Substitute Nurse Practitioner 1-15-16

To comply with Section 4708 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), the Arkansas Medicaid Program implemented the following requirements to adhere to **locum tenens**

nurse practitioner and **substitute nurse practitioner** billing and coverage policies and procedures.

A. Description of Service

Locum tenens and substitute nurse practitioner are terms used to describe the relationship of a nurse practitioner who is acting as a fill-in for a beneficiary's regular nurse practitioner. The regular nurse practitioner could be a specialist the beneficiary sees regularly for a chronic condition or a specific problem. A locum tenens or substitute nurse practitioner must be the same discipline as the regular nurse practitioner. Documentation of the locum tenens arrangement must include the services provided, the date the services were performed and must be made available upon request. A record of the service would include the date and place of the service, the procedure code, the charge and the beneficiary involved.

B. Substitute Nurse Practitioners

A substitute nurse practitioner is a nurse practitioner who is asked by the regular nurse practitioner to see a beneficiary in a reciprocal arrangement when the regular nurse practitioner is unavailable to see the beneficiary. In the substitute nurse practitioner arrangement, the regular nurse practitioner reciprocates the substitute nurse practitioner by paying the substitute the amount received for the service rendered or by serving in the same capacity in return. For this provision to occur, both the regular and the substitute nurse practitioner must be enrolled in Arkansas Medicaid.

The following billing protocol must be utilized for substitute nurse practitioner circumstances:

1. The regular nurse practitioner's office submits the claim and receives payment using the regular Arkansas Medicaid provider number. The payment amount will be the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
2. The modifier Q5 must be placed in form indicator 24D of the CMS-1500 claim form to indicate services were rendered by a substitute nurse practitioner.
3. The substitute nurse practitioner arrangement should not exceed 14 consecutive days. The substitute nurse practitioner arrangement does not apply to substitution for nurse practitioners in the same medical group with claims submitted in the name of the medical group. (For situations in which one group member substitutes for another, the substitution is noted by listing the substitute group member number as the rendering provider in field 24J on the CMS-1500 claim form, and the Q5 modifier is **not** used. The **group number** is listed as the billing provider.)

C. Locum Tenens Nurse Practitioners

A locum tenens arrangement is made when the regular nurse practitioner must leave his/her practice due to illness, vacation, or medical education opportunity and does not want to leave patients without service during this period. The locum tenens nurse practitioner usually has no practice of his or her own and moves from area to area as needed. The nurse practitioner is usually paid a fixed amount per diem with the status of an independent contractor, not an employee. The locum tenens nurse practitioner must meet all state, hospital and other institutional credentialing requirements. The locum tenens nurse practitioner is required to be enrolled in Arkansas Medicaid.

Documentation of the locum tenens arrangement must include the services provided by the locum tenens and when those services were performed and must be made available upon request. A record of the service would include the date and place of the service, the procedure code, the charge and the beneficiary involved.

The following billing protocol must be utilized for locum tenens nurse practitioner circumstances:

1. The regular nurse practitioner's office submits their claims for locum tenens services using the regular nurse practitioner's provider identification number.
2. Modifier Q6 is placed in the indicator 24D of the CMS-1500 claim form to indicate services were provided by a locum tenens nurse practitioner. The payment amount is the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
3. Locum tenens arrangements should not exceed 60 days. If a nurse practitioner is away more than 60 days, additional locum tenens can be used to fill in for different 60-day periods. This means that various nurse practitioners would be required to fill in for different 60-day time periods. Locum tenens is not designed to fill nurse practitioner vacancies within a practice.

Exception: In accordance with Public Law 110-173, the exception to the 60-day limit on substitute nurse practitioner billing occurs when a nurse practitioner is ordered to active military duty in the Armed Forces.

See the table below which compares the requirements for substitute and locum tenens nurse practitioners according to Arkansas Medicaid Policy.

REQUIREMENT	SUBSTITUTE NURSE PRACTITIONER	LOCUM TENENS NURSE PRACTITIONER
Must be enrolled as an Arkansas Medicaid Provider	Yes	Yes
May be enrolled by the same group as the regular nurse practitioner	No	No
Claims are submitted by the regular nurse practitioner's office and that office receives payment	Yes	Yes
Modifier required to identify arrangement	Yes, Q5	Yes, Q6
May use the regular nurse practitioner's certification code for PCP authorization	Yes	Yes
Maximum time frame allowed	14 days	60 days

252.460 Outpatient Hospital Services

252.461 Emergency Services 10-13-03

The appropriate CPT procedure codes should be used when billing for nurse practitioner visits in an outpatient hospital setting for emergency services.

252.462 Non-Emergency Services 2-1-22

Procedure code should be billed for a non-emergency nurse practitioner visit.

View or print the procedure codes for Nurse Practitioner services.

252.463 Outpatient Hospital Surgical Procedures 1-15-16

For consideration of any claims with payable 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 include justification for medical necessity.

All other billing requirements must be met in order for payment to be approved.

252.464 Multiple Surgery 10-13-03

If multiple surgical procedures are done on the same date of service, but not in the same operative session, each should be coded in the "Procedures, Services or Supplies" field as a separate procedure.

252.465 Observation Status 10-13-03

When claims are filed for services provided to a patient in "observation status," nurse practitioners must adhere to Arkansas Medicaid definitions of inpatient and outpatient. Observation status is an outpatient designation. Nurse practitioners must also follow the guidelines and definitions in *Current Procedural Terminology* (CPT), under "Hospital Observation Services" and "Evaluation and Management Services Guidelines."

Arkansas Medicaid criteria determining 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 nurse practitioner should consider the patient an outpatient (i.e., the patient is an outpatient unless the nurse practitioner has admitted him or her as an inpatient).

B. If the nurse practitioner 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, though the nurse practitioner has not yet formally admitted the patient.

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

252.466 Billing Examples 10-13-03

The following table gives examples of appropriate nurse practitioner claims for several common hospital scenarios. In the table, instructions under the headings "NURSE PRACTITIONER MAY BILL…" do not necessarily include all services that the nurse practitioner may bill. For instance, the provider may bill for interpretation of X-rays or diagnostic tests, though the table below does not indicate this. The purpose of this table is to illustrate Arkansas Medicaid observation status policy and to give guidance for filing claims related to evaluation and management services.

ARKANSAS MEDICAID OBSERVATION STATUS POLICY ILLUSTRATION

PATIENT IS ADMITTED TO OBSERVATION	PATIENT IS	NURSE PRACTITIONER MAY BILL FOR TUESDAY SERVICES:	NURSE PRACTITIONER MAY BILL FOR WEDNESDAY SERVICES:
Tuesday, 3:00 PM	Still in Observation Wednesday, 3:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM	Discharged Wednesday, 12:00 PM (noon)	Appropriate level of Initial Observation Care	Observation care Discharge Day Management
Tuesday, 3:00 PM	Discharged Wednesday, 4:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM, after outpatient surgery	Discharged Wednesday, 10:00 AM	Outpatient surgery	No evaluation and Management Services
Tuesday, 3:00 PM, after exam in Emergency Department–emergency or non-emergency	Discharged Tuesday, 7:00 PM	Appropriate level of Initial Observation Care	Not Applicable; Patient was Discharged Tuesday

252.470 Prior Authorization Control Number 3-1-05

When billing for procedures that have been prior authorized, the 10-digit prior authorization control number must be entered in the CMS-1500 claim format. See Section 220.000 of this manual for additional information on prior authorization.

252.480 Medicare 11-1-09

When a beneficiary is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse for those services if Medicare has not been billed prior to Medicaid billing. The beneficiary cannot be billed for the charges. See Section 142.700 for detailed information regarding Medicare participation and Sections 332.000 through 332.300 for detailed information regarding Medicare-Medicaid Crossover claims procedures.

252.481 Services Prior to Medicare Entitlement 3-1-05

Services that have been denied by Medicare with the explanation “Services Prior to Medicare Entitlement” may be filed with Medicaid. These services should be filed on the CMS-1500 claim form for processing and forwarded to the Inquiry Unit. **View or print the Inquiry Unit contact information**.

These services usually can be filed electronically unless they are covered by Medicare and the beneficiary was 65 or older on the date of service. It may be necessary to attach a copy of the Medicare denial to the claim.

A note of explanation should accompany these claims in order that they may receive special handling.

252.482 Services Not Medicare Approved 3-1-05

Services that are not Medicare approved for patients with joint Medicare/Medicaid coverage usually are not payable by Medicaid unless they are services that are not covered by Medicare, but are covered by Medicaid. There are exceptions and those may require special handling.

252.483 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 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; 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 Nurse Practitioner services, including PANS and PANDAS procedure codes.

252.484 Injections, Therapeutic and/or Diagnostic Agents 2-1-22

Nurse practitioners shall administer injections, therapeutic and diagnostic agents in accordance with the rules set forth in the Arkansas Medicaid Physician's policy manual and within the scope of their practice guidelines.

View or print the procedure codes for Nurse Practitioner services.