SECTION II - RURAL HEALTH CLINIC

CONTENTS

200.000 RURAL HEALTH CLINIC GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Rural Health Clinic (RHC) Providers

10-15-09

Rural Health Clinic services 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:

Providers must be certified by the Centers for Medicare and Medicaid Services as a Rural Health Clinic and participate in the Title XVIII (Medicare) Program. A copy of the current Medicare Certification must accompany the provider application packet and Medicaid contract.

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 Providers in Arkansas and Bordering States

10-13-03

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

201.110 Routine Services Providers

1-1-04

A. Routine services providers may be enrolled in the program as providers of routine services.

B. Claims must be filed according to the specifications in this manual.

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

Providers in non-bordering states may enroll only as limited services providers.

201.210 Limited Services Providers 3-1-11

A. Limited services providers may enroll in the Arkansas Medicaid program to provide prior authorized or emergency services only.

Emergency services are defined as inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available equipped to furnish those services.
Source: 42 U.S. Code of Federal Regulations §422.2 and §424.101.

Prior authorized services are those that are medically necessary and not available in Arkansas. Each request for these services must be made in writing, forwarded to the Utilization Review Section and approved before the service is provided. See Section 230.000 of this manual for instructions for obtaining prior authorization. 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 Medicaid contract. **View or print the Utilization Review Section contact information.** **View or print the provider enrollment and contract package (Application Packet).** **View or print Medicaid Provider Enrollment Unit contact information.**

B. Limited services provider claims will be manually reviewed prior to processing to ensure that only emergency or prior authorized services are approved for payment. These claims should be mailed to the Division of Medical Services, Program Communications Unit. **View or print the Arkansas Division of Medical Services, Program Communications Unit contact information.**

202.000 Medical Records 10-15-09

Documentation, record keeping and Medicaid participation requirements are detailed within Section 140.000, Provider Participation, of this manual. Additionally, RHC's are required to keep the following records:

1. Specific services provided
2. The date and the actual time of the services
3. Who provided each service
4. Chief complaint on each visit
5. Tests and results
6. Diagnosis
7. Treatment, including prescriptions
8. Signature or initials of physician or attending health professional after each visit

203.000 The Role of the RHC in the Child Health Services (EPSDT) Program 10-13-03

The Arkansas Medical Assistance Program includes a Child Health Services (Early and Periodic Screening, Diagnosis and Treatment) Program for eligible individuals under 21 years of age. The purpose of this program is to detect and treat health problems in their early stages. RHCs may enroll in the Child Health Services Program to perform EPSDT screenings by referral from eligible children's PCPs.

204.000 RHC's Role in the Early Intervention Part C Program 10-13-03

Health care providers offering any early intervention service to an eligible child must refer the child to the Division of Developmental Disabilities Services for possible enrollment in First Connections, the Early Intervention Part C Program in Arkansas. Federal regulations at 34 CFR 303.321.d.2.ii require health care professionals and day care centers to refer potentially eligible children within two days of identifying them as candidates for early intervention.

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

A. Developmental Delay—a delay of 25% or greater in one of the following areas of development:

1. Physical (gross/fine motor),
2. Cognitive,
3. Communication,
4. Social/emotional or
5. Adaptive and self-help skills.

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

1. Down's Syndrome and chromosomal abnormalities associated with mental retardation,
2. Congenital syndromes associated with delays such as Fetal Alcohol Syndrome, intra-uterine drug exposure, prenatal rubella, severe microcephaly and macrocephaly,
3. Maternal Acquired Immune Deficiency Syndrome (AIDS) and
4. Sensory impairments such as visual or hearing disorders.

The Division of Developmental Disabilities is the lead agency for Part C Early Intervention in Arkansas. Referrals must be made on form **DDS/FS#0001.a**, **Referral/Application For Services.** The referring provider must retain a copy of the completed referral form with the child's medical records. **View or print DDS/FS#0001.a.**

Contact the local DHS office in the child's county of residence for the name of the DDS service coordinator and/or the DDS licensed community program to which the child should be referred.

210.000 PROGRAM COVERAGE

211.000 Scope 6-1-09

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

A. A provider-based rural health clinic is one which is an integral part of a hospital, skilled nursing facility or home health agency that participates in Medicare and which is licensed, governed and supervised with other departments of the facility.

B. An independent (free-standing) rural health clinic is one that participates in Medicare and is not provider based.

C. Visit is defined as a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, nurse midwife or other specialized nurse practitioner whose services are reimbursed under the rural health clinic payment method. Encounters with more than one health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

211.100 Rural Health Clinic Core Services 2-1-24

Rural Health Clinic core services are as follows:

A. Professional services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services;

B. Services and supplies furnished “incident to” a physician’s professional services;

C. Services provided by non-physician, services of physician assistants, nurse practitioners, nurse midwives, and specialized nurse practitioners when the provider is legally:

1. employed by, or receiving compensation from a rural health clinic;
2. under the medical supervision of a physician;
3. acting in accordance with any medical orders for the care and treatment of a patient prepared by a physician; and
4. acting within their scope of practice by providing services they are legally permitted to perform by the state in which the service is provided if the services would be covered if furnished by a physician;

D. Services and supplies that are furnished as an incident to professional services furnished by a nurse practitioner, physician assistant, nurse midwife, or other specialized nurse practitioner;

E. Visiting nurse services on a part-time or intermittent basis to home-bound patients in areas in which there is a shortage of home health agencies.

Note: For purposes of visiting nurse care, a home-bound patient is one who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. Institutions, such as a hospital or nursing care facility, are not considered a patient’s residence.

Note: A patient’s place of residence is where he or she lives, unless he or she is in an institution such as a nursing facility, hospital, or intermediate care facility for individuals with intellectual disabilities (ICF/IID); and

F. Medication Assisted Treatment (MAT) 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.

211.200 Definition of “Incident To” Services

211.210 Services and Supplies "Incident To" a Physician's Professional Service 10-13-03

Services and supplies "incident to" a physician's professional service are covered if the service or supply is:

A. Of a type commonly furnished in physicians' offices;

B. Of a type commonly furnished without charge or included in the RHC's bill;

C. Furnished as an incidental, although integral, part of a physician's professional services;

D. Furnished under the direct, personal supervision of a physician and

E. In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

211.220 Services and Supplies "Incident To" a Nurse Practitioner's or Physician Assistant's Service 10-13-03

Services and supplies "incident to" a nurse practitioner's or physician assistant's services are covered if the service or supply is:

A. Of a type commonly furnished in physicians' offices;

B. Of a type commonly furnished without charge or included in the RHC's bill;

C. Furnished as an incidental, although integral, part of the professional services of a nurse practitioner or physician assistant;

D. Furnished under the direct, personal supervision of a nurse practitioner, physician assistant, nurse midwife, specialized nurse practitioner or a physician and

E. In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a nurse practitioner, physician assistant, nurse midwife or specialized nurse practitioner only if such a person is permitted to supervise such services under the written policies governing the RHC.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

211.300 Interactive Electronic ("Telemedicine") Encounters 10-13-03

Arkansas Medicaid covers RHC encounters and two ancillary services (fetal echography and echocardiography) as "telemedicine" services.

Arkansas Medicaid defines telemedicine services as medical services performed as electronic transactions in real time. In order for a telemedicine encounter to be covered by Medicaid, the practitioner and the patient must be able to see and hear each other in real time. Physician interpretation of fetal ultrasound is covered as a telemedicine service if the physician views the echography or echocardiography output in real time while the patient is undergoing the procedure.

212.000 Rural Health Clinic Ambulatory Services 10-13-03

RHCs providing other ambulatory services must enroll in the applicable Medicaid program in order for the services to be covered.

212.100 Rural Health Clinic Provider Based Ambulatory Services 10-13-03

Provider based RHC ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the RHC provider offers such a service, (e.g., Dental, Visual, etc.). Refer to Section 240.100 for information concerning Provider Based RHCs' methods of reimbursement for ambulatory services.

212.200 Independent (Free-Standing) Rural Health Clinic Ambulatory Services 10-13-03

Independent (free-standing) RHC ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the RHC provider offers such a service, (e.g., Dental, Visual, etc.).

212.210 Rural Health Clinic (RHC) Non-Core Services 10-13-03

A. The following services are not to be Rural Health Clinic (RHC) core services.

1. Emergency and non-emergency outpatient hospital visits,
2. Inpatient hospital visits,
3. Surgeries performed in the inpatient or outpatient hospital or in an ambulatory surgical center,
4. Technical components of radiology procedures and
5. Technical components of electrocardiograms and echocardiography.

B. Inpatient and outpatient hospital visits, home and nursing facility visits and other off-site visits remain core services if the physician or nurse practitioner must, as a condition of his or her employment by or contract with the RHC, see patients at sites away from the RHC and is compensated by the RHC.

C. Physicians and nurse practitioners enrolled in the Arkansas Medicaid Program may bill for RHC non-core services according to the guidelines in their respective Medicaid manuals.

D. Rural Health Clinics desiring to bill for RHC non-core physician services must enroll with Arkansas Medicaid as physician group providers, even if they intend to bill for the services of only one physician. See Section II of the Arkansas Medicaid **Physician/Independent Lab/CRNA/Radiation Therapy Center** manual for participation requirements.

E. Rural Health Clinics desiring to bill for RHC non-core nurse practitioner services must enroll with Arkansas Medicaid as nurse practitioner group providers, even if they intend to bill for the services of only one nurse practitioner. See Section II of the Arkansas Medicaid **Nurse Practitioner** manual for participation requirements.

213.000 Staff Requirements and Responsibilities 1-1-18

A. The RHC must have a health care staff that includes one or more physicians and one or more physician assistants or nurse practitioners. The physicians, physician assistants or nurse practitioners may be the owners of the RHC and/or under agreement with the RHC to carry out the responsibilities required.

B. The staff may include ancillary personnel who are supervised by the professional staff.

C. A physician, physician assistant or nurse practitioner must be available to furnish patient care services at times the RHC operates. These staff must be available to furnish patient care services at least 50% of the time the RHC operates.

D. The physician must provide medical direction for the RHC activities and consultation for the medical supervision of the health care staff. The physician also must participate in developing, executing and periodically reviewing policies, services, patient records and must provide medical orders and medical care services to patients of the RHC.

E. The physician assistant and nurse practitioner, as members of the RHC staff, must participate in the development, execution and periodic review of the written policies governing the services the RHC furnishes and participate with the physician in a periodic review of patients' health records.

F. The physician assistant or nurse practitioner must perform the following functions, to the extent they are not being performed by a physician:

1. Provide services in accordance with RHC policies;
2. Arrange for or refer patient for services that cannot be provided by the RHC; and
3. Assure adequate patient health records are maintained and transferred as required when patients are referred.
4. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information.

214.000 A Patient of the RHC 6-1-09

Any Medicaid beneficiary who receives RHC services and/or other ambulatory services at the RHC is considered a patient of the RHC. Also, any Medicaid beneficiary who receives RHC services by the RHC off-site from the RHC is considered a patient of the RHC.

215.000 Off-Site RHC Services 10-13-03

RHC services are covered under the RHC benefit when furnished off-site only when the employed practitioner of the RHC furnishes the services on behalf of the RHC, or the RHC practitioner's agreement with the RHC requires he or she provide the services and seek compensation from the RHC.

216.000 Limitations and/or Non-Covered Services 10-13-03

RHC services are subject to the limitation and coverage restrictions that exist for medical services provided in other settings. Services not covered by the Arkansas Medicaid Program include, but are not limited to, the following:

A. The services of nurse practitioners, physician assistants, nurse midwives or specialized nurse practitioners if state law or regulations require that the services be performed under a physician's order and no such order was prepared.

B. Services that are not considered medically necessary.

C. Services that are not properly documented.

D. Visits in which a direct relationship does not exist between the patient and a physician, a physician assistant or nurse practitioner (e.g., visit to pick up a prescription, telephone consultation, etc.)

E. Cosmetic surgery performed primarily for aesthetic purposes only (e.g., ear piercing, tattoo removal, etc.)

F. Well child care, routine physical examinations or examinations for school. (See the Child Health Services (EPSDT) Manual, Section II, for coverage of these services and for billing instructions.)

G. Dietary counseling.

H. Most screening-type services unless being used to make a diagnosis (e.g., hypertension H screening, diabetes screening, hair analysis, etc.)

I. Literature, booklets and other educational services.

217.000 Family Planning

217.100 Family Planning Visits 10-13-03

An RHC encounter is covered as a family planning visit if:

A. The visit meets the criteria of either the Basic Family Planning Visit or the Periodic Family Planning Visit, as described in A and B below, and

B. A documented diagnosis of family planning is the primary reason or justification for the visit.

217.110 Basic Family Planning Visits 6-1-09

The Basic Family Planning Visit includes:

A. Medical history and medical examination that includes: 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 and
3. HIV/STD prevention.

C. Prescription for any contraceptives selected by the beneficiary.

D. Laboratory services, including:

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

217.120 Periodic Family Planning Visits 10-13-03

Medicaid neither requires periodic visits nor specifies intervals between them. The visits may occur as needed.

A. The Periodic Family Planning Visit includes:

1. Follow-up medical history, weight and blood pressure and
2. Counseling regarding contraceptives and possible complications of contraceptives

B. The purpose of the periodic visit is to:

1. Evaluate the patient's contraceptive program;
2. Renew or change the contraceptive prescription and
3. Provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

217.130 Post-Sterilization Visits 12-18-15

Individuals who are eligible in a Title XIX State Plan ("Regular Medicaid") Aid Category and for whom such a service is medically necessary, may obtain the needed care as a regular Medicaid benefit, subject to any applicable coverage or benefit limitations.

217.200 Contraception

217.210 Prescription and Non-Prescription Contraceptives 10-13-03

A. Medicaid covers birth control pills and other prescription contraceptives under the family planning prescription benefit.

B. Medicaid covers non-prescription contraceptives under the family planning benefit, when a physician writes a prescription for them.

217.220 Other Contraceptive Methods 12-1-21

Additional contraceptive methods covered by Medicaid are:

A. Contraceptive implant systems, their implantations and removal,

B. Intrauterine devices (IUD) and

C. Depo-Provera injections

217.230 Sterilization 12-18-15

Sterilization is a covered benefit in the RHC program only when sterilization takes place in the RHC.

A. Medicaid covers sterilization of men and women.

1. All adult (aged 21 or older) male and female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures and medically necessary follow-ups as long as they remain Medicaid-eligible.

B. Medicaid coverage of sterilizations is contingent upon the provider's documented compliance with federal and state regulations, including obtaining the patient's signed consent in a manner prescribed by law.

C. Non-therapeutic sterilization means any procedure or operation for which the primary purpose is to render an individual permanently incapable of reproducing.

1. Non-therapeutic sterilization is neither:
   a. A necessary part of the treatment of an existing illness or injury nor
   b. Medically indicated as an accompaniment of an operation of the genitourinary tract.

2. The reason the individual decides to take permanent and irreversible action is irrelevant. It may be for social, economic or psychological reasons or because a pregnancy would be inadvisable for medical reasons.

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

E. Federal regulations are very explicit concerning coverage of non-therapeutic sterilization. Therefore, all the following conditions must be met:

1. The person on whom the sterilization procedure is to be performed voluntarily requests such services.
2. The person is mentally and legally competent to give informed consent.
3. The person is 21 years of age or older at the time informed consent is obtained.
4. The person to be sterilized shall not be an institutionalized individual. The regulations define "institutionalized individual" as a person who is:
   a. Involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including those for mental illness, or
   b. Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
5. The person has been counseled, both orally and in writing, concerning the effect and impact of sterilization and alternative methods of birth control.
6. Informed consent and counseling must be properly documented. Only the official Sterilization Consent Form DMS-615, properly completed, complies with documentation requirements. **View or print Sterilization Consent Form DMS-615.**
7. Copies may be ordered from the Arkansas Medicaid fiscal agent. See Section III. If the patient needs the Sterilization Consent Form in an alternative format, such as large print, contact our Americans with Disabilities Act Coordinator. **View or print Americans with Disabilities Act Coordinator contact information.**
8. Available by order from the Arkansas Medicaid fiscal agent are two free informational publications: Sterilization Consent Form-Information for Women (PUB-019) and Sterilization Consent Form-Information for Men (PUB-020). See Section III of any Arkansas Medicaid provider manual for instructions for ordering forms and publications.
9. If you have any questions regarding any of these requirements, contact the Arkansas Medicaid Program ***before*** the sterilization.

217.231 Informed Consent to Sterilization 7-15-12

A. By signing the Sterilization Consent Form DMS-615, the patient certifies that she or he understands the entire process.

1. By signing the consent form, the person obtaining consent and the physician certify that, to the best of their knowledge, the patient is mentally competent to give informed consent.
2. If any questions concerning this requirement arise, you should contact the Arkansas Medicaid Program for clarification ***before*** the sterilization procedure is performed.

B. The person obtaining the consent for sterilization must sign and date the form ***after*** the beneficiary and interpreter sign, if an interpreter is used.

1. This may be done immediately after the beneficiary and interpreter sign, or it may be done later, but it must always be done ***before*** the sterilization procedure.

2. The signature will attest to the fact that all elements of informed consent were given and understood and that consent was voluntarily given.

C. By signing the physician's statement on the consent form, the physician is certifying that shortly before the sterilization was performed, he or she again counseled the patient regarding the sterilization procedure.

1. The State defines "shortly before" as one week (seven days) or less before the performance of the sterilization procedure.

2. The physician's signature on the consent form must be an ***original*** signature and not a rubber stamp.

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

1. In labor or childbirth,

2. Seeking to obtain or obtaining an abortion, or

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

E. The sterilization must be performed at least 30 days, but not more than 180 days, after the date of informed consent. The following exceptions to the 30-day waiting period must be properly documented on the form DMS-615. **View or print Sterilization Consent Form DMS-615 and checklist.**

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

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

F. The person is informed, before any sterilization discussion or counseling, that no benefits or rights will be lost because of refusal to be sterilized and that sterilization is an entirely voluntary matter. This should be explained again just before the sterilization procedure takes place.

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

H. A copy of the properly completed form DMS-615, with all items legible, must be attached to each claim submitted from each provider. Providers include RHCs, FQHCs, 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 Sterilization Consent Form DMS-615 to the hospital, anesthesiologist and assistant surgeon.

I. Sterilizations are covered only when informed consent is properly documented by means of the form DMS-615.

1. The checklist for form DMS-615 lists consent form items that DMS medical staff reviews to determine whether a sterilization procedure will be covered. **View or print Sterilization Consent Form DMS-615 and checklist.**

2. Using the checklist will help ensure the submittal of a correct form DMS-615.

J. The individual undergoing the procedure must receive, from the physician performing the procedure or the facility in which the sterilization procedure takes place, an identical copy of the completed consent form that he or she signed and dated.

218.000 Benefit Limits

218.100 RHC Encounter Benefit Limits 2-1-24

A. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program do not have a rural health clinic RHC encounter benefit limit.

B. A benefit limit of sixteen (16) encounters per state fiscal year (SFY), July 1 through June 30, has been established for clients twenty-one (21) years or older. The following services are counted toward the per SFY encounter benefit limit:

1. Provider visits in the office, client's home, or nursing facility;
2. Certified nurse-midwife visits;
3. RHC encounters;
4. Medical services provided by a dentist;
5. Medical services provided by an optometrist;
6. Advanced practice registered nurse (APRN) services in the office, client's home, or nursing facility; and
7. Federally qualified health center (FQHC) encounters.

Global obstetric fees are not counted against the service encounter limit. Itemized obstetric office visits are not counted in the limit.

The established benefit limit does not apply to individuals receiving Medication Assisted Treatment for Opioid Use Disorder when it is the primary diagnosis (**View ICD OUD Codes**).

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 218.310 of this manual for procedures for obtaining extension of benefits.

218.200 Family Planning Benefit Limits

218.210 Basic Family Planning Visit 10-13-03

The Basic Family Planning Visit benefit limit is one per state fiscal year.

218.220 Periodic Family Planning Visit 10-13-03

The Periodic Family Planning Visit benefit limit is three per state fiscal year (July 1 – June 30).

218.230 Reserved 12-18-15

218.240 Contraception

218.241 Prescription and Non-Prescription Contraceptives 10-13-03

Contraceptives are not benefit-limited, with the following exception.

A. Implantable contraceptive capsule kits are limited to 2 per 5-year period per beneficiary.

B. The benefit limit for removal of the kit is once within five years of the last implantation.

218.300 Extension of Benefits 7-1-22

RHC encounters count toward the service benefit limits per state fiscal year. Arkansas Medicaid considers, upon written request, extending the RHC benefit for reasons of medical necessity.

A. Extensions of family planning benefits are not available.

B. Extensions of the RHC core service encounter benefit are automatic for certain diagnoses. The following diagnoses do not require a benefit extension request.

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

218.310 Benefit Extension Requests 8-1-21

A. Requests to extend the RHC core service encounter benefit must be submitted to DHS or its designated vendor. **View or print contact information to obtain instructions for submitting the request.** Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

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

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

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available.

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

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

A. The Medicaid Program's diagnostic laboratory services 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 or 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.

View or print the essential health benefit procedure codes.

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

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

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

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

F. Enter the revenue code, modifier(s) when applicable and the applicable nomenclature.

G. Enter the number of units (encounters) requested under the extension.

218.312 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. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests and requests for reconsideration of denied benefit extension requests.

C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and emergency room records for dates of service in chronological order;
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include obstetrical record related to current pregnancy when applicable; and
7. 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.

D. Diagnostic laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles, and fetal non-stress tests (if applicable)

218.313 Provider Notification of Benefit Extension Determinations 2-1-05

AFMC will approve or deny a benefit extension request—or ask for additional information—within 30 calendar days.

A. AFMC reviewers will simultaneously advise the provider and the beneficiary when a benefit extension request is denied.

B. Provider notification of benefit extension approval includes:

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

C. A denial notification letter is signed by a member of the benefit extension reviewing staff.

218.314 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.

218.320 Reserved 6-1-25

218.400 Benefit Limits for Other Ambulatory Services Encounters 10-13-03

A. Arkansas Medicaid has established benefit limits in each program in which an RHC may enroll to provide other ambulatory services.

1. Other ambulatory services are counted for benefit limit purposes in the program in which they are provided and covered.
2. The established benefit limits for each such program can be found in the "Benefit Limits" section in Section II of each program's provider manual or in official correspondence released since the most recent provider manual update.
3. Services provided as other ambulatory services are considered encounters for settlement purposes, but they do not count against the RHC core service encounter benefit limit.

B. Provider manuals can be ordered from the Provider Enrollment Unit or downloaded from the Arkansas Medicaid website, **https://medicaid.mmis.arkansas.gov/**. Provider manuals ordered from Provider Enrollment include unincorporated official correspondence. When downloading a program's provider manual from the Medicaid website, download the program's official notices as well. See Section I of this manual to order provider manuals.

230.000 PRIOR AUTHORIZATION 10-13-03

Prior authorization is not applicable to RHC services.

240.000 REIMBURSEMENT 10-13-03

Rural Health Clinics (RHCs) are reimbursed in accordance with different reimbursement methodologies for dates of service before January 1, 2001, and dates of service on and after

January 1, 2001, regardless of their fiscal year end or cost reporting period. Section 240.100 and its subsections describe the methodology in effect for dates of service before January 1, 2001. Section 241.000 describes the methodology effective for dates of service on and after January 1, 2001.

240.100 Reimbursement Methodologies for Dates of Service Before January 1, 2001

There are two reimbursement methodologies in place for dates of service before January 1, 2001: one for provider-based RHCs and one for independent (free-standing) RHCs.

240.110 Methods of Reimbursement-Provider Based RHCs, for Dates of Service Before January 1, 2001

Provider-based Rural Health Clinics are reimbursed in the interim using a cost to charge ratio with a year end cost settlement for all RHC core and ambulatory services. The cost to charge ratio and the cost settlement are calculated using the applicable Medicare principals of reimbursement found in 42 CFR 413.

Provider-based RHCs must report their costs on the cost report of the parent provider (e.g., hospital). Please follow cost report procedures for the parent provider. Medicaid reimburses Provider-based RHCs at 100% of reasonable cost.

240.120 Methods of Reimbursement-Independent RHCs, for Dates of Service Before January 1, 2001 4-1-07

Independent (free-standing) RHCs are reimbursed at an interim rate with a year end cost settlement. The interim rate and cost settlements are calculated using the applicable Medicare principles of reimbursement found in 42 CFR 413.

Independent (free-standing) RHCs are required to report their costs on the CMS-222-92 cost reporting form. Independent (free-standing) RHCs are reimbursed at 100% of reasonable cost for Rural Health Clinic services.

“Other ambulatory services” and Medicare-Medicaid crossover claims are not cost reimbursed. Independent (free-standing) RHCs may bill for these services using the applicable procedure codes and provider identification numbers. Arkansas Medicaid pays the lesser of the amount billed or the Medicaid maximum.

241.000 Reimbursement Methodology for Dates of Service On and After January 1, 2001

In accordance with Section 1902(aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for dates of service occurring January 1, 2001, and after, payments to Rural Health Clinics (RHCs) for Medicaid-covered services will be made using a prospective payment system (PPS) based on per visit compensation.

A. The PPS per visit rate for each facility will be calculated based on 100 percent of the average of the facility’s reasonable costs for providing Medicaid-covered services as determined from audited Medicare cost reports with ending dates in calendar year 1999 and calendar year 2000. Reasonable costs are defined as those costs which are allowable under Medicare cost principles outlined in 42 CFR 413 with no lesser-of-costs-or-charges limits and no per-visit payment limit. Cost reports used for rate setting purposes must cover a fiscal period of at least a full six months. If a provider has more than one cost report period ending in the same calendar year, Arkansas Medicaid will use the most recent cost report to calculate rates. Adjustments to the Medicare RHC Program allowable costs per the cost report may be necessary due to differences with Medicaid Program covered services.

B. PPS per visit rates will be calculated by adding the total audited allowable costs as determined from the 1999 and 2000 cost reports and dividing the total by the total audited

visits for the same two periods. Allowable costs for each period used to set the initial PPS rate will include applicable adjustments in accordance with the Medicare Economic Index (MEI) for primary care services, an index compiled and published by the Centers for Medicare and Medicaid Services. Until audited cost report information is available, interim rates will be implemented as of January 1, 2001, at the average cost per visit as determined from the two most recent provider cost reports. Interim rates will be calculated by adding the two periods' per visit costs and dividing the total by two. Interim rates will be retroactively adjusted to January 1, 2001, when audited cost report information becomes available and final rates are calculated.

C. Each facility's PPS per visit rate will be adjusted to account for increases or decreases in scope of services. A scope of services change is defined as:

1. An addition or deletion of an RHC-covered service,
2. A change in the magnitude, intensity, or character of currently offered RHC-covered services,
3. A change in State or Federal regulatory requirements,
4. A change due to relocation, remodeling, opening a new clinic site or closing an existing clinic site,
5. A change in applicable technologies and medical practices, or
6. A change due to recurring taxes, malpractice insurance premiums or workmen's compensation insurance premiums that were not recognized and included in the base year's rate calculation.

D. The following examples of scope of services changes are offered as guidance to understanding their definition, not as a definitive and comprehensive delineation of that definition.

1. Examples of adding or deleting an RHC-covered service include adding or deleting dental services or mental health services.
2. Examples of changes in the magnitude, intensity, or character of currently offered RHC - covered services may include:
    a. Adding or deleting specialties or specialists (e.g., pediatrics, geriatric specialists) or
    b. Adding or deleting HIV services or chronic disease treatments.
3. Changes in State or Federal regulatory requirements may result in:
    a. Mandated revisions in the types of practitioners and professional personnel employed by the facility (including ratios of assistants or nursing staff to particular practitioners) or
    b. Changes in support service equipment or personnel, such as those related to lab and X-ray or other automated diagnostic services, subject to reasonable costs criteria identified at 42 CFR 413.
4. Item 4 in part C provides its own examples and needs no further explanation.
5. Examples of changes in applicable technologies and medical practices may include:
    a. Replacing obsolete computer systems or computer hardware,
    b. Automating medical records,
    c. Updating software or replacing obsolete software,
    d. Converting to wireless communications systems, or
    e. Updating or replacing obsolete diagnostic equipment (which may necessitate personnel changes), subject to reasonable costs criteria identified at 42 CFR 413.

6. Item 6 in part C provides its own examples and needs no further explanation.

E. All requested PPS rate increases due to scope of services changes are subject to reasonable costs criteria identified at 42 CFR 413.

F. Written requests for both cost increases and cost decreases due to scope of services changes must be submitted by the provider. The request must be submitted (postmarked) within 5 months after the end of the provider's fiscal period. The request must identify the beginning date that the change occurred and include detailed descriptions, documentation and calculations of the changes and costs differences.

G. In order to qualify for a PPS rate change, the scope of services changes must equal at least a 5% total difference in the allowable per visit cost as determined for the fiscal period and the changes must have existed during the last full 6 months of the fiscal period. Arkansas Medicaid will review the submitted documentation and will notify the provider within 90 days whether a PPS rate change will be implemented. If implemented, the PPS rate change will reflect the cost difference of the scope of service change and be effective as of the later of the first date that the scope of service changed or the beginning date of the fiscal period. PPS rate changes will also be made due to scope of service changes identified through an audit or review process. If this occurs, the effective date of the PPS rate change will be the later of the first date that the scope of services changed or the beginning date of the cost report period for which the changes should have been reported.

H. Independent (free-standing) RHCs that do not have minimal 1999 and 2000 cost report periods (at least 6 months) or who enroll in Medicaid after 2000, will have their initial PPS per visit rate established at the average of the current rates of the three nearest independent RHCs with similar caseloads. Determination of the nearest facilities will be by map mileage. A final PPS per visit rate shall be established using the facility's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months. The final PPS rate will be made effective as of the first day after the provider's second fiscal cost report period used for rate setting.

I. Provider based RHCs that do not have minimal 1999 and 2000 cost report periods (at least six months) or who enroll in Medicaid after 2000 will have their initial PPS per visit rate established at the average of the current rates of the provider hospital's other enrolled RHCs with similar caseloads. Should a newly enrolled provider-based RHC be the only clinic operated by the hospital, the initial PPS rate shall be established at the average of the current rates of the three nearest provider - based RHCs with similar caseloads. Determination of the nearest facilities will be by map mileage. A final PPS per visit rate shall be established using the facility's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months. The final PPS rate will be made effective as of the first day after the provider's second fiscal cost report period used for rate setting.

J. Beginning July 1, 2001, interim rates, initial PPS rates and final PPS rates will be adjusted annually, as of July 1st of each year, by the Medicare Economic Index (MEI) for primary care services, an index compiled and published by the Centers for Medicare and Medicaid Services. Rate adjustments will be equal to the previous calendar year's index percentage change.

242.000 Submitting Cost Reports

Cost reports are due within 5 months following the end of the provider's fiscal year or other cost-reporting period.

Please forward the CMS-222-92 to the Division of Medical Services, Financial Activities Unit.
View or print Financial Activities Unit contact information.

If Financial Activities does not receive the cost report by the 5-month deadline, DMS will notify the provider by letter that all payments will be suspended until the cost report is received. Suspension of a provider allows claims to be processed but a check will not be issued to the provider. The provider's remittance statement will indicate a statement number rather than an internal check number. The suspensions will be in effect until the cost report is received. Continued failure to file a cost report will result in termination of the provider's participation in the Program.

242.010 Fee Schedule 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.

243.000 Rate Appeal and/or Cost Settlement Appeal Process

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

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the 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 questions(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

251.000 Introduction to Billing 7-1-20

Rural Health Clinic providers who submit paper claims must use either the CMS-1450 claim form, which also is known as the UB-04 claim form, or the CMS-1500.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

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

252.000 CMS-1450 (UB-04) Billing Procedures

252.100 Revenue Codes 10-13-03

RHCs may use only these revenue codes when billing.

Revenue Code	Revenue Code Description
520	Encounter—Independent Rural Health Clinic
521	Encounter—Provider-based Rural Health Clinic
524	Basic or Periodic Family Planning Visit—Independent Rural Health Clinic
525	Basic of Periodic Family Planning Visit—Provider-based Rural Health Clinic

252.101 Billing Instructions for Family Planning Visits 2-1-22

Effective on and after April 30, 2010, all claims submitted from RHC providers for family planning visits are to use the following billing protocol, regardless of the date of service. No RHC family planning visits should be billed under the physician's provider number. The revised billing protocol will allow correct payment according to the benefit limit for eligible Arkansas Medicaid beneficiaries.

Rural Health Clinic providers are to bill revenue codes **0524** (for Independent RHCs) and **0525** (for Provider-Based RHCs), as well as an applicable procedure code and modifier. Procedure code with modifier **U9** will be used for the basic family planning visit, and with modifier **U9** will be used for the periodic family planning visit. This is shown in the following table. RHC basic and periodic family planning visits are billable electronically and on paper claim forms. All family planning services require a primary diagnosis of family planning on the claim.

View or print the procedure codes for Rural Health Clinic (RHC) services.

252.102 Billing Instructions for EPSDT and ARKids First-B Medical Screenings 2-1-22

Effective on or after April 30, 2010, all claims submitted by RHC providers for EPSDT and ARKids First-B medical screens performed by RHC personnel are to use the following billing protocol, regardless of the date of service. No screens should be billed under the physician's provider number. **However, if the screens were billed earlier under the physician's provider number, do not re-bill.** RHC providers are to bill the appropriate screen codes and modifiers. Each RHC's individual encounter rate will now be reimbursed when the RHC bills one of these medical screen procedure codes with the correct modifier(s). However, the encounter rate will only be reimbursed if the charge for the service submitted on the claim is greater than or equal to the RHC's encounter rate. The RHC will be reimbursed the lesser of the billed amount or their encounter rate.

Example – If an RHC's encounter rate is $75 and the RHC submits a screen claim with a billed amount of $85, the RHC will be reimbursed the lesser $75 encounter rate. If the same RHC submits a screen claim with a billed amount of $70, the RHC will be reimbursed the $70 lesser amount and not the encounter rate. Screens are billable electronically and on paper claims.

For ARKids First-A (EPSDT) electronic billing, medical screens will require the electronic 837P with the special program indicator "01" in the header, along with the appropriate certification condition indicator and code. At the detail level, the procedure code will be billed with the EP modifier and the second modifier. For ARKids First-A (EPSDT) paper billing, providers will bill on

the CMS-1500 claim form using the EP modifier and the second modifier. See the Physician provider manual for more information.

For ARKids First-B (ARKids First) electronic billing, medical screens will require the 837P without the special program indicator (professional electronic claim) with no modifier except for newborn care procedures, which require a UA modifier. For ARKids First-B (ARKids First) paper billing, providers will bill on the CMS-1500 claim form with no modifier except for newborn care procedure codes, which require a UA modifier. See the ARKids First provider manual for more information.

This billing protocol is shown in the following table.

View or print the procedure codes for Rural Health Clinic (RHC) services.

252.103 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 Rural Health Clinic (RHC) 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.

252.110 Non-Payable Diagnosis Codes 10-1-15

The following ICD diagnosis codes are non-payable.

(View ICD codes.)	Other physical therapy

(View ICD codes.)	Occupational therapy and vocational rehabilitation
(View ICD codes.)	Speech therapy
(View ICD codes.)	Radiological examination, not elsewhere classified
(View ICD codes.)	Laboratory examination

252.120 Diagnosis Codes not Covered for Beneficiaries under 21 10-1-15

The following ICD diagnosis codes are non-payable for beneficiaries under the age of 21. Refer to the Child Health Services (EPSDT) Provider Manual and the ARKids First-B Provider Manual for instructions regarding procedure and diagnosis coding on well childcare claims.

(View ICD codes.)	Routine general medical examination at a health care facility
(View ICD codes.)	Other medical examination for administrative purposes
(View ICD codes.)	Health examination of defined subpopulations
(View ICD codes.)	Examination for normal comparison or control in clinical research
(View ICD codes.)	Unspecified general medical examination
(View ICD codes.)	Other specified examination

252.200 Place of Service and Type of Service Codes 10-13-03

Not applicable to this program.

252.300 Billing Instructions—Paper Claims 11-1-17

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) **View or print NUBC contact information.**

The committee develops, maintains and distributes to its subscribers the Official UB-04 Data Specifications Manual (UB-04 Manual) and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Manual, a CMS-1450 (UB-04) claim form.

Please forward the original of the completed form to the Claims Department. One copy of the claim form should be retained for your records. **View or print Claims Department contact information.**

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

252.310 Completion of CMS-1450 (UB-04) Claim Form 12-15-14

Field #	Field name	Description
1.	(blank)	Enter the provider's name, (physical address – service location) city, state, zip code, and telephone number.
2.	(blank)	The address that the provider submitting the bill intends payment to be sent if different from FL 01. (Use this address for provider's return address for returned mail.)
3a.	PAT CNTL #	The provider may use this optional field for accounting purposes. It appears on the RA beside the letters "MRN." Up to 16 alphanumeric characters are accepted.
3b.	MED REC #	Required. Enter up to 15 alphanumeric characters.
4.	TYPE OF BILL	Type of Bill Enter the three digit numeric code found in the Data Specifications Manual to indicate the specific type of bill.
5.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
6.	STATEMENT COVERS PERIOD	Enter the beginning and ending service dates of the period covered by this bill. To bill on a single claim for services occurring on multiple dates, enter the beginning and ending service dates in the FROM and THROUGH fields. The "FROM" and "THROUGH" dates may not span calendar months. When billing for multiple dates of service on a single claim, a date of service is required in field 45 for each HCPCS code in field 44 and/or each revenue code in field 42.
7.	Not used	Reserved for assignment by the NUBC.

Field #	Field name	Description
8a.	PATIENT NAME	Enter the patient's last name and first name. Middle initial is optional.
8b.	(blank)	Not required.
9.	PATIENT ADDRESS	Enter the patient's full mailing address. Optional.
10.	BIRTH DATE	Enter the patient's date of birth. Format: MMDDYYYY.
11.	SEX	Enter M for male, F for female, or U for unknown.
12.	ADMISSION DATE	Not applicable.
13.	ADMISSION HR	Not applicable.
14.	ADMISSION TYPE	Not applicable.
15.	ADMISSION SRC	Not applicable.
16.	DHR	Not applicable.
17.	STAT	Not applicable.
18.-28.	CONDITION CODES	Required when applicable. See the UB-04 Manual for requirements and for the codes used to identify conditions or events relating to this bill.
29.	ACDT STATE	Not required.
30.	(blank)	Unassigned data field.
31.-34.	OCCURRENCE CODES AND DATES	Required when applicable. See the UB-04 Manual.
35.-36.	OCCURRENCE SPAN CODES AND DATES	See the UB-04 Manual.
37.	Not used	Reserved for assignment by the NUBC.
38.	Responsible Party Name and Address	See the UB-04 Manual.
39.	VALUE CODES	Not required.
a.	CODE	Not applicable.
	AMOUNT	Not applicable.
b.	CODE	Not applicable.
	AMOUNT	Not applicable.
40.	VALUE CODES	Not applicable.
41.	VALUE CODES	Not applicable.
42.	REV CD	Enter 0521 for an RHC Visit (encounter).
43.	DESCRIPTION	Enter the Revenue Code's corresponding Standard Abbreviation found in the UB-04 Manual.
44.	HCPCS/RATE/HIPPS CODE	See the UB-04 Manual.

Field #	Field name	Description
45.	SERV DATE	When the “FROM” and “THROUGH” dates indicate the claim is for multiple dates of service, enter the service (encounter) date for each revenue code. Always enter the service date of each HCPCS or CPT procedure code. Format: MMDDYY.
46.	SERV UNITS	Enter the number of units furnished of each itemized service per date of service.
47.	TOTAL CHARGES	The total charge for the line-item number of units reported in field 46. See the UB-04 Manual for additional information.
48.	NON-COVERED CHARGES	Not required.
49.	Not used	Reserved for assignment by the NUBC.
50.	PAYER NAME	Line A is required. See the UB-04 for additional regulations.
51.	HEALTH PLAN ID	Report the HIPAA National Plan Identifier; otherwise report the legacy/proprietary number.
52.	REL INFO	Required.
53.	ASG BEN	Required. See “Notes” at field 53 in the UB-04 Manual.
54.	PRIOR PAYMENTS	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. * Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
55.	EST AMOUNT DUE	Situational. See the UB-04 Manual.
56.	NPI	Enter NPI of billing provider or enter the Medicaid ID.
57.	OTHER PRV ID	Not required.
58. A, B, C	INSURED’S NAME	Comply with the UB-04 Manual’s instructions when applicable to Medicaid.
59. A, B, C	P REL	Comply with the UB-04 Manual’s instructions when applicable to Medicaid.
60. A, B, C	INSURED’S UNIQUE ID	On line A, enter the RHC patient’s Arkansas Medicaid or ARKids First (A or B) identification number on first line of field.
61. A, B, C	GROUP NAME	Using the plan name if the patient is insured by another payer or other payers, follow instructions for field 60.
62. A, B, C	INSURANCE GROUP NO	When applicable, follow instructions for fields 60 and 61.
63. A, B, C	TREATMENT AUTHORIZATION CODES	Enter any applicable prior authorization or benefit extension number on line 63A.
64. A, B, C	DOCUMENT CONTROL NUMBER	Field used internally by Arkansas Medicaid. No provider input.

Field #	Field name	Description
65. A, B, C	EMPLOYER NAME	When applicable, based upon fields 51 through 62, enter the name(s) of the individuals and entities that provide health care coverage for the patient (or may be liable).
66.	DX	Diagnosis Version Qualifier. See the UB-04 Manual. Qualifier Code “9” designating ICD-9-CM diagnosis required on claims. Qualifier Code “0” designating ICD-10-CM diagnosis required on claims. Comply with the UB-04 Manual’s instructions on claims processing requirements.
67. A-H	(blank)	Enter the ICD-9-CM or ICD-10-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Fields are available for up to 8 codes.
68.	Not used	Reserved for assignment by the NUBC.
69.	ADMIT DX	Not required.
70.	PATIENT REASON DX	Not applicable.
71.	PPS CODE	Not required.
72	ECI	See the UB-04 Manual. Required when applicable (for example, TPL and torts).
73.	Not used	Reserved for assignment by the NUBC.
74.	PRINCIPAL PROCEDURE CODE AND DATE and OTHER PROCEDURE CODES AND DATES	Not required.
75.	Not used	Reserved for assignment by the NUBC.
76.	ATTENDING NPI	Enter NPI of the primary attending physician or enter the Medicaid ID.
	QUAL	NPI not required.
	LAST	Enter the last name of the primary attending physician.
	FIRST	Enter the first name of the primary attending physician.
77.	OPERATING NPI	NPI not required.
	QUAL	Not applicable.
	LAST	Not applicable.
	FIRST	Not applicable.
78.	OTHER NPI	Enter NPI of the primary care physician or enter the Medicaid ID.
	QUAL	NPI not required.
	LAST	Enter the last name of the primary care physician.

Field #	Field name	Description
	FIRST	Enter the first name of the primary care physician.
79.	OTHER NPI/QUAL/LAST/FIRST	Not used.
80.	REMARKS	For provider's use.
81.	Not used	Reserved for assignment by the NUBC.

252.400 Special Billing Procedures 9-1-20

252.401 Upper Respiratory Infection – Acute Pharyngitis 2-1-22

A Rural Health Center (RHC) must submit a claim that includes CPT code in the Upper Respiratory Infection (URI)-Acute Pharyngitis episode if a strep test is performed when prescribing an antibiotic for beneficiaries. This allows DMS to determine if the Principle Accountable Provider (PAP) met or exceeded the quality threshold in order to qualify for a full positive supplemental payment for the URI-Pharyngitis episode.

View or print the procedure codes for Rural Health Clinic (RHC) services.

252.402 Medication Assisted Treatment 9-1-20

When billing a claim for MAT the actual attending provider's NPI must be entered on the claim.