ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Office of Rules Promulgation

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – ARKids First-B

EFFECTIVE DATE: December 1, 2019

SUBJECT: Provider Manual Update Transmittal ARKIDS-4-18

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
221.200	7-1-17	221.200	12-1-19

Explanation of Updates

Section 221.200 is updated to add ADDT and EIDT, and remove CHMS, DDTCS and Domiciliary Care from the list of services which are not covered for ARKids First-B beneficiaries.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Office of Rules Promulgation at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC not required

221.200 Exclusions ~~127-1-17~~19

Services Not Covered for ARKids First-B Beneficiaries:

Adult Developmental Day Treatment (ADDT)

Audiological Services; EXCEPTION, Tympanometry, CPT procedure code **92567**, when the diagnosis is within the ICD range. (**View ICD codes**.)

~~Child Health Management Services (CHMS)~~

Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

~~Developmental Day Treatment Clinic Services (DDTCS)~~

Diapers, Underpads and Incontinence Supplies

~~Domiciliary Care~~

Early Intervention Day Treatment (EIDT)

End Stage Renal Disease Services

Hearing Aids

Hospice

Hyperalimentation

Non-Emergency Transportation

Nursing Facilities

Orthotic Appliances and Prosthetic Devices

Personal Care

Private Duty Nursing Services

Rehabilitation Therapy for Chemical Dependency

~~Rehabilitative Services for Children~~

Rehabilitative Services for Persons with Physical Disabilities (RSPD)

Targeted Case Management

Ventilator Services

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TO: Arkansas Medicaid Health Care Providers – Domiciliary Care

EFFECTIVE DATE: December 1, 2019

SUBJECT: Provider Manual Update Transmittal DOMCARE-1-18

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
ALL	—	—	—

Explanation of Updates

The Domiciliary Care manual is being removed.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

200.000 DOMICILIARY CARE GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Domiciliary Care Providers 10-13-03

Domiciliary Care 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 located within the State of Arkansas.

B. The provider must submit a cost statement with the application and contract.

202.000 Documentation Requirements 10-13-03

Domiciliary Care providers are required to keep the following records, and upon request, furnish the records to authorized representatives of Arkansas Division of Medical Services, the state Medicaid Fraud Control Unit and representatives of the Centers for Medicare and Medicaid Services.

A. Copy of Medicaid claim form

B. Verification of registration for accommodations at provider facility

C. Verification of appointment for medical care

D. Documentation supporting medical necessity for additional services, if applicable (See Section 212.100).

All records must be made available for audit and inspection by the Department of Human Services, or their authorized representatives, during normal business hours.

Failure to furnish records upon request may result in sanctions being imposed. All records must be retained for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. All documentation must be made available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be made available at the provider's place of business. If an audit determines that recoupment is necessary, there will be only thirty (30) days after receipt of recoupment in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.

211.000 Introduction 9-1-08

The Medical Assistance Program (Medicaid) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Reimbursement will be made for domiciliary care services rendered by an approved Medicaid provider when policy and billing requirements are met as detailed in this manual.

212.000 Scope 9-1-08

Domiciliary care for eligible Medicaid beneficiaries is a covered service under the Arkansas Medicaid Program. Domiciliary care is defined as the provision of meals, lodging and transportation en route to and from a medical care facility. Medicaid covers domiciliary care for the Medicaid eligible beneficiary only. Coverage is not available for family members or friends who are accompanying the patient receiving medical care.

212.100 Program Restriction 9-1-08

In order to be eligible for domiciliary care, a beneficiary must reside outside a 50 mile radius from the medical facility from which he or she is receiving medical care. If the beneficiary resides within a 50 mile radius of the medical facility, documentation establishing medical necessity for domiciliary care must be available in the beneficiary's medical record.

Coverage of domiciliary care services is limited to the day(s) the patient is scheduled to receive medical treatment unless documentation supports additional services.

Providers must document medical necessity in the beneficiary's record indicating the necessity for domiciliary care before and after medical treatment is received. Medicaid does allow coverage for domiciliary care services prior to and after medical treatment if documentation supports the medical necessity for domiciliary care services.

213.000 Exclusions 10-13-03

The following items are examples of non-covered domiciliary care services:

A. Beauty Shop

B. Cot for visitors

C. Meals for visitors

D. Transportation for visitors

E. Telephone charges

F. Guest tray

G. Miscellaneous

H. Social Services

I. Dietary or nutritional consultation or plan

J. Private duty nurse

K. Television charges

L. Laundry services

214.000 Electronic Signatures 10-8-10

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

[redacted]

Prior authorization is not applicable to domiciliary care services.

[redacted]

251.000 Method of Reimbursement 10-13-03

Reimbursement for domiciliary care providers is an interim negotiated rate per day. An audited cost report is required by the Medicaid Program at the end of the provider's fiscal year. Upon receipt of the audited cost report, state personnel audit the data and adjustments may be made to the rate of reimbursement if necessary.

252.000 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 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 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.

[redacted]

261.000 Introduction to Billing 7-1-07

Domiciliary Care providers who submit paper claims must use the CMS-1450 claim form, which also is known as the UB-04 claim form.

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

Section III of every Arkansas Medicaid provider manual contains information about Provider Electronic Solutions (PES) and other available electronic claim options.

262.000 CMS-1450 (UB-04) Procedures

262.100 Procedure Codes 10-13-03

Not applicable to this program.

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

Not applicable to this program.

262.300 Billing Instructions – Paper Only 11-1-17

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

Arkansas Medicaid program claims must be completed 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 UB-04. **View or print NUBC contact information.**

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

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

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

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

262.310 Completion of CMS-1450 (UB-04) Claim Form 9-1-14

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. The entry appears on the RA beside the letters "MRN." Up to 16 alphanumeric characters are accepted.
3b.	MED REC #	*Inpatient and Outpatient:* Required .Enter up to 15 alphanumeric characters.
4.	TYPE OF BILL	*Inpatient and Outpatient:* See the UB-04 manual. Four-digit code with a leading zero that indicates the type of bill.
5.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
6.	STATEMENT COVERS PERIOD	Enter the covered beginning and ending service dates. Format: MMDDYY. The FROM and THROUGH dates cannot span the State's fiscal year end (June 30) or the provider's fiscal year end. To file correctly for covered days that span a fiscal year end, submit 2 claims. E.g., the THROUGH date is the last day of the fiscal year that ended during the stay.
7.	Not used	Reserved for assignment by the NUBC.
8a.	PATIENT NAME	Required. Enter the beneficiary'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	*Inpatient and Outpatient:* Enter M for male, F for female, or U for unknown.
12.	ADMISSION DATE	Enter the admission date. Format: MMDDYY.
13.	ADMISSION HR	Not applicable to Domiciliary Care.
14.	ADMISSION TYPE	Not applicable to Domiciliary Care.
15.	ADMISSION SRC	Not applicable to Domiciliary Care.
16.	DHR	Not applicable to Domiciliary Care.
17.	STAT	*Inpatient:* Enter the national code indicating the patient's status on the Statement Covers Period THROUGH date (field 6). *Outpatient:* Not applicable.
18.-28.	CONDITION CODES	Not applicable to Domiciliary Care.
29.	ACDT STATE	Not required.

30.	(blank)	Unassigned data field.
31.-34.	OCCURRENCE CODES AND DATES	Not applicable to Domiciliary Care. *Outpatient:* See the UB-04 manual.
35.-36.	OCCURRENCE SPAN CODES AND DATES	Not applicable to Domiciliary Care.
37.	Not used	Reserved for assignment by the NUBC.
38.	Responsible Party Name and Address	Not applicable to Domiciliary Care.
39.-41.	VALUE CODES AND AMOUNTS	Not applicable to Domiciliary Care.
42.	REV CD	Enter the Revenue Code 0110.
43.	DESCRIPTION	Enter room and board.
44.	HCPCS/RATE/HIPPS CODE	Enter the facility's daily rate for room and board.
45.	SERV DATE	Not applicable to Domiciliary Care.
46.	SERV UNITS	Enter the number of days being billed.
47.	TOTAL CHARGES	Enter the total charges for the period indicated in the "Statement Covers Period"
48.	NON-COVERED CHARGES	Not applicable to Domiciliary Care.
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	Not required.
53.	ASG BEN	Not required.
54.	PRIOR PAYMENTS	Required when applicable. See the UB-04 Manual.
55.	EST AMOUNT DUE	Not required.
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	Required. Enter the patient's Medicaid 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	Not applicable to Domiciliary Care.
64. A, B, C	DOCUMENT CONTROL NUMBER	Not applicable to Domiciliary Care unless the claim is a replacement or a void. See the UB-04 manual if applicable.
65. A, B, C	EMPLOYER NAME	When applicable, based upon fields 51 and 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 applicable to Domiciliary Care.
70.	PATIENT REASON DX	Not applicable to Domiciliary Care.
71.	PPS CODE	Not required.
72	ECI	Not applicable to Domiciliary Care.
73.	Not used	Reserved for assignment by the NUBC.
74.	PRINCIPAL PROCEDURE CODE AND DATE and OTHER PROCEDURE CODES AND DATES	Not applicable to Domiciliary Care.
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	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 is not required.
	QUAL	Not required.
	LAST	Not required.
	FIRST	Not required.
78.	OTHER NPI	NPI is not required.
	QUAL	Not required.

	LAST	Not required.
	FIRST	Not required.
79.	OTHER NPI/QUAL/LAST/FIRS	Not required.
80.	REMARKS	For provider's use.
81.	Not used	Reserved for assignment by the NUBC.

262.400 Special Billing Procedures 10-13-03

Not applicable to this program.

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TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: December 1, 2019

SUBJECT: Provider Manual Update Transmittal Secl-5-18

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
103.200	1-1-16	103.200	12-1-19
124.230	1-1-16	124.230	12-1-19
172.100	5-1-18	172.100	12-1-19

Explanation of Updates

Sections 103.200, 124.230 and 172.100 are each revised to update listed covered services.

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Janet Mann
Director

TOC not required

103.200 Optional Services ~~1-1-16~~12-1-19

Program	Coverage
Adult Behavioral Health Services for Community Independence	18 or older
Adult Developmental Day Treatment (ADDT)	Pre-School and Age 18 or Older
Ambulatory Surgical Center	All Ages
Audiological	Under Age 21
Certified Registered Nurse Anesthetist (CRNA)	All Ages
~~Child Health Management Services (CHMS)~~	~~Under Age 21~~
Chiropractic Services	All Ages
Dental Services	Under Age 21
~~Developmental Day Treatment Clinic Services (DDTCS)~~	~~Pre-School and Age 18 or Older~~
Developmental Rehabilitation Services	Under Age 3
~~Domiciliary Care~~	~~All Ages~~
Durable Medical Equipment	All Ages
Early Intervention Day Treatment (EIDT)	Under Age 21
End-Stage Renal Disease (ESRD) Facility Services	All Ages
Hearing Aid Services	Under Age 21
Hospice	All Ages
Hyperalimentation	All Ages
IndependentChoices (Self-Directed Personal Assistance)	Age 18 or Older
Inpatient Psychiatric Services	Under Age 21
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	All Ages
~~Licensed Mental Health Practitioner~~	~~Under Age 21~~
Medical Supplies	All Ages
Nursing Facility	Under Age 21
Occupational, Physical and Speech-Language Therapy	Under Age 21
Orthotic Appliances	All Ages
Outpatient Behavioral Health Services	All Ages
PACE (Program of All-Inclusive Care for the Elderly) (*Participants must meet additional medical and non-medical criteria in addition to age eligibility.)	Age 55 or older*

Program	Coverage
Personal Care	All Ages
Podiatrist	All Ages
Portable X-Ray	All Ages
Prescription Drugs	All Ages
Private Duty Nursing Services (High Technology, Non-Ventilator Dependent, EPSDT Program)	Under Age 21
Private Duty Nursing Services (Non-Ventilator Dependent Beneficiaries Age 21 or Older)	Age 21 or Older
Private Duty Nursing Services (Ventilator-Dependent)	All Ages
Prosthetic Devices	All Ages
Rehabilitative Hospital and Extended Rehabilitative Hospital Services	All Ages
~~Rehabilitative Services for Persons with Mental Illness (RSPMI)~~	~~All Ages~~
Rehabilitative Services for Persons with Physical Disabilities (RSPD)	Under Age 21
Rehabilitative Services for Youth and Children	Under Age 21
Respiratory Care	Under Age 21
School-Based Mental Health Services	Under Age 21
Targeted Case Management for Beneficiaries of DDS Children's Services (Title V Agency)	Under Age 21
Targeted Case Management for DDS Children's Services (Title V Agency) who are SSI Beneficiaries and TEFRA Waiver Participants	Under Age 16
Targeted Case Management for Beneficiaries Age 21 or Under with a Developmental Disability	Age 21 or Under
Targeted Case Management for Beneficiaries Age 22 or Older with a Developmental Disability	Age 22 or Older
Targeted Case Management for Beneficiaries in the Child Health Services (EPSDT) Program	Under Age 21
Targeted Case Management for Beneficiaries in the Division of Children and Family Services	Under Age 21
Targeted Case Management for Beneficiaries in the Division of Youth Services	Under Age 21
Targeted Case Management for Beneficiaries Age 60 or Older	Age 60 or Older
Targeted Case Management for Pregnant Women	Pregnant Women - All Ages
Ventilator Equipment	All Ages
Visual Care	All Ages

124.230 Working Disabled ~~1-1-16~~12-1-19

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

There are two levels of cost sharing in this aid category, depending on the individual's income:

A. Regular Medicaid cost sharing.

Beneficiaries with gross income below 100% of the Federal Poverty Level (FPL) are responsible for the regular Medicaid cost sharing (pharmacy, inpatient hospital and prescription services for eyeglasses). They are designated in the system as "WD RegCO."

B. New cost sharing requirements.

Beneficiaries with gross income equal to or greater than 100% FPL have cost sharing for more services and are designated in the system as "WD NewCo".

The cost sharing amounts for the "WD NewCo" eligibles are listed in the chart below:

Program Services	**New Co-Payment***
Adult Developmental Day Treatment Services	$10 per day
ARChoices Waiver Services	None
Ambulance	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiological Services	$10 per visit
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
~~Child Health Management Services~~	~~$10 per day~~
Chiropractor	$10 per visit
Dental	$10 per visit (no co-pay on EPSDT dental screens)
~~Developmental Disability Treatment Center Services~~	~~$10 per day~~
Diapers, Underpads and Incontinence Supplies	None
~~Domiciliary Care~~	~~None~~
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Early Intervention Day Treatment	$10 per day
Emergency Department: Emergency Services	$10 per visit
Emergency Department: Non-emergency Services	$10 per visit
End Stage Renal Disease Services	None

Program Services	New Co-Payment*
Early and Periodic Screening, Diagnosis and Treatment	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals ages 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient	25% of the hospital's Medicaid per diem for the first Medicaid-covered inpatient day
Hospital: Outpatient	$10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None
Laboratory and X-Ray	$10 per encounter, regardless of the number of services per encounter
Medical Supplies	None
Inpatient Psychiatric Services for Under Age 21	25% of the facility's Medicaid per diem for the first Medicaid-covered day
Outpatient Behavioral Health	$10 per visit
Nurse Practitioner	$10 per visit
Private Duty Nursing	$10 per visit
Certified Nurse Midwife	$10 per visit
Orthodontia (not covered for individuals ages 21 and older)	None
Orthotic Appliances	10% of Medicaid maximum allowable amount
Personal Care	None
Physician	$10 per visit
Podiatry	$10 per visit
Prescription Drugs	$10 for generic drugs; $15 for brand name
Prosthetic Devices	10% of Medicaid maximum allowable amount
Rehabilitation Services for Persons with Physical Disabilities (RSPD)	25% of the first covered day's Medicaid inpatient per diem
Rural Health Clinic	$10 per core service encounter
Targeted Case Management	10% of Medicaid maximum allowable rate

Program Services	New Co-Payment*
	per unit
Occupational Therapy (Age 21 and older have limited coverage**)	$10 per visit
Physical Therapy (Age 21 and older have limited coverage**)	$10 per visit
Speech-Language Therapy (Age 21 and older have limited coverage**)	$10 per visit
Transportation (non-emergency)	None
Ventilator Services	None
Visual Care	$10 per visit

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

** **Exception:** This service is NOT covered for individuals within the Occupational, Physical and Speech-Language Therapy Program for individuals ages 21 and older.

NOTE: Providers must consult the appropriate provider manual to determine coverage and benefits.

172.100 **Services not Requiring a PCP Referral** ~~5-1-18~~12-1-19

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

A. Adult Developmental Day Treatment (ADDT) core services

B. ARChoices waiver services

~~B~~C. Anesthesia services, excluding outpatient pain management

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

~~D~~E. Chiropractic Services

~~E~~F. Dental services

~~F~~G. Developmental Disabilities Services Community and Employment Support~~DDS Alternative Community Services (ACS) Waiver services~~

~~G. Developmental Day Treatment Clinic Services (DDTCS) core services~~

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

~~I. Domiciliary care~~

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

~~K~~J. Family Planning services

~~L~~K. Gynecological care

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

~~N~~M. Mental health services, as follows:

1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner.
2. ~~Rehabilitative services for persons with mental illness (RSPMI Program) ages 21 or older, or for specified procedures for persons under age 21, as listed in the RSPMI provider manual, Section 216.000.~~
3. ~~Rehabilitative Services for Youth and Children (RSYC) Program.~~

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

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

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

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

~~R~~Q. Optometry services

~~S~~R. Pharmacy services

~~T~~S. Physician services for inpatients in an acute care hospital. This includes:

1. Direct patient care (initial and subsequent evaluation and management services, surgery, etc.), and
2. Indirect care (pathology, interpretation of X-rays, etc.)

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

~~V~~U. Physician visits (except consultations) in the outpatient departments of acute care hospitals:

1. Medicaid will cover these services without a PCP referral only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations.
2. Consultations require PCP referral.

~~W~~V. Professional components of diagnostic laboratory, radiology and machine tests in the outpatient departments of acute care hospitals. Medicaid covers these services without a PCP referral only:

1. If the Medicaid beneficiary is enrolled with a PCP and

2. The services are within applicable benefit limitations.

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

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

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

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Office of Rules Promulgation

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
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TO: **Arkansas Medicaid Health Care Providers – All Providers**

EFFECTIVE DATE: **December 1, 2019**

SUBJECT: **Provider Manual Update Transmittal SecIII-4-18**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
332.000	11-1-17	332.000	12-1-19

Explanation of Updates

Section 332.000 is updated to remove Domiciliary Care and Rehabilitative Services for Persons with Mental Illness (RSPMI) from coverage and to rename Occupational, Physical and Speech-Language Therapy Services.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Office of Rules Promulgation at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx.

Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC not required

332.000 Patients With Joint Medicare-Medicaid Coverage ~~11-1-17~~12-1-19

The following provider types accept Medicare-Medicaid Crossovers: Ambulatory Surgical Center, Chiropractic, Clinics, Dental, ~~Domiciliary Care,~~ Family Planning, Federally Qualified Health Center, Health Department, Hearing Services, Hemodialysis, Home Health, Hospital, Hyperalimentation, Independent Laboratory, Independent Radiology, Inpatient Psychiatric Services for Under Age 21, Nurse Practitioner, Nursing Home, Occupational, Physical and Speech-Language Therapy Services, Physician, Podiatrist, Prosthetics, Rehabilitation Center, ~~Rehabilitative Services for Persons with Mental Illness,~~ Rural Health Clinic Services, Transportation, Ventilator Equipment and Visual Care.

Claim filing procedures for these provider types are in Sections 332.100 through 332.300.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) Volunteer Transportation

Volunteer carriers are reimbursed for providing transportation to recipients to medical services provided the carriers are registered by the Arkansas Department of Human Services and Medical Services and the medical services are part of the case plan. A General Relief check is issued by local Human Services staff for payment of Medicaid transportation if a licensed carrier is not available.

These services may be billed once per day, per recipient for a maximum of 300 miles per day. The benefit limit does not apply to EPSDT recipients.

~~(5) Domiciliary Care - The cost of meals, lodging and transportation en route to and from medical care.~~

b. Services of Christian Science Nurses - Not Provided.

c. Care and services provided in Christian Science sanitoria - Not Provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) Volunteer Transportation

Volunteer carriers are reimbursed for providing transportation to recipients to medical services provided the carriers are registered by the Arkansas Department of Human Services and Medical Services and the medical services are part of the case plan. A General Relief check is issued by local Human Services staff for payment of Medicaid transportation if a licensed carrier is not available.

These services may be billed once per day, per recipient for a maximum of 300 miles per day. The benefit limit does not apply to EPSDT recipients.

~~(5) Domiciliary Care - The cost of meals, lodging and transportation en route to and from medical care.~~

b. Services of Christian Science Nurses - Not Provided.

c. Care and services provided in Christian Science sanitoria - Not Provided.

d. Nursing facility services provided for patients under 21 years of age - Not Provided.

e. Emergency Hospital Services

Limited to immediate treatment and removal of patient to a qualifying hospital as soon as patient's condition warrants.

State: ARKANSAS

Citation	Condition or Requirement
1905(t)	The following PCCM exempt services do not require PCP authorization: Dental Services Emergency hospital care ~~DDS Alternative Community Services~~Developmental Disabilities Services Community and Employment Support Family Planning Anesthesia Alternative Waiver Programs Adult Developmental Day Treatment ~~Services~~ Core Services only Disease Control Services for Communicable Diseases ~~Domiciliary care~~ ARChoices waiver services Gynecological care Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment Mental health services as follows: a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner b. ~~Rehabilitative services for persons with mental illness aged 21 or older or for specified procedures for persons under age 21~~ c. Rehabilitative Services for Youth and Children Nurse Midwife services ICF/IID services Nursing Facility services Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment. Ophthalmology and Optometry services Obstetric (antepartum, deliver and postpartum) services Pharmacy Physician Services for inpatients acute care. Transportation Sexual Abuse Examination. Targeted case management provided by the Division of Youth Services or the Division of Children and Family services under an interagency agreement with the Division of Medical Services.
1932 (a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

State: ARKANSAS

Citation	Condition or Requirement

4. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
CFR 438.50
CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 42 438.10(i) for information requirements specific to MCOs and PCCM programs 42 operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:
Dental Services
Emergency hospital care
~~DDS Alternative Community Services~~Developmental Disabilities Services
Community and Employment Support
Family Planning Anesthesia
Alternative Waiver Programs
~~Developmental Day Treatment Services~~ Adult Developmental Day Treatment Core Services only
Disease Control Services for Communicable Diseases
~~Domiciliary care~~
ARChoices waiver services
Gynecological care
Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment
Mental health services as follows:
a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner
b. ~~Rehabilitative services for persons with mental illness aged 21 or older or for specified procedures for persons under age 21~~
c. Rehabilitative Services for Youth and Children Nurse
Midwife services
ICF/IID Services
Nursing Facility services
Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment.
Ophthalmology and Optometry services
Obstetric (antepartum, deliver and postpartum) services
Pharmacy
Physician Services for inpatients acute care.
Transportation

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) Non-Emergency (Continued)

(b) Non-Public Transportation

Effective for dates of service on or after December 1, 2001, Non-Public Transportation Services reimbursement is based on the lesser charges or the Title XIX maximum allowable. The Title XIX maximum is based on the Internal Revenue Service (IRS) reimbursement for private mileage in a business setting, plus an additional allowance for the cost of the driver. The standard mileage private reimbursement is compliant to the 1997 Standard Federal Tax Report, paragraph #8540.011. The calculation of the additional allowance for the cost of the driver is based on the minimum wage per hour, plus 28% of salaries (minimum wage) for fringe benefits, plus a fixed allowance of $2.11 for the provider's overhead and billings, divided by 30 (average number of miles per trip). The average number of miles was determined by utilizing data from SFY 1996 and dividing the number of miles per trip by the number of trips made.

The State Agency will negotiate with the affected provider group representatives should recipients access become an issue.

(5) Volunteer Transportation: Amount of payment is agreed on by County Human Services Office and the Carrier. Medicaid reimburses the County Human Services Office for the agreed amount.

The rate of reimbursement equals the amount of travel reimbursement per mile for a state employee. Medicaid reimbursement will not be made for services provided free of charge.

~~(6) Domiciliary Care: Fixed price set by Assistant Director, Division of Medical Services, based on reasonable cost. The provider submits a statement of expenses, i.e. salaries, repairs, supplies, rent, etc. for their past fiscal year. These costs are reviewed by the State's auditors for reasonableness. These costs are reviewed annually and adjusted if necessary, therefore, an inflation factor is not applied.~~

~~The cost of meals and lodging are provided only when necessary in connection with transportation of a recipient to and from medical care.~~