

SECTION II - FEDERALLY QUALIFIED HEALTH CENTER

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200.000 FQHC GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Federally Qualified Health Centers 10-15-09

Federally Qualified Health Centers (FQHC) are eligible for participation in the Arkansas Medicaid Program if they meet the following criteria:

- A. Providers must be located in Arkansas.
- B. An FQHC must submit, from among the following, a copy of the current Notice of Grant Award from Public Health Services (PHS): 1) Section 329-Migrant Health Centers, 2) Section 330-Community Health Centers or 3) Section 340-Services to Homeless Individuals.
 - 1. Each grant year, FQHC must provide evidence that they continue to receive PHS grant funds in order to continue participation in the Medicaid Program as an FQHC.
 - a. Providers must submit a Notice of Grant Award every grant year to verify receipt of PHS grant funds.
 - b. This documentation must be sent to the Division of Medical Services, Provider Enrollment Unit. [View or print Division of Medical Services, Provider Enrollment Unit contact information.](#)
 - 2. Providers failing to submit their current Notice of Grant Award are subject to suspension of payments and termination of their Medicaid enrollment.
- C. Non-federally funded health centers, which the Secretary of the Department of Health and Human Services has designated as FQHC ("FQHC look-alikes"), must submit a copy of the

letter from PHS designating the facility as an "FQHC look-alike" or as a non-federally funded health center.

- D. Non-federally funded health centers that the Secretary of the Department of Health and Human Services determines may, for good cause, qualify through waivers of the PHS requirements, must submit a copy of the letter from PHS designating the facility as an "FQHC look-alike." Waivers may be granted for up to two (2) years.
- E. An FQHC must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual to be eligible to participate in the Arkansas Medicaid Program.
- F. An FQHC must execute a Primary Care Physician Participation Agreement form DMS-2608. [View or print Primary Care Physician Participation Agreement Form DMS-2608.](#)
- G. An FQHC must execute the "Agreement to Participate as a Screening Provider in the Arkansas Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program."

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 Participation Requirements for FQHC "Satellite" Clinics 10-13-03

FQHCs with more than one clinic must enroll each clinic with Arkansas Medicaid. Each clinic will be assigned a unique provider number that is linked to the center's federal Employer Identification Number (EIN). Each clinic must bill Medicaid only for the services it provides.

201.200 Enrollment Requirement for Coverage of FQHC Services not Covered by Medicare 10-13-03

- A. Medicaid covers some FQHC services that Medicare does not.
 - 1. For example, an inpatient hospital visit may be covered by Medicaid as an FQHC encounter if the physician's agreement with the FQHC includes providing inpatient hospital visits.
 - 2. Medicare does not cover inpatient hospital visits as FQHC encounters, so an FQHC bills Medicare for that service as a physician service.
- B. In order for an FQHC to receive the applicable Medicare coinsurance and deductible from Medicaid for the physician service, the FQHC must enroll in the Arkansas Medicaid Medicare/Medicaid Crossover Only Program.

201.300 Participation Requirements for FQHCs Providing "Other Ambulatory Services" 10-13-03

- A. To be eligible for coverage of other ambulatory services, FQHCs must enroll in the Medicaid program in which the particular service is covered.
 - 1. Participation requirements for each Medicaid program are listed in Section 201.000 of the program's provider manual.
 - 2. Provider manuals may be obtained from the Provider Enrollment Unit or downloaded at <https://medicaid.mmis.arkansas.gov/>.

- B. See Sections 213.000, 214.200, 220.300, 251.400, 252.130, 252.230 and 262.424 of this manual for additional information regarding "other ambulatory services."

202.000 The FQHC's Role 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 (EPSDT) Program for eligible individuals less than 21 years of age. The purpose of this program is to detect and treat health problems in their early stages.

- A. Participation in the Child Health Services (EPSDT) Program does not require a separate provider number.
- B. Arkansas Medicaid providers eligible to be Child Health Services (EPSDT) providers must sign the "Agreement to Participate as a Screening Provider in the Arkansas Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program" form to participate. [View or print EPSDT Agreement.](#)
- C. Arkansas Medicaid requires FQHCs to participate as Child Health Services (EPSDT) screening providers.
1. Child Health Services procedure codes and billing instructions are in the Child Health Services provider manual.
 2. For additional information regarding Child Health Services, contact Central Child Health Services. [View or print the Central Child Health Services contact information.](#)
- D. FQHCs, as single-entity primary care physician (PCP) participants, are required to ensure that Child Health Services (EPSDT) medical and hearing screens and ARKids First-B preventive health medical and hearing screens (except newborn screens) are administered to the eligible children on their caseloads. FQHCs not performing the required screens may refer children to other qualified Medicaid-enrolled providers. Qualified Medicaid providers to whom referral may be made include Medicaid-enrolled FQHCs, Rural Health Clinics (RHCs), physicians and nurse practitioners.

202.100 The FQHC's Role in the Vaccines for Children (VFC) Program 10-13-03

FQHCs may enroll in the Vaccines for Children (VFC) Program by contacting the Arkansas Department of Health. [View or print Arkansas Department of Health contact information.](#) The Arkansas Department of Health furnishes available vaccines free to participating physicians and clinics.

Arkansas Medicaid covers the administration of the vaccine. FQHCs that do not participate in the VFC Program may refer their patients to participating clinics or physicians for childhood disease immunizations. See Sections 251.510, 252.141 and 252.241 for reimbursement methodology. See the Arkansas Medicaid Child Health Services provider manual for medical criteria, coverage and billing information.

202.200 The FQHC's Role in the Arkansas Medicaid Pharmacy Program 8-1-21

Medicaid covers prescription drugs in accordance with rules set forth in this section (Section 202.200) and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with current rebate agreements and listed labeler codes.

[Click here to obtain the latest information regarding prescription drug coverage.](#)

203.000 Primary Care Physician (PCP) Twenty-four Hour Patient Access Requirement 10-13-03

PCPs must maintain 24-hour access to information, referrals and emergency services for their Medicaid enrollees. No PCP, including single-entity PCPs, such as Federally Qualified Health Centers, may issue standing orders or standing referrals to hospital outpatient departments.

- A. Individuals telephoning their PCP's office during the hours that the office is closed must be able to contact a live person.
 1. A recorded message may direct the caller to the number of another telephone, which will be answered by a live person who is authorized to substitute for the PCP or authorized to contact the PCP directly.
 2. Alternatively, the machine's recording may direct the caller to leave a message. If the recording instructs the caller to leave a message, it must also affirm that a live person, who is authorized to substitute for the PCP or authorized to contact directly the PCP or the PCP substitute, will return the call.
 3. PCPs may use an answering service or a physicians' exchange. The same conditions apply as with the use of answering machines. The caller must be able to speak to a live person who is authorized to substitute for the PCP or who is authorized to contact the PCP or PCP substitute directly.
- B. Regardless of the method of access employed by the PCP, a caller must receive an appropriate response within thirty minutes of his or her initial call. This means that a patient must receive medical instructions within thirty minutes of his or her initial call, whether he or she initially leaves a message or speaks with a live person and without regard to the type or number of intermediaries involved.

204.000 Medical Records that FQHC are Required to Keep 10-15-09

All Medicaid providers are required to maintain records and documentation as outlined in Section 140.000 of this manual. FQHC are also required to keep the following documentation and records:

1. History and physical examinations,
2. The specific services provided,
3. The date and actual time the services were provided,
4. The provider of the services,
5. The chief complaint on each visit,
6. Tests and results,
7. The diagnosis or diagnoses,
8. Treatment, including prescriptions,
9. The signature or initials of the physician or attending health professional who had face-to-face contact with the patient (for each such contact) and
10. The setting in which the services were furnished.

210.000 PROGRAM COVERAGE**211.000 Introduction 10-13-03**

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 a definition of "medical necessity."

212.000 **Scope**

212.100 **A Patient of the FQHC**

10-13-03

Any Medicaid beneficiary who receives FQHC services or other ambulatory services at the FQHC is considered a patient of the FQHC. In addition, any Medicaid beneficiary who receives FQHC services furnished by the FQHC off-site from the FQHC is considered a patient of the FQH.

212.200 **FQHC Core Services**

1-1-22

Covered FQHC core services are:

- A. Physician services;
- B. Services and supplies incidental to physician services (including drugs and biologicals that cannot be self-administered);
- C. Pneumococcal vaccine and its administration and influenza vaccine and its administration;
- D. Services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, licensed certified social workers, licensed professional counselors, licensed mental health counselors, and licensed marriage and family therapists;
- E. Services and supplies incidental to physician assistant, nurse practitioner, clinical psychologist, clinical social worker, licensed certified social worker, licensed professional counselor, licensed mental health counselor, and licensed marriage and family therapist services as would otherwise be covered if furnished by or incidental to physician services; and
- F. Part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area in which the Secretary of the Department of Health and Human Services has determined there is a shortage of home health agencies.

212.210 **Services "Incident To" a Physician's Professional Services**

10-13-03

- A. Services and supplies "incident to" a physician's professional services are covered if a service or supply is:
 - 1. Of a type commonly furnished in physicians' offices;
 - 2. Of a type commonly furnished either without charge or included in the FQHC's bill;
 - 3. Furnished as an incidental, although integral, part of a physician's professional services;
 - 4. Furnished under the supervision of or in collaboration with, a physician. "The supervision of a physician" means:
 - a. The physician must be physically present (under the same roof and immediately available for consultation) when the services are furnished and
 - b. The person furnishing the service must be a member of the clinic's health care staff as an employee of the clinic.

"In collaboration with a physician" is defined below in Section 212.220.

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

212.220 Services Furnished in Collaboration with a Physician

2-1-24

Nurse practitioner services are performed in collaboration with a physician or physicians.

- A. Collaboration is a process in which a nurse practitioner works with one (1) or more physicians to deliver health care services within the scope of the practitioner's expertise, with medical direction, and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by State law.
- B. The collaborating physician does not need to be present with the nurse practitioner when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner.
- C. 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.

212.230 Services and Supplies "Incident To" a Nurse Practitioner's or Physician Assistant's Services

10-13-03

- A. Services and supplies "incident to" a nurse practitioner's or physician assistant's service are covered if the service or supply is:
 - 1. Of a type commonly furnished in physicians' offices;
 - 2. Of a type commonly furnished either without charge or included in the FQHC's bill;
 - 3. Furnished as an incidental, although integral, part of the professional services furnished by a nurse practitioner or physician assistant;
 - 4. In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic and
 - 5. Furnished under the direct supervision of a nurse practitioner, physician assistant or a physician as follows:
 - a. The nurse practitioner, physician assistant or physician must be physically present (under the same roof and immediately available for consultation) when the services are furnished and
 - b. A nurse practitioner or physician assistant may fill this supervisory function only if such a person is permitted to supervise such services under state law and the written policies governing the FQHC.
- B. Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

212.240 Services and Supplies "Incident To" a Clinical Psychologist's Services

10-13-03

- A. The services of clinical psychologists working within the scope of their State licenses are covered if the services would be covered if furnished by a physician or incident to physician services.
- B. Services and supplies incident to clinical psychologist services are covered if the following requirements are met:
 - 1. The services and supplies would be covered if furnished by a physician or incident to a physician's services.

2. The services and supplies are of a type commonly furnished in a physician's or clinical psychologist's office and are either furnished without charge or included in the physician's or clinical psychologist's bill.
3. The services are an incidental, although integral, part of the professional services performed by the clinical psychologist.
4. The services are performed under the direct supervision of a clinical psychologist. "Direct supervision" means that the clinical psychologist must be present in the FQHC and immediately available to provide assistance and direction throughout the time the service is being performed.
5. The individual performing the service must be an employee of the FQHC.

212.250 Clinical Social Worker Services 10-13-03

- A. The services of clinical social workers working within the scope of their State licenses are covered if the services would be covered if furnished by a physician or incident to physician services.
- B. Supplies and services incident to a clinical social worker's services are covered if they would be covered if incident to a physician's services.

212.260 Licensed Certified Social Worker 1-1-22

- A. The services of licensed certified social workers working within the scope of their State licenses are covered if the services would be covered when furnished by a physician or incidental to physician services.
- B. Supplies and services incident to a licensed certified social worker's services are covered if they would be covered incidental to a physician's services.

212.270 Licensed Professional Counselor 1-1-22

- A. The services of licensed professional counselors working within the scope of their state licenses are covered if the services would be covered when furnished by a physician or incidental to physician services.
- B. Supplies and services incident to a licensed professional counselor's services are covered if they would be covered incidental to a physician's services.

212.280 Licensed Mental Health Counselor 1-1-22

- A. The services of licensed mental health counselors working within the scope of their state licenses are covered if the services would be covered when furnished by a physician or incidental to physician services.
- B. Supplies and services incident to a licensed mental health counselor's services are covered if they would be covered when incidental to a physician's services.

212.290 Licensed Marriage and Family Therapist 1-1-22

- A. The services of licensed marriage and family therapists working within the scope of their state licenses are covered if the services would be covered when furnished by a physician or incidental to physician services.
- B. Supplies and services incident to a licensed marriage and family therapist's services are covered if they would be covered when incidental to a physician's services.

212.300 Off-Site FQHC Services 10-13-03

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

212.310 Inpatient Hospital Visits 10-13-03

Inpatient hospital visits are covered under the FQHC benefit when the practitioner visiting the patient is licensed and qualified to perform that service and is providing the service on behalf of the FQHC or because the practitioner's agreement with the FQHC requires that he or she provide the service and seek compensation from the FQHC. Medicaid covers one visit per Medicaid-covered hospital day, regardless of the number of times the practitioner sees the patient.

212.400 Interactive Electronic ("Telemedicine") Encounters 8-1-18

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

213.000 FQHC Other Ambulatory Services 10-13-03

FQHC other ambulatory services are other services covered under the Arkansas Title XIX (Medicaid) State Plan that the FQHC offers beyond FQHC core services, such as dental or optometry services. FQHCs may enroll as "pay to" providers in the Medicaid programs in which those services are covered, such as the Arkansas Medicaid Dental Program for coverage of dental services and the Arkansas Medicaid Visual Care Program for optometry services and eyeglasses.

214.000 FQHC Encounters 10-13-03

- A. An FQHC encounter is a face-to-face contact between a patient of the FQHC and a health care professional whose services are covered by the Arkansas Title XIX (Medicaid) State Plan.
- B. For coverage and reimbursement purposes, Arkansas Medicaid distinguishes between "core services" encounters and "other ambulatory services" encounters.

214.100 Definition of an FQHC "Core Service" Encounter 1-1-22

A Federally Qualified Health Center (FQHC) "core service" encounter is a face-to-face contact between a patient of the FQHC and a physician, physician assistant, nurse practitioner, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed mental health counselor, or licensed marriage and family therapist and includes services and supplies incidental to the face-to-face contact.

214.101 Group Psychotherapy as an FQHC Core Service Encounter 10-13-03

Group psychotherapy is covered as an FQHC core service.

- A. The number of Medicaid-covered encounters per session is equal to the number of Medicaid-eligible beneficiaries in the group.
- B. The total number of encounters per session is equal to the number of individuals in the group, both Medicaid-eligible and Medicaid non-eligible.

214.110 Services "Incident To" an FQHC Core Service Encounter 10-13-03

Services defined as "incident to" services are components of the encounter of which they are "incident to." They are not considered separate encounters, even if they occur on different days.

For example, a nurse practitioner at the FQHC may instruct a patient to return to the clinic every day for a specified period for blood pressure checks. The blood pressure checks are incident to the encounter and are not separate encounters.

214.111 Ancillary Services "Incident To" Core Service Encounters 10-13-03

Laboratory, X-ray and machine test procedures are ancillary services that are incident to core service encounters.

- A. FQHCs may report these services by procedure code, separately from the applicable encounter code.
- B. See Section 262.400 for any special billing instructions.

214.112 Specimen Handling and Collection 10-13-03

Specimen handling fees are not covered.

- A. Specimen collection is:
 - 1. Drawing a blood sample through venipuncture (i.e., inserting into a vein, a needle with syringe or vacutainer, to draw the specimen) or
 - 2. Collecting a urine sample by catheterization.
- B. Specimen collection may be covered as a separate service only when the specimen collected is sent to a reference laboratory for tests.
- C. Coverage of specimen collection is included in the coverage of the lab tests when the practitioner, clinic or facility that collects the specimen performs the tests.

214.113 Vaccines for Children (VFC) Program Immunizations "Incident To" Core Service Encounters 10-13-03

Childhood immunizations in the Vaccines for Children (VFC) Program are incident to core service encounters. FQHCs must report these services by procedure code, separately from the applicable encounter code. See Sections 251.510, 252.141 and 252.241 for reimbursement methodology as it affects VFC Program immunizations. See the Arkansas Medicaid Child Health Services provider manual for medical criteria, coverage and billing information.

214.200 Definition of an FQHC "Other Ambulatory Services" Encounter 10-13-03

An FQHC "other ambulatory services" encounter is a face-to-face contact between a patient of the FQHC and a contractor or employee of the FQHC whose services for the patient are covered by the particular Medicaid program (e.g., Dental or Visual Care) in which the FQHC is enrolled to provide the other ambulatory services. For example: A physician in an FQHC diagnoses a 22-year-old patient's pregnancy and sends her to the FQHC's dentist for an oral examination as a precaution against dental problems that may complicate the pregnancy. Arkansas Medicaid covers medical services in a dentist's office for Medicaid beneficiaries of all ages. The dentist's office visit is an "other ambulatory services" encounter. It is not incident to the FQHC core service encounter because it is not itself an FQHC core service.

See Section 220.300 for information regarding FQHC other ambulatory services encounter benefit limits.

215.000 FQHC Obstetric and Gynecologic Encounters 10-13-03

FQHCs may report five obstetric and gynecologic surgeries by CPT procedure code, instead of by encounter code. These five obstetric and gynecologic encounters are considered FQHC core service encounters only when establishing an FQHC's cost per encounter. See Section 220.000, part A, for benefit limit information regarding the obstetric and gynecologic procedures that FQHCs may report by CPT procedure code.

216.000 Family Planning Encounters and Ancillary Services 10-13-03

States participating in the Medicaid Program are required to cover family planning services. Arkansas Medicaid covers family planning services in a variety of settings, including FQHCs.

- A. See Sections 216.100 through 216.410 for detailed explanations of family planning coverage in FQHCs.
- B. See Sections 220.100 through 220.150 for family planning benefit limit information (family planning benefit limits are separate from FQHC benefit limits).

216.100 Family Planning Visits**216.110 Basic Family Planning Visit 10-13-03**

The basic family planning visit comprises:

- A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight and blood pressure.
- B. Counseling and education regarding:
 1. Breast self-exam,
 2. The full range of contraceptive methods available and
 3. HIV/STD prevention.
- C. Prescription for any contraceptives selected by the patient.
- D. Laboratory services, including, as necessary:
 1. Pregnancy test,
 2. Urinalysis testing for albumin and glucose,
 3. Hemoglobin and Hematocrit,
 4. Papanicolaou smear for cervical cancer,
 5. Sickle cell screening and
 6. Testing for sexually transmitted diseases.

216.120 Periodic Family Planning Visit 10-13-03

The periodic family planning visit comprises:

- A. Follow-up medical history, weight and blood pressure,
- B. Counseling regarding contraceptives and possible complications of contraceptives,
- C. Evaluating the patient's contraceptive program,
- D. Renewing or changing the contraceptive prescription and

- E. Providing the patient with additional opportunities for counseling regarding reproductive health and family planning.

216.130 Post-Sterilization Visit 12-18-15

Annual post-sterilization visits by an FQHC are covered as FQHC encounters for other Medicaid-eligible women with available benefits.

216.200 Contraceptive Devices 10-13-03

Medicaid covers intrauterine devices (IUDs) and their insertion and removal and implantable contraceptive capsules (such as Norplant) and their insertion and removal.

216.300 Other Contraceptives and Supplies 10-13-03

Medicaid covers other contraceptives and supplies (over-the counter as well as by-prescription-only, such as birth control pills) when they are prescribed.

216.310 Depo-Provera Injections 10-13-03

Medroxyprogesterone acetate (Depo-Provera) for contraception, 150 mg by injection, is covered for Medicaid-eligible women as a service incident to the family planning encounter (visit).

216.400 Sterilizations 12-18-15

- A. Medicaid covers sterilization of men and women.
 - 1. All adult (age 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 and Checklist.](#)
 - a. Copies may be ordered from the Arkansas Medicaid fiscal agent. [View or print the Medicaid Form Request.](#) See Section III of any Arkansas Medicaid provider manual for instructions for ordering forms and publications.
 - b. 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 ADA Coordinator contact information.](#)
7. 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). [View or print the Medicaid Form Request.](#) See Section III of any Arkansas Medicaid provider manual for instructions for ordering forms and publications.
8. If you have any questions regarding any of these requirements, contact the Arkansas Medicaid Program before the sterilization.

216.410 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 exist, you should contact the Arkansas Medicaid Program for clarification before the sterilization procedure is performed.
- B. The person obtaining the consent for sterilization must sign and date the form after the beneficiary and interpreter 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 are exceptions to the 30-day waiting period:
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.

Either of these 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.](#)

- 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 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. [View or print a checklist for Form DMS-615](#), which lists consent form items that DMS medical staff reviews to determine whether a sterilization procedure will be covered.
 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.

217.000 Non-Covered Services

12-15-14

Medicaid does not cover services that are not medically necessary, cosmetic, experimental or that are not generally accepted by the medical profession. Medicaid does not cover services that are not documented by diagnoses that certify medical necessity. Arkansas Medicaid has identified some ICD diagnosis codes that do not certify medical necessity. See Sections 262.430 and 262.440 for diagnosis codes that are not covered by Arkansas Medicaid

220.000 Benefit Limits

7-1-25

- A. Arkansas Medicaid clients aged twenty-one (21) and older are limited to sixteen (16) FQHC core service encounters per state fiscal year (SFY, July 1 through June 30).

The following services are counted toward the sixteen (16) encounters per SFY benefit limit:

1. Federally Qualified Health Center (FQHC) encounters;
2. Physician visits in the office, patient’s home, or nursing facility;
3. Certified nurse-midwife visits;
4. RHC encounters;
5. Medical services provided by a dentist;
6. Medical services provided by an optometrist; and
7. Advanced practice registered nurse services in the office, patient’s home, or nursing facility.

- B. The following services are not counted toward the sixteen (16) encounters per SFY benefit limit:

1. FQHC inpatient hospital visits do not count against the FQHC encounter benefit limit. Medicaid covers only one (1) FQHC inpatient hospital visit per Medicaid-covered inpatient day, for clients of all ages.
2. Obstetric and gynecologic procedures reported by CPT surgical procedure code do not count against the FQHC encounter benefit limit.
3. Postpartum visits are to be billed as an encounter, with an appropriate postpartum diagnosis code. These will not count against the FQHC encounter benefit limit.
4. Family planning surgeries and encounters do not count against the FQHC encounter benefit limit.
5. Medication Assisted Treatment for Opioid Use Disorder does not count against the FQHC encounter limit when it is the primary diagnosis ([View ICD OUD Codes](#)).

- C. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program are not subject to an FQHC encounter benefit limit.

220.100 Family Planning Benefit Limits

220.110 Family Planning Visit Benefit Limit 10-13-03

Family planning visits are considered encounters for determining an FQHC’s cost per encounter, but the family planning visit benefit limit is separate from the FQHC encounter benefit limit.

- A. Medicaid has established a benefit limit of one basic family planning visit per state fiscal year (SFY).
- B. Medicaid has established a benefit limit of three periodic family planning visits per SFY.

220.120 Implantable Contraceptive Capsules Benefit Limit 10-13-03

- A. The benefit limit for an implantable contraceptive capsule (such as Norplant System) kit is two per five-year period per beneficiary.
- B. The benefit limit for removal of the kit is once within five years of the last implantation.

220.130 Intrauterine Device (IUD) 10-13-03

There are no benefit limits on IUDs, IUD removals or IUD insertions.

220.140 Sterilization 10-13-03

- A. There is a once-in-a-lifetime benefit limit on sterilization procedures, but DMS may authorize a second sterilization procedure in the rare occurrence of a failure.
- B. Medicaid does not cover procedures to reverse sterilizations.

220.150 Reserved 12-18-15

220.200 Extension of Benefits 9-1-20

- A. Extensions of family planning benefits are not available.
- B. Extensions of the FQHC core service encounter benefit are automatic for the following diagnoses:
 - 1. Malignant Neoplasm ([View ICD codes.](#))
 - 2. HIV Infection and AIDS ([View ICD codes.](#))
 - 3. Renal Failure ([View ICD codes.](#))
 - 4. Opioid Use Disorder when treated with MAT ([View ICD OUD Codes](#)).

220.201 Benefit Extension Requests 8-1-21

- A. Requests to extend the FQHC core service encounter benefit must be submitted to DHS or its designated vendor. [View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient days.](#)

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.
- B. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.
- C. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.
- D. Additional information shall be requested when needed to process a benefit extension request. Failures to provide requested additional information within the specified timeline will result in technical denials. Reconsideration are no 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.

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

- A. 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.](#)
- B. 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.

- C. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extensions for more than four (4) encounters, use a separate form for each set of encounters.
- D. Enter a valid ICD diagnosis code and brief narrative description of the diagnosis.
- E. Enter the procedure code, modifier(s) (when applicable) and a brief narrative description of the procedure.
- F. Enter the number of units (encounters) requested under the extension.

220.203 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.
- [View or print the essential health benefit procedure codes.](#)
- 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 when applicable.

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

Approval or denial of a benefit extension request—or request for additional information—will be made within thirty (30) calendar days.

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

220.205 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.

220.210 Reserved 6-1-25

220.220 Reserved 6-1-25

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

- A. Arkansas Medicaid has established benefit limits in each program in which an FQHC 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 FQHC 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.

240.000 PRIOR AUTHORIZATION 10-13-03

Prior authorization is not applicable to FQHC services.

250.000 REIMBURSEMENT

251.000 Reimbursement Methodology for Dates of Service before January 1, 2001 10-13-03

Reimbursement methodology in Sections 251.100 through 251.510 regards dates of service before January 1, 2001. See Sections 252.000 through 252.241 for reimbursement methodologies in effect for dates of service on and after January 1, 2001.

251.100 Cost Report Form CMS-222-92 (formerly HCFA-222-92) 10-13-03

According to the law that established Federally Qualified Health Centers (FQHCs), Medicaid must reimburse, at 100% of reasonable cost, services that meet the FQHC service definition. Medicaid will establish an FQHC encounter rate unique to each center, based on each center's Medicare cost report. The encounter rate will be reimbursed for all allowable encounters performed by all of the center's qualified clinics. Each FQHC will submit to the Division of Medical Services (DMS), a copy of the CMS-222-92 cost report (all pages) submitted to Medicare. [View or print DMS Financial Activities contact information](#). The centers will complete the CMS-222-92 cost reports according to Medicare principles of reimbursement for Federally Qualified Health Centers, found at 42 CFR 405, subpart X and 42 CFR 413. Desk review and/or on-site audit by the Medicare intermediary and the Division of Medical Services will determine a center's allowable and reasonable costs. Medicaid will make settlement at 100% of allowable and reasonable costs reported on Worksheet A of the CMS-222-92, as verified by audit staff. Reasonable costs are those applicable costs that are allowable under Medicare cost principles as outlined in 42 CFR 413. Medicaid cost settles with FQHCs only for services that the FQHC service definition includes and that Medicaid covers.

251.200 Adjustments to the Cost Report 10-13-03

Direct compensation per each line is determined from Column 1 reported compensation net of Column 4 reclassifications (Column 1 \pm Column 4).

- A. DMS will calculate the ratio of non-FQHC compensation (Worksheet A, Lines 51-61) to total direct compensation (Worksheet A, Lines 1-3; plus Worksheet A, Lines 51-61). The Division will apply this ratio to total overhead costs (Worksheet A, Line 50, Column 7), allocating the result to non-FQHC costs (the center reports non-FQHC costs on Worksheet A, Lines 51-61).
- B. The managed care expense will equal the managed care fees paid to the FQHC under the Arkansas Medicaid Primary Care Case Management Program (PCCM). The center may correctly document its PCCM managed care adjustment by reclassifying (from Worksheet A, Line 1, Column 4, to Worksheet A, Lines 58-60, Column 4) an amount equal to PCP managed care fees paid for the months within the cost reporting period. The center should adequately identify this adjustment on Worksheet A-1. If the center does not reclassify PCCM managed care costs on the cost report, DMS will perform an adjustment to remove managed care costs from the FQHC costs.
- C. The costs of non-related and unallowable FQHC Program services will be identified and eliminated.
- D. In lieu of determining and eliminating each detailed line item cost of these non-related and unallowable costs, the related income may be used to offset the costs if the center can justify and document (calculations to be retained by the center) that the revenue received is reasonably equivalent to the costs incurred.

251.300 Calculation of Encounter Cost and Cost Settlement 10-13-03

- A. Medicaid calculates each center's cost per encounter by dividing the total allowable and reasonable costs included on Worksheet A, by total encounters performed, identified on Worksheet B, column 2.
- B. Multiplying the cost per encounter by the number of paid Medicaid encounters yields the cost reimbursement amount due the center.
- C. The cost reimbursement amount due the center, minus prior Medicaid payments for dates of service within the cost reporting period, equals the cost settlement amount.

- D. Medicaid will make a tentative cost settlement, remitting 80% of the cost settlement amount, pending the final Medicare cost settlement.
- E. The Medicaid encounter cost calculated in part A, above, becomes the new interim encounter rate, effective for dates of service after the last day of the cost report period under review. The Medicaid encounter cost per each year's cost report becomes the interim encounter rate for the succeeding year.
- F. For dates of service between the close of the audited fiscal year and the completion of the Medicaid audit, Medicaid will initiate a mass adjustment of payments made at the previous encounter rate, remitting to the center the difference of: the new interim encounter rate, multiplied by the number of paid encounters, minus the sum of the prior payments.
- G. Upon the final Medicare cost settlement, Medicaid will reconcile its calculations with those of Medicare and will pay the center the remainder of the Medicaid cost settlement, as adjusted per that reconciliation. This will be the final Medicaid cost settlement.
- H. At the time of the final Medicaid cost settlement, Medicaid will also cost settle for paid dual-eligible (Medicare/Medicaid beneficiary) encounters at 20% of the final Medicare-settled encounter rate.
- I. See Section 253.000 for instructions for filing Form CMS-222-92 (formerly HCFA-222-92).

251.400 Cost Settling for Other Ambulatory Services Encounters (for Dates of Service before January 1, 2001) 10-13-03

Medicaid will reimburse the FQHC for "other ambulatory services" encounters within the program covering each particular service, if the FQHC is enrolled as a Medicaid provider of that service. The center will bill for dental services under the Dental Program, visual services under the Visual Care Program, etc. Interim reimbursement for other ambulatory services encounters is at the lesser of the billed charge or the established Medicaid maximum allowable for the service within the program in which it is covered. Medicaid will cost settle for the other ambulatory services encounters at the time of the cost settlement for the FQHC core service encounters. Cost settlement per other ambulatory services encounter will be at the same rate as that for core service encounters.

251.500 Cost Settling for Services Reported by CPT or HCPCS Procedure Code Other Than the FQHC Encounter Code (for Dates of Service before January 1, 2001) 10-13-03

Arkansas Medicaid initially reimburses FQHCs for some procedures (including some family-planning-related ancillary services) by means of a fee-for-service methodology. They are then cost-settled as encounters (or incident to encounters as appropriate) at the time of Medicaid cost settlement. See Section 260.000 for procedure codes and billing information.

251.510 Cost Settling for Vaccines for Children (VFC) Program Immunization Administration (for Dates of Service before January 1, 2001) 10-13-03

Medicaid requires FQHCs to report VFC immunization administration by procedure code and applicable modifier. Medicaid pays interim reimbursement to FQHCs for the administration. The vaccine administration is incident to an encounter and is cost settled as such.

252.000 Reimbursement Methodologies for Dates of Service on and after January 1, 2001 10-13-03

Effective for dates of service on and after January 1, 2001, Federally Qualified Health Centers (FQHCs) will be reimbursed under the prospective payment system (PPS) described in Sections

252.100 through 252.141, unless they agree to the alternative payment methodology described in Sections 252.200 through 252.241.

252.100 **Prospective Payment System (PPS) Methodology for Dates of Service on and after January 1, 2001** **10-13-03**

- A. Effective for dates of service on and after January 1, 2001, payments to Federally Qualified Health Centers (FQHCs) for Medicaid-covered services are made under a prospective payment system (PPS) on a per encounter basis.
1. FQHCs may be reimbursed under the method described in Sections 252.100 through 252.141 or they may execute a written agreement with the Division of Medical Services to elect the alternative methodology described in Sections 252.200 through 252.241.
 2. An encounter is a face-to-face contact between a patient of an FQHC and any health professional whose services are reimbursed under the Arkansas Title XIX (Medicaid) State Plan.
 - a. Contacts with more than one health professional and multiple contacts with the same health professional that take place on the same day and at a single location constitute a single encounter except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.
 - b. A patient of the FQHC may have a separate family planning encounter during the same visit to the FQHC for a core service encounter; however, a family planning visit is not reimbursed separately when it takes place on the same day as a family planning surgical procedure.
 - c. An FQHC encounter is not reimbursed separately on the same day as an obstetric or gynecologic procedure that the FQHC reports by CPT procedure code unless the encounter is for a different disorder or condition.
- B. The PPS per encounter rate for each center is calculated based on 100% of the average of the center's reasonable costs for providing Medicaid-covered services as determined from audited cost reports with ending dates in calendar year 1999 and calendar year 2000.
1. Reasonable costs are defined as those costs which are allowable under Medicare cost principles outlined in 42 CFR 413.
 2. Cost reports used for rate setting purposes must cover a fiscal period of at least a full six months.
 3. If a provider has more than one cost report period ending in the same calendar year, Arkansas Medicaid uses the most recent cost report to calculate rates.

252.110 **Calculation of PPS Per Encounter Rate** **10-13-03**

- A. PPS per encounter rates are 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 encounters for the two periods.
1. Allowable costs for each period used to set the PPS rate 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.
 2. If audited cost report information was available, interim rates were implemented as of January 1, 2001, at the average cost per encounter as determined from the two most recent provider cost reports.
 3. Interim rates are calculated by adding the per-encounter costs from each of the two periods and dividing the total by two.

4. Interim rates are retroactively adjusted to January 1, 2001, after audited cost report information has become available and final rates have been calculated.
- B. FQHCs that do not have minimal 1999 or 2000 cost report periods (at least 6 months) or that enroll in Medicaid after 2000, will have their initial PPS per encounter rate established at the average of the current rates of the three nearest FQHCs with similar caseloads.
1. Determination of the nearest FQHCs will be by map mileage.
 2. A final PPS per encounter rate shall be established using the center's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months.
 3. 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.
 4. This rate setting method based on the three nearest centers does not apply to new clinics opened under an existing center.
 - a. For these new clinics, the same reimbursement rate as is paid to the other clinics of the center will be paid to the new clinic.
 - b. When clinics open or close, the center should review for possible scope of services rate changes. See Sections 252.120 and 252.220.
- C. Beginning July 1, 2001, initial rates, interim rates and final PPS rates will be adjusted annually by the Medicare Economic Index (MEI) for primary care services.
1. Rate adjustments will be equal to the previous calendar year's index percentage change and will be effective for dates of service on and after July 1 of each year.
 2. Annual MEI increases will be reduced per the number of applicable months if already used in the calculation of the initial January 1, 2001 rate.

252.120**Rate Adjustments for Scope of Services Changes****10-13-03**

- A. Each center's PPS per encounter rate will be adjusted to account for increases or decreases in scope of services. Scope of services changes are defined as:
1. An addition or deletion of an FQHC-covered service;
 2. A change in the magnitude, intensity or character of currently offered FQHC-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 Workers' Compensation insurance premiums that were not recognized and included in the base year's rate calculation.
- B. The following examples of scope of services changes are offered as guidance to understanding their definitions but not as a definitive and comprehensive delineation of that definition.
1. Examples of adding or deleting an FQHC-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 FQHC-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 center (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 A provides its own examples.
 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 also necessitate personnel changes), subject to reasonable costs criteria identified at 42 CFR 413.
 6. Item 6 in part A provides its own examples.
- C. All requested PPS rate increases due to scope of services changes are subject to reasonable costs criteria identified at 42 CFR 413.
- D. The provider must submit written requests for both cost increases and cost decreases due to scope of services changes. The request must be submitted (postmarked) within 5 months after the end of the provider's fiscal period and the request must identify the beginning date that the change occurred and include detailed descriptions, documentation and calculations of the changes and costs differences.
 1. To qualify for a PPS rate change, the scope of services changes must equal at least a 5% total difference in the allowable per encounter cost as determined for the fiscal period and the changes must have existed during the last full 6 months of the provider's fiscal period.
 2. 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 services changes and will be effective on the later of:
 - a. The first date that the scope of services changed or
 - b. The beginning date of the fiscal period.
 3. PPS rate changes will also be made when scope of services changes are identified through an audit or review process. In such a case, the effective date of the PPS rate change will be the later of:
 - a. The first date that the scope of services changed or
 - b. The beginning date of the cost report period for which the changes should have been reported.
- E. Examples:
 1. FQHC provider XYZ has a fiscal reporting period of January 1 through December 31. On September 1, 2002, Provider XYZ purchases new lab equipment to replace old obsolete equipment. The following calculations represent the changes in allowable per encounter cost for reporting periods ending December 31, 2002 and December 31, 2003.

- a. Reporting Period 2002
For the reporting period ending December 31, 2002, Provider XYZ does not qualify for a scope of services PPS rate change because the change did not exist during the last six months of the fiscal period.
- b. Reporting Period 2003

\$85.78	Per Encounter Cost With New Equipment (Actual Per Encounter Cost for the Period)
<u>(81.45)</u>	Less: Per Encounter Cost With Old Equipment (Calculate Per Encounter Cost Using the Cost of the Old Equipment)
\$4.33	Difference or 5.32% Increase (Provider Qualifies for PPS Rate Increase for 2003)

For reporting period ending December 31, 2003, Provider XYZ would qualify for a scope of services PPS rate change. Provider XYZ should request the PPS rate change with the submission of their December 31, 2003 cost report. If approved, the \$4.33 rate change would be retroactively applied to January 31, 2003.

- 2. PPS rate changes due to scope of services changes will also be applied cumulatively. In other words, less than 5% changes for a previous reporting period can be brought forward to future reporting periods. For example:

FQHC provider XYZ with a reporting period ending December 31, 2002, purchases new lab equipment to replace old obsolete equipment as of January 1, 2002, but the cost difference is less than 5%.

- a. Reporting Period 2002

\$85.78	Per Encounter Cost With New Equipment (Actual Per Encounter Cost for the Period)
<u>(83.90)</u>	Less: Per Encounter Cost With Old Equipment (Calculate Per Encounter Cost Using the Cost of the Old Equipment)
\$1.88	Difference or 2.24% Increase (Provider does not qualify for PPS rate increase for 2002)

FQHC provider XYZ then purchases more new lab equipment to replace old obsolete equipment as of January 1, 2003. If the new equipment purchased January 1, 2002 and January 1, 2003 combined equals to at least a 5% difference during the reporting period ending December 31, 2003, a PPS rate change can be requested for 2003.

- b. Reporting Period 2003

\$89.27	Per Encounter Cost With New Equipment (Actual Per Encounter Cost for the Period)
<u>(85.01)</u>	Less: Per Encounter Cost Without New Equipment (Calculate Per Encounter Cost Using the Cost of the Old Equipment)
\$4.26	Difference or 5.01% Increase (Provider qualifies for PPS rate increase for 2003)

- F. PPS rate changes due to scope of services changes will be adjusted for the amount of the change only during the reporting period.
 - 1. In Example 1, a PPS rate increase of \$4.33 should be requested for the reporting period ending December 31, 2003.
 - 2. In Example 2, a PPS rate increase of \$4.26 should be requested for the reporting period ending December 31, 2003.
- G. Cost changes of less than 5% for a reporting year can only be used once in order to increase the PPS rate per scope of services changes. Per Example 2 and if the \$4.26 increase was approved, the cost increases incurred for new equipment purchased January 1, 2003 could not be used again with 2004 cost changes when calculating a percentage increase for 2004.

252.130 **Rate Settling For Other Ambulatory Services Encounters** **10-13-03**

- A. The initial January 1, 2001, PPS rate will include any necessary adjustment (further adjusted for inflation, per the MEI) for the cost of providing other ambulatory services.
- B. For dates of service on and after January 1, 2001, Medicaid will continue to reimburse the FQHC on a fee-for-service basis for services defined as "other ambulatory services" within the program covering each particular service.
 - 1. The FQHC must be enrolled as a "pay to" provider of that service in order to be reimbursed.
 - 2. The center will bill for dental services under the Dental Program, visual services under the Visual Care Program, etc.
 - 3. Medicaid will initially reimburse the center for other ambulatory services encounters at the lesser of the billed charge or the established Medicaid maximum allowable for the service within the program in which it is billed.
 - 4. Providers must bill Medicaid their customary charge for other ambulatory services.
- C. Centers adding other ambulatory services after January 1, 2001, may be eligible for a scope of services PPS rate change under the conditions explained in Sections 252.120 and 252.220.
- D. Other ambulatory services encounters will be rate settled up to the PPS rate annually. The settlement period will be for dates of service occurring July 1 through June 30, the same period that is inflated per the MEI.
- E. Pharmacy reimbursement and costs are not included for cost settlement purposes. Pharmacy services are considered reimbursed at cost through the Pharmacy Program.

252.140 **Rate Settling for Services Reported by CPT or HCPCS Procedure Code Other Than the FQHC Encounter Code** **10-13-03**

Arkansas Medicaid initially reimburses FQHCs for some services reported by CPT or HCPCS procedure codes other than the FQHC encounter code. They are later rate-settled as encounters in the same manner as other ambulatory services are rate-settled. See Section 260.000 for procedure codes and billing information.

- A. Effective for dates of service on and after January 1, 2003, the procedure codes listed in this manual, the Child Health Services (EPSDT) provider manual and the ARKids First-B Provider Manual (with the exception of the FQHC encounter procedure code and the telemedicine procedure code) will be initially reimbursed in accordance with the Arkansas Medicaid fee schedule, at the lesser of the billed charge or the Medicaid maximum allowable fee.

- B. The telemedicine procedure code and procedure codes for ancillary services, except for family planning-related laboratory procedures listed in this manual, will be denied.
- C. Except for ancillary services (lab, X-ray and machine tests), FQHC providers may not bill Medicaid with procedure codes that are not listed in this provider manual, the Child Health Services (EPSDT) provider manual and the ARKids First-B Provider Manual.

252.141 **Rate Settling for Vaccines for Children (VFC) Program** **10-13-03**
Immunization Administration

Medicaid requires FQHCs to report VFC immunization administration by procedure code and applicable modifier. Medicaid pays interim reimbursement to FQHCs for the administration. The vaccine administration is incident to an encounter and is rate-settled as such.

252.200 **Alternative Reimbursement Methodology for Dates of Service on** **10-13-03**
and after January 1, 2001

Written and signed agreements will be obtained from all FQHC providers who choose this alternative method.

- A. 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, FQHCs will be reimbursed an interim per encounter rate for Medicaid covered services with cost settlement at the greater of 100% of reasonable costs or the allowable per encounter rate as determined under the prospective payment system (PPS).
- B. Cost settlement will be determined from provider-submitted cost reports. See Section 250.000 for cost settlement procedures.
- C. Separate cost settlements will be made for cost reporting periods with dates of service occurring before and beginning January 1, 2001, based on the number of Medicaid encounters provided before and beginning January 1, 2001.
 - 1. An encounter means a face-to-face contact between an FQHC patient and any health professional whose services are reimbursed under the Arkansas Title XIX (Medicaid) State Plan.
 - 2. Contacts with more than one health professional and multiple contacts with the same health professional that take place on the same day and at a single location constitute a single encounter, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.
 - 3. A patient of the FQHC may have a separate family planning encounter during the same visit to the FQHC for a core service encounter; however, a family planning visit is not reimbursed separately when it takes place on the same day as a family planning surgical procedure.
 - 4. An FQHC encounter is not reimbursed separately on the same day as an obstetric or gynecologic procedure that the FQHC reports by CPT procedure code unless the encounter is for a different disorder or condition.

252.210 **Calculation of PPS Per Encounter Rate** **10-13-03**

- A. The PPS per encounter rate for each center will be calculated based on 100% of the average of the center's reasonable costs for providing Medicaid-covered services as determined from audited cost reports with ending dates in calendar year 1999 and calendar year 2000.

1. Reasonable costs are defined as those costs which are allowable under Medicare cost principles outlined in 42 CFR 413.
 2. Cost reports used for rate setting purposes must cover a fiscal period of at least a full six months.
 3. 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.
- B. PPS per encounter rates are 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 encounters for these two periods.
1. Allowable costs for each period used to set the initial PPS rate 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.
 2. Interim rates are implemented as of January 1, 2001, at the average cost per encounter as determined from the two most recent provider cost reports.
 3. Interim rates are calculated by adding the per-encounter costs of the two periods and dividing the total by two.
- C. Interim rates, initial PPS rates and final PPS rates will be adjusted annually by the Medicare Economic Index (MEI) for primary care services.
1. Rate adjustments will be equal to the previous calendar year's index percentage change and will be effective as of the first day of the provider's fiscal period.
 2. Annual MEI increases will be reduced per the number of applicable months if already used in the calculation of the initial January 1, 2001 rate.

252.211 Provider-Initiated PPS Rate Reductions**10-13-03**

Providers will receive written notification of interim rate revisions in advance of the implementation of the revised rates.

- A. Providers may request reductions of up to 20% of their January 1, 2001, interim rates by submitting a written request within 21 days after notification by Medicaid of their new interim rate.
- B. Thereafter, interim rates will be established at the allowable cost per encounter as determined from the most recent audited cost report and will be effective as of the first day after the audited cost report period.
- C. Providers may request reductions of up to 10% of subsequent interim rates by submitting a written request within 21 days after notification by Medicaid of a new interim rate. Submit interim rate reduction requests to Division of Medical Services, Financial Activities Unit. [View or print DMS, Financial Activities Unit contact information.](#)

252.220 Rate Adjustments for Scope of Services Changes**10-13-03**

- A. Each center's PPS per encounter rate will be adjusted to account for increases or decreases in scope of services. Scope of services changes are defined as:
 1. An addition or deletion of an FQHC-covered service,
 2. A change in the magnitude, intensity or character of currently offered FQHC-covered services,
 3. A change in state or federal regulatory requirements,

4. Changes 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.
- B. 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 FQHC-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 FQHC-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 center (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 A provides its own examples.
 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 A provides its own examples.
- C. All requested PPS rate increases due to scope of services changes are subject to reasonable costs criteria identified at 42 CFR 413.
- D. The provider must submit written requests for both cost increases and cost decreases due to scope of services changes. The request must be submitted (postmarked) within 5 months after the end of the provider's fiscal period and the request must identify the beginning date that the change occurred and include detailed descriptions, documentation and calculations of the changes and costs differences.
1. To qualify for a PPS rate change, the scope of services changes must equal at least a 5% total difference in the allowable per encounter cost as determined for the fiscal period and the changes must have existed during the last full 6 months of the provider's fiscal period.
 2. 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 services change and will be effective on the later of:

- a. The first date that the scope of services changed or
 - b. The beginning date of the fiscal period.
3. PPS rate changes will also be made when scope of services changes are identified through an audit or review process. In such a case, the effective date of the PPS rate change will be the later of:
- a. The first date that the scope of services changed or
 - b. The beginning date of the cost report period for which the changes should have been reported.

E. Examples:

1. FQHC Provider XYZ has a fiscal reporting period of January 1 through December 31. On September 1, 2002, Provider XYZ purchases new lab equipment to replace old obsolete equipment. The following calculations represent the changes in allowable per encounter cost for reporting periods ending December 31, 2002 and December 31, 2003.

a. Reporting Period 2002

For the reporting period ending December 31, 2002, Provider XYZ does not qualify for a scope of services PPS rate change because the change did not exist during the last six months of the fiscal period.

b. Reporting Period 2003

\$85.78	Per Encounter Cost With New Equipment (Actual Per Encounter Cost for the Period)
<u>(81.45)</u>	Less: Per Encounter Cost With Old Equipment (Calculate Per Encounter Cost Using the Cost of the Old Equipment)
\$4.33	Difference or 5.32% Increase (Provider Qualifies for PPS Rate Increase for 2003)

For reporting period ending December 31, 2003, Provider XYZ would qualify for a scope of services PPS rate change. Provider XYZ should request the PPS rate change with the submission of their December 31, 2003 cost report. If approved, the \$4.33 rate change would be retroactively applied to January 1, 2003.

2. PPS rate changes due to scope of services changes will also be applied cumulatively. In other words, less than 5% changes for a previous reporting period can be brought forward to future reporting periods. For example:

FQHC Provider XYZ with a reporting period ending December 31, 2002 purchases new lab equipment to replace old obsolete equipment as of January 1, 2002 but the cost difference is less than 5%.

a. Reporting Period 2002

\$85.78	Per Encounter Cost With New Equipment (Actual Per Encounter Cost for the Period)
<u>(83.90)</u>	Less: Per Encounter Cost With Old Equipment (Calculate Per Encounter Cost Using the Cost of the Old Equipment)
\$1.88	Difference or 2.24% Increase

(Provider does not qualify for PPS rate increase for 2002)

FQHC Provider XYZ then purchases more new lab equipment to replace old obsolete equipment as of January 1, 2003. If the new equipment purchased January 1, 2002 and January 1, 2003 combined equals to at least a 5% difference during the reporting period ending December 31, 2003, a PPS rate change can be requested for 2003.

b. Reporting Period 2003

\$89.27	Per Encounter Cost With New Equipment (Actual Per Encounter Cost for the Period)
<u>(85.01)</u>	Less: Per Encounter Cost Without New Equipment (Calculate Per Encounter Cost Using the Cost of the Old Equipment)
\$4.26	Difference or 5.01% Increase (Provider qualifies for PPS rate increase for 2003)

- F. PPS rate changes due to scope of services changes will be adjusted for the amount of the change only during the reporting period.
 - 1. In Example 1, a PPS rate increase of \$4.33 should be requested for the reporting period ending December 31, 2003.
 - 2. In Example 2, a PPS rate increase of \$4.26 should be requested for the reporting period ending December 31, 2003.
- G. Cost changes of less than 5% for a reporting year can only be used once in order to increase the PPS rate per scope of services changes. Per Example 2 and if the \$4.26 increase was approved, the cost increases incurred for new equipment purchased January 1, 2003 could not be used again with 2004 cost changes when calculating a percentage increase for 2004.
- H. MEI adjustments will be allocated per months of service applicable to an approved PPS rate change.

252.230 Reimbursement for Other Ambulatory Services Encounters in FQHCs Electing the Alternative Reimbursement Methodology for Dates of Service on and after January 1, 2001 10-13-03

Medicaid will reimburse the FQHC for services defined as "other ambulatory services" within the program covering each particular service.

- A. The FQHC must enroll as a "pay to" provider of that service.
 - 1. The center will bill for dental services under the Dental Program, visual services under the Visual Care Program, etc.
 - 2. Medicaid will reimburse the center for other ambulatory services encounters at the lesser of the billed charge or the established Medicaid maximum allowable for the service within the program in which it is billed.
 - 3. Providers must bill Medicaid their customary charge for other ambulatory services.
- B. Medicaid will include the other ambulatory services encounters and applicable costs when calculating annual settlements at the greater of costs or the prospective rate.
- C. Pharmacy reimbursement and costs will not be included for cost settlement purposes. Pharmacy services are considered reimbursed at cost through the Pharmacy Program.

252.231 **Fee Schedules** **12-1-12**

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov/> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

252.240 **Settlement for Services Reported by CPT or HCPCS Procedure Code Other than the FQHC Encounter Code** **10-13-03**

Arkansas Medicaid initially reimburses FQHCs for some services reported by CPT or HCPCS procedure codes other than the FQHC encounter code. They are later settled as encounters in the same manner as other ambulatory services are settled.

- A. Effective for dates of service on and after January 1, 2003, the procedure codes listed in this manual, the Child Health Services (EPSDT) provider manual and the ARKids First-B Provider Manual (with the exception of the FQHC encounter procedure code and the telemedicine procedure code) will be initially reimbursed in accordance with the Arkansas Medicaid fee schedule, at the lesser of the billed charge or the Medicaid maximum allowable fee.
- B. The telemedicine procedure code and procedure codes for services, except for family planning-related laboratory procedures listed in this manual, will be denied.
- C. Except for ancillary services (lab, X-ray and machine tests), FQHC providers may not bill Medicaid with procedure codes that are not listed in this provider manual, the Child Health Services (EPSDT) provider manual and the ARKids First-B Provider Manual.

252.241 **Settling for Vaccines for Children (VFC) Program Immunization Administration** **10-13-03**

Medicaid requires FQHCs to report VFC immunization administration by procedure code and applicable modifier. Medicaid pays interim reimbursement to FQHCs for the administration. The vaccine administration is incident to an encounter and is settled as such.

253.000 **Filing Cost Report Form CMS-222-92 (formerly HCFA-222-92)** **10-13-03**

- A. At the end of an FQHC's fiscal year, it must complete form CMS-222-92 (formerly HCFA-222-92).
- B. The deadline for submission to Medicaid is 5 months from the end date of the cost reporting period.
- C. Forward the completed Form CMS-222-92 (formerly HCFA-222-92) to Division of Medical Services, Financial Activities Unit. [View or print DMS, Financial Activities Unit contact information.](#)
- D. Medicaid will suspend reimbursement, pending receipt of the CMS-222-92 (formerly HCFA-222-92), to any FQHC not submitting the CMS-222-92 to Financial Activities by the 5-month deadline.
- E. If a written request for an extension is received by the Financial Activities Unit ten or more working days in advance of the report due date and a written extension is granted,

Medicaid will not suspend reimbursement, provided that the extended due date is met. Each request for extension will be considered on its merit. No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which caused a late report.

254.000 Access to Subcontractor's Records 10-13-03

When the FQHC has a contract with a subcontractor for services costing or valued at \$10,000.00 or more over a 12-month period, the contract must contain a clause giving the Medicaid agency access to the subcontractor's books. Access must also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor. The contract shall contain a provision allowing access as explained in Section 204.000.

255.000 Rate Appeal and/or Cost Settlement Appeal Process 10-13-03

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. [View or print Director, Division of Medical Services contact information](#). 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.

260.000 BILLING PROCEDURES 3

261.000 Introduction to Billing 7-1-20

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

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

For settlement purposes, each of these procedures are considered an encounter.

262.000 CMS-1500 Billing Procedures

262.100 CPT Procedure Codes

262.110 FQHC Encounter Service 2-1-22

FQHCs bill Medicaid for a core services encounter (which includes all services and supplies incident to the encounter) with procedure code, "FQHC Encounter Service."

[View or print the procedure codes for Federally Qualified Health Center \(FQHC\) services.](#)

Use type of service code 9 (paper claims only) with. Medicaid pays the facility's current established rate for each encounter.

262.120 Telemedicine 2-1-22

Use procedure code and type of service code Y (paper claims only) to indicate telemedicine charges.

[View or print the procedure codes for Federally Qualified Health Center \(FQHC\) services.](#)

The charge associated with this procedure code should be an amount attributable to the telemedicine service, such as line (or wireless) charges. Medicaid will deny the charge and capture it in the same manner as with ancillary charges.

262.130 Obstetric and Gynecologic Encounters 2-1-22

Bill for the following obstetric and gynecologic procedures with the CPT procedure codes indicated and type of service code 2 (paper claims only).

[View or print the procedure codes for Federally Qualified Health Center \(FQHC\) services.](#)

For settlement purposes, each of these procedures is considered an encounter.

262.140 Family Planning 2-1-22

Bill Medicaid for family planning services with applicable procedure codes listed in Sections [262.141](#) through [262.152](#).

262.141 Family Planning and Post-Sterilization Visits 2-1-22

Bill for family planning visits and post-sterilization visits with type of service code A (paper billing only) and a family planning diagnosis.

[View or print the procedure codes for Federally Qualified Health Center \(FQHC\) services.](#)

262.142 Family Planning Procedures 2-1-22

Bill for family planning procedures with a type of service code A (paper billing only) and a family planning diagnosis.

[View or print the procedure codes for Federally Qualified Health Center \(FQHC\) services.](#)

262.143 Contraceptives 2-1-22

Bill for contraceptives with type of service code A (paper claims only) and a family planning diagnosis.

[View or print the procedure codes for Federally Qualified Health Center \(FQHC\) services.](#)

262.144 Contraceptive Injections—Depo-Provera 2-1-22

[View or print the procedure codes for Federally Qualified Health Center \(FQHC\) services.](#)

262.150 Family Planning Laboratory Procedures

262.151 Local Procedure Codes 2-1-22

Bill for family planning laboratory procedures with type of service code A (paper claims only) and a family planning diagnosis.

[View or print the procedure codes for Federally Qualified Health Center \(FQHC\) services.](#)

262.152 National Procedure Codes 2-1-22

Bill for family planning laboratory procedures with a type of service A (paper claims only) and a family planning diagnosis.

[View or print the procedure codes for Federally Qualified Health Center \(FQHC\) services.](#)

262.160 Non-Payable and Excluded Procedure Codes 10-13-03

FQHC providers may bill Medicaid only with the procedure codes authorized, directly or by reference, in Sections 262.141 through 262.152 above and in subsequent official correspondence from the Arkansas Medicaid Program. All other procedure codes will be denied as non-payable to FQHCs. All Medicaid-covered services and supplies not included, directly or by reference, in Sections 262.141 through 262.152 above are incident to FQHC encounters. The charges for any such services and supplies are to be included in the FQHC's charge for the encounter.

262.200 FQHC National Standard Place of Service Codes

262.210 FQHC Place of Service Codes 7-1-07

Place of Service (POS)	National POS Code
Inpatient Hospital	21
Outpatient Hospital	22
Emergency Room - Hospital	23
Patient's Home	12
Nursing Facility	32
Skilled Nursing Facility	31
Ambulance	41
Other Locations	99
Ambulatory Surgical Center	24
Federally Qualified Health Center (FQHC)	50
Inpatient Psychiatric Facility	51

262.300 Billing Instructions – Paper Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](#)

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

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](#)

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

262.310 Completion of the CMS-1500 Claim Form

12-15-14

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/emergency telephone
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.

9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED SEX	Reserved for NUCC use. Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
<hr/>	
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
<hr/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH SEX	Not required. Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
<hr/>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
<hr/>	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

<p>14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</p>	<p>Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.</p> <p>Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.</p>
<p>15. OTHER DATE</p>	<p>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</p> <p>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</p> <p>454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation</p>
<p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</p>	<p>Not required.</p>
<p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</p>	<p>Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.</p>
<p>17a. (blank)</p>	<p>Not required.</p>
<p>17b. NPI</p>	<p>Enter NPI of the referring physician.</p>
<p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</p>	<p>When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.</p>
<p>19. ADDITIONAL CLAIM INFORMATION</p>	<p>Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.</p>
<p>20. OUTSIDE LAB? \$ CHARGES</p>	<p>Not required Not required.</p>

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use “9” for ICD-9-CM.</p> <p>Use “0” for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>
22. RESUBMISSION CODE ORIGINAL REF. NO.	<p>Reserved for future use.</p> <p>Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.</p>
23. PRIOR AUTHORIZATION NUMBER	<p>The prior authorization or benefit extension control number if applicable.</p>
24A. DATE(S) OF SERVICE	<p>The “from” and “to” dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	<p>Two-digit national standard place of service code.</p>
C. EMG	<p>Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.</p>
D. PROCEDURES, SERVICES, OR SUPPLIES	<p>CPT/HCPCS One CPT or HCPCS procedure code for each detail.</p> <p>MODIFIER Modifier(s) if applicable.</p>
E. DIAGNOSIS POINTER	<p>Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.</p>

F.	\$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. * Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30.	RESERVED	Reserved for NUCC use.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a.	(blank)	Not required.
b.	(blank)	Not required.
33.	BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a.	(blank)	Enter NPI of the billing provider or

b. (blank) Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

262.400 Special Billing Procedures

262.410 Ancillary Charges 10-13-03

Diagnostic laboratory, X-ray and machine test procedures are ancillary services. FQHCs may include ancillary charges in their billings to the Arkansas Medicaid Program for services provided to eligible Medicaid beneficiaries. Medicaid denies the ancillary charges and captures them for tracking purposes only. Bill for ancillary services at the provider's usual rate, not at the FQHC encounter rate. Use CPT procedure codes unless instructed otherwise in this manual or in official Arkansas Medicaid correspondence.

262.420 Preventive Medicine 10-13-03

262.421 Child Health Services (EPSDT) Screens 10-13-03

Bill Medicaid for Child Health Services (EPSDT) screens in accordance with the billing instructions in the Child Health Services (EPSDT) provider manual.

262.422 ARKids First-B Preventive Health Screens 10-13-03

Bill Medicaid for ARKids First-B preventive health screens in accordance with the billing instructions in the ARKids First-B provider manual.

262.423 Vaccines for Children (VFC) Program 10-13-03

Bill Medicaid for the administration of VFC Program immunizations in accordance with instructions in the Child Health Services (EPSDT) provider manual and the ARKids First-B provider manual.

262.424 Other Ambulatory Services 4-1-07

FQHCs must bill for other ambulatory services (e.g., Dental, Visual Care, etc.) in accordance with the billing instructions of the program in which the other ambulatory services are covered and with the provider identification number for that program. Initial reimbursement for other ambulatory services is by fee schedule, at the lesser of the billed charge or the Medicaid maximum allowable fee.

262.430 Medication Assisted Treatment 9-1-20

When billing an encounter for (MAT) the actual rendering provider's NPI must be entered on the claim. If the billing provider's number is used, the claim will deny.

262.440 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.

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 (View ICD codes.)

262.441

National Drug Codes (NDCs)

1-1-23

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor](#) website.

A complete listing of “**Covered Labelers**” is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

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

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the “5-4-2” format.

Diagram 2

00123	0456	78
LABELER CODE	PRODUCT CODE	PACKAGE CODE
(5 digits)	(4 digits)	(2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

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

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233

01111 456 71	01111045671
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B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

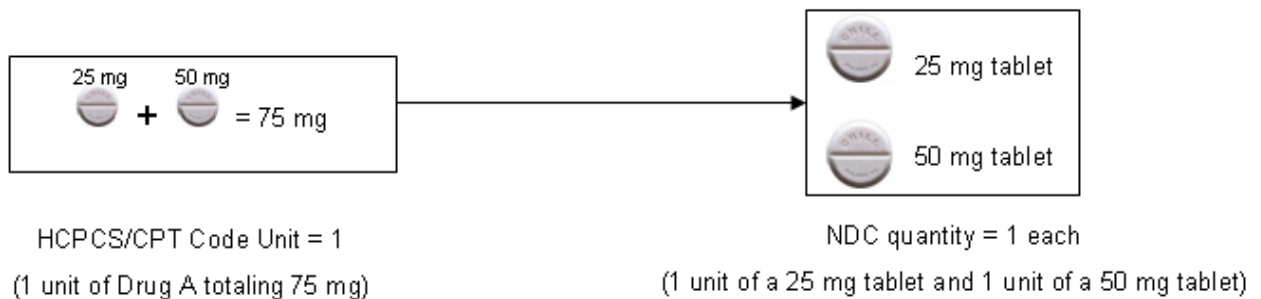
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

I. Claims Filing

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

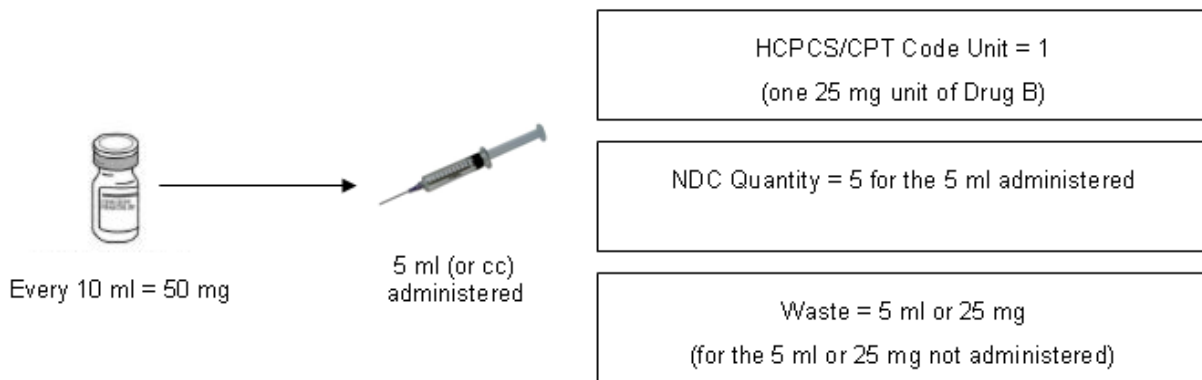
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC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

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5. For billing wastage, see bullets A (Electronic Claims Filing) and B (Paper Claims Filing) below.

Diagram 5



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

Providers are instructed to bill as follows:

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

NOTE: The NDCs listed above are not the same (unless with a JW modifier). Same NDCs shall be billed on a single line with appropriate units.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

B. Paper Claims Filing – CMS-1500

Providers are instructed to bill as follows:

- 1 NDC for a procedure – 1st/only detail shall be billed with no modifier
- 2 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- 4 or more NDCs for same procedure – 1st detail shall be billed with a KP and 2nd and subsequent details shall be billed with a KQ modifier
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation

- JW = Drug wastage

Diagram 6

1	24. A. DATE(S) OF SERVICE					B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF UNITS	H. SPEC. INQ. NO.	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
	MM	DD	YY	MM	DD			YY	CPT/HCPCS	MODIFIER							
1	N4	12345678912	UN	1.00				Z1234	KP		1	25 00	1		NPI	123456789	
2	01	01	22	01	01	22	11										
2	N4	01111222223	UN	1.00				Z1234	KQ		1	25 00	1		NPI	123456789	
3	01	01	22	01	01	22	11										
3	N4	44444455506	ML	3.0				Z1234	KQ		1	75 00	3		NPI	123456789	
4	01	01	22	01	01	22	11										
4	N4	44444455506	ML	2.0				Z1234	JW		1	50 00	2		NPI	123456789	
5	01	01	22	01	01	22	11										
6																	

II. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

III. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

262.442 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 Federally Qualified Health Center \(FQHC\) 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.

See Section 262.441 for additional information regarding National Drug Code (NDC) billing.