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200.000 PHARMACY GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Pharmacy Providers 11-1-09

Pharmacy services providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. The pharmacy must have a current retail pharmacy permit issued by the applicable State Board of Pharmacy. A current copy of the pharmacy permit must accompany the provider application and Medicaid contract.
- B. The pharmacy must have a DEA number issued by Drug Enforcement Agency. A current copy of the DEA certificate must accompany the provider application and Medicaid contract.
- C. Indian Health Services (IHS) pharmacy providers enrolled in other states' pharmacy programs will meet Arkansas enrollment criteria if they provide proof of other state enrollment.

201.100 Arkansas Medicaid Participation Requirements for Prescribing Pharmacists and for Pharmacies Administering Vaccines 6-1-22

The Arkansas Medicaid Program will allow pharmacists to enroll individually as atypical providers to prescribe and administer specified drugs and test and screen for certain health conditions, per current allowable protocols. Pharmacists are not billing providers, but they may be rendering providers on medical claims. Pharmacists will be allowed as prescribing providers on pharmacy claims for drugs identified in current protocol.

The Arkansas Medicaid Program will reimburse pharmacies the cost and administration fee for selected vaccines and immunizations for Medicaid clients three (3) years of age and older under current protocol and written consent of the parent or legal guardian of the minor. Consent must be obtained before the administration of the vaccine or immunization. Written protocol and consent must be retained and is subject to reporting requirements. For a complete list of covered vaccines and CMS-1500 billing instructions, please refer to the [CMS-1500 Claim Form Billing Instructions](#).

The Arkansas Medicaid Program will reimburse pharmacies the administration fee for selected vaccines that are obtained through the Vaccine for Children Program (VFC) or ARKids-B SCHIP Vaccine Program. Please refer to section 292.950 of the Physician manual for VFC vaccines billing procedures and section 262.430 for ARKids-B SCHIP vaccine. All Arkansas State Board of Pharmacy laws and regulations will apply.

To be eligible for participation, the pharmacy must meet the following criteria, in addition to those specified in Section 201.000:

- A. Complete Section III, Item 22, of the enrollment application ([view or print Provider Enrollment application material](#)) if the pharmacist is certified to administer the influenza virus and pneumococcal polysaccharide vaccines; and
- B. Pharmacies must be enrolled in the Title XVIII (Medicare) Program to administer the vaccines.

Refer to Section 210.100 for scope of coverage; Section 213.000 for benefit limits.

202.000 Pharmacy Providers in Arkansas and Bordering States 3-14-15

Pharmacies in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as **routine services providers** if they meet all Arkansas Medicaid participation requirements as outlined in Section 201.000 and Section 201.100.

- A. A **routine services provider** may provide the full range of pharmacy services.
- B. Reimbursement for pharmacy services is contingent on:
 - 1. Medicaid coverage (see Scope, Section 210.100) and
 - 2. The provider's compliance with billing requirements (see Reimbursement, Section 250.000, of this manual).

NOTE: Border state Pharmacy providers who deliver services across the state line into Arkansas must maintain an Arkansas pharmacy permit on file. If you have questions regarding this policy, please contact the Arkansas State Pharmacy Board.

203.000 Pharmacies in Non-Bordering States 3-14-15

Pharmacies in non-bordering states may be enrolled as routine services providers for prescription claims resulting from emergency services provided in a non-bordering state or for products not available in Arkansas.

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

Source: 42 U.S. Code of Federal Regulations §422.2 and §424.101.

Requests for enrollment as a non-bordering routine services provider must be made in writing and forwarded to Provider Enrollment. [View or print Provider Enrollment contact information](#). If a pharmacy is approved to enroll as a non-bordering pharmacy provider, an Arkansas Medicaid Provider Contract must be signed and approved before reimbursement can be made. A provider number will be assigned upon receipt and approval of the application and contract.

Providers who have agreements with Medicaid to provide other services to Medicaid beneficiaries must have a separate provider application, Medicaid contract and Request for Taxpayer Identification Number and Certification in order to provide pharmacy services. A separate provider number, exclusive to pharmacy services, is assigned.

204.000 Administrative Requirements for Pharmacies 1-1-16

- A. Pharmacy providers are prohibited from offering incentives (e.g., discounts, rebates, refunds or any other similar gratuity) for the purpose of soliciting the patronage of Medicaid beneficiaries. See Section I of this manual.
- B. Pharmacies may be required to participate in studies as the Department of Health and Human Services deems necessary in order to maintain an equitable program.
- C. In order to maintain the integrity of the program, the Arkansas Division of Medical Services has the right to collect medication samples from the beneficiaries (or long-term care facility, if a beneficiary is a patient there).

- D. Information regarding ownership or financial interest and the identity of any agent or managing employee convicted of a Medicaid-related offense must be provided to the Arkansas Division of Medical Services within thirty (30) days of a written request.

205.000 Regulations and Procedures Governing Payment to Pharmacies for Pharmaceutical Services for Eligible Medicaid Beneficiaries 4-25-14

Clozapine must be billed as one prescription for a month's supply. Medicaid must be billed when the first week's supply is given. If the patient does not receive a full month's supply, the claim can be adjusted at the end of the month to the quantity actually dispensed to the patient.

206.000 Electronic Signatures 10-8-10

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

210.000 PROGRAM COVERAGE

211.000 Scope 2-1-20

The Arkansas Medicaid Pharmacy Program conforms to 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.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the [DHS Contracted Pharmacy Vendor website](#). [View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.](#) Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes. Additions or deletions by labelers are submitted to the State by the Centers for Medicare and Medicaid Services (CMS), the website will be updated.

The Arkansas Medicaid Program will cover the following drug categories:

- A. Prescription drugs are covered by the Arkansas Medicaid Program pursuant to an order from an authorized prescriber. The Drug Listing located on the [DHS Contracted Pharmacy Vendor website](#) lists those products covered by the Arkansas Medicaid Program that have a State Actual Acquisition Cost (SAAC).

As changes are made to the drug coverage, providers will be notified of the revisions.

- B. Over-the-counter items are listed on the [DHS Contracted Pharmacy Vendor website](#). These items are covered only if they contain an appropriate National Drug Code on their label and are manufactured by a company that has signed a rebate agreement. Over-the-counter items are not covered for long-term care facility residents. [View or print a list of over-the-counter items.](#)

The Arkansas Medicaid Program will reimburse pharmacies the cost and administration fee for selected vaccines and immunizations for Medicaid beneficiaries age seven (7) years of age to eighteen (18) years of age under a general written protocol and written consent of the parent or legal guardian of the minor. Consent must be obtained before the administration of the vaccine or immunization. Written protocol and consent must be retained and is subject to reporting requirements. The Arkansas Medicaid Program will continue to reimburse pharmacies the cost and administration fee of selected vaccines for Medicaid beneficiaries age nineteen (19) and older. For a complete list of covered vaccines and CMS-1500 billing instructions, please refer to the [CMS-1500 Claim Form Billing Instructions](#). **Error! Hyperlink reference not valid.**No primary care physician (PCP) referral is required to administer the vaccines.

The influenza virus vaccine is limited to one (1) per state fiscal year (July through June). The pneumococcal polysaccharide vaccine is limited to one every ten (10) years.

The Arkansas Medicaid Program will reimburse pharmacies the administration fee for selected vaccines that are obtained through the Vaccine for Children Program (VFC) or ARKids-B SCHIP Vaccine program. Please refer to section 292.950 of the Physician manual for VFC vaccines billing procedures and section 262.430 for ARKids-B SCHIP vaccine. No primary care physician (PCP) referral is required to administer the vaccines. All Arkansas State Board of Pharmacy laws and regulations will apply.

Effective 8/1/15, ARKids-B beneficiaries are no longer eligible for the VFC program. However, providers are still able to obtain vaccines to administer to ARKids-B beneficiaries by contacting the Arkansas Department of Health (ADH) and indicating the need to order “ARKids-B SCHIP vaccines or Vaccines for Children (VFC).” VFC vaccines can also still be obtained by contacting ADH. For dates of service on or after 8/1/15, modifier “SL” will be required when billing for the administration of SCHIP vaccines to ARKids-B beneficiaries. Modifier EP, TJ is required when billing for administration of VFC vaccines for ARKids-A beneficiaries.

Medicaid will reimburse the Medicare deductible or coinsurance for all beneficiaries receiving both Medicare and Medicaid benefits in reference to vaccines.

Pharmacies must use the CMS-1500 claim form when billing Medicaid for these vaccines.

211.105 Coverage of Medication Assisted Treatment and Opioid Use Disorder or Alcohol Use Disorder Treatment Drugs 2-1-24

Coverage of preferred prescription drugs (preferred on the PDL) for opioid or alcohol use disorder are available without prior authorization to eligible Medicaid beneficiaries. Products for other use disorders may still require PA. Additional criteria can be found at the [DHS contracted Pharmacy vendor's website](#).

Coverage and Limitations

- A. Reimbursement for preferred drugs is available with a valid prescription when prescribed according to FDA approved label.
- B. Prescription drugs will not count against the monthly prescription benefit limit and are not subject to co-pay when used for a primary diagnosis of opioid or alcohol use disorder.
- C. FDA dosing and prescribing limitations apply.

212.000 Exclusions 8-1-24

- A. Products manufactured by non-rebating pharmaceutical companies.
- B. Effective January 1, 2006, the Medicaid agency will not cover any drug covered by Medicare Part D for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
- C. The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid beneficiaries under § 1927 (d) of the Social Security Act, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses; with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 CFR § 423.104 (f) (1) (ii) (A), to full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs are set forth on the [DHS Contracted Pharmacy Vendor website](#).

1. Select agents when used for weight gain

2. Select agents when used for the symptomatic relief of cough and colds
 3. Select prescription vitamins and mineral products, except prenatal vitamins and fluoride
 4. Select nonprescription drugs
- D. Medical accessories are not covered under the Arkansas Medicaid Pharmacy Program. Typical examples of medical accessories are atomizers, nebulizers, hot water bottles, fountain syringes, ice bags and caps, urinals, bedpans, cotton, gauze and bandages, wheelchairs, crutches, braces, supports, diapers, and nutritional products.

213.000 Benefit Limits

213.100 Monthly Prescription Limits

2-1-24

- A. Each prescription for all Medicaid-eligible clients may be filled for up to a maximum thirty-one-day supply. Maintenance medications for chronic illnesses must be prescribed and dispensed in quantities sufficient (not to exceed the maximum thirty-one-day supply per prescription) to effect optimum economy in dispensing. For drugs that are specially packaged for therapy exceeding thirty-one (31) days, the days' supply limit (other than thirty-one (31)), as approved by the agency, will be allowed for claims processing. Contact the Pharmacy Help Desk to inquire about specific days' supply limits on specially packaged dosage units.

[View or print the contact information for the DHS contracted Pharmacy vendor.](#)

- B. Each Medicaid-eligible client twenty-one (21) years of age and older is limited to six (6) Medicaid-paid prescriptions per calendar month.

Each prescription filled counts toward the monthly prescription limit except for the following:

1. Family planning items. Including without limitation, birth control pills, contraceptive foams, contraceptive sponges, suppositories, jellies, prophylactics, and diaphragms;
 2. Prescriptions for Medicaid-eligible long-term care facility residents(must be for Medicaid-covered drugs);
 3. Prescriptions for Medicaid-eligible clients under twenty-one (21) years of age in the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. (must be for Medicaid-covered drugs);
 4. Prescriptions for opioid or alcohol use disorder treatment;
 5. Prescriptions for tobacco cessation products;
 6. Prescriptions for the treatment of high blood pressure;
 7. Prescriptions for the treatment of hypercholesterolemia;
 8. Blood modifier medications;
 9. Prescriptions for the treatment of diabetes; and
 10. Inhalers to treat respiratory illness.
- C. Living Choices Assisted Living Program clients are eligible for up to nine (9) medically necessary prescriptions per month.
- D. After the client has received the maximum monthly benefit or the maximum monthly extended benefit, they will be responsible for paying for their own medications for the remainder of the month.

213.200 Prescription Refill Limit 1-1-22

Refills are reimbursable under the Arkansas Medicaid Pharmacy Program only if they are specifically authorized on the original prescription or if authorized by the prescribing provider at a later date and recorded by the pharmacist on the original prescription when refilled. Refills shall be in accordance with federal and state laws.

Pharmacies will have a maximum of fourteen (14) days to reverse original prescriptions and refills that were not provided to the client.

214.000 Administrative Reconsiderations 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.

215.000 Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program 1-1-22

Medicaid provides a Child Health Services (EPSDT) Program to detect, diagnose, and treat medical problems in Medicaid clients under twenty-one (21) years of age. Prescriptions for Medicaid clients under twenty-one (21) years of age in the Child Health Services (EPSDT) Program are not subject to a monthly prescription limit.

As with all other Medicaid prescriptions, Medicaid clients under twenty-one (21) years of age in the Child Health Services (EPSDT) Program may have each prescription filled for a maximum thirty-one-day supply.

216.000 Long-Term Care Facility Residents**216.100 Medical Supplies for Long-Term Care Facility Residents 8-1-24**

A pharmacy often supplies items that are not covered under the Arkansas Medicaid Program to Medicaid eligibles in a long-term care facility. Under the cost-related reimbursement system in which long-term care (LTC) facilities are reimbursed, many of these items are the financial responsibility of the facility; therefore, the patient or the patient's family should not be billed for these items. The facility must furnish the following items to Medicaid beneficiaries:

- A. First aid supplies (e.g., small bandages, merthiolate, mercurochrome, hydrogen peroxide, ointments for minor cuts and abrasions);
- B. Dietary supplies (e.g., salt and sugar substitutes, supplemental feedings, equipment for preparing and dispensing tube feedings);
- C. Items normally stocked by the facility in gross supply and distributed in small quantities (e.g., alcohol, hydrogen peroxide, applicators, cotton balls, tongue depressors);
- D. All over-the-counter drugs and glucose monitors and supplies;
- E. Enemas and douches—including equipment and solution (also disposables);
- F. Catheters;

- G. Special dressings (e.g., gauze, 4-by-4s, ABD pads, surgical and micropore tape, telfa gauze, ace bandages);
- H. Colostomy drainage bags and
- I. Equipment required for simple tests such as clinitest, acetest and dextrostix.

216.101 Medical Supplies Covered as a Pharmacy Benefit 8-1-24

The pharmacy National Council for Prescription Drug Program (NCPDP) benefit for the Arkansas Medicaid pharmacy program covers continuous glucose monitors (CGMs) and other diabetic supplies. This coverage would include CGMs and supplies, patch type insulin pumps and supplies, and blood glucose monitors (BGMs) and supplies.

- A. Medicaid beneficiaries are eligible for diabetic supplies processed as a pharmacy claim submission by pharmacies or DME providers and the provider (DME or pharmacy) will be reimbursed at the Wholesale Acquisition Cost (WAC) plus the applicable professional dispensing fee.
- B. Traditional insulin pumps requiring tubing and cannula type supplies will remain processed as a medical benefit.
- C. Beneficiaries with Medicare Part B benefits will continue to be serviced under the Durable Medical Equipment (DME) program.
- D. For coverage details concerning prior authorization requirements and preferred product list see the [DHS Pharmacy Vendor's website](#) for specific information.

216.200 Prescription Benefits for Long-Term Care Facility Residents 8-1-21

Prescriptions for Medicaid-eligible LTC facility residents are not subject to a monthly prescription limit; however, the drug product must be covered under the Arkansas Medicaid Pharmacy Program. Information is available from DHS or its contracted Pharmacy Vendor. [View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.](#)

216.201 Prescription Benefits for Hospice Patients in Long-Term Care Facilities 1-1-22

Medicaid clients who have elected to receive hospice services in LTC facilities may only use their prescription drug benefits to treat conditions not directly related to their terminal illness. Please refer to section 213.100 for monthly prescription limits. *Drugs related to the terminal illness must be furnished by the hospice.*

216.202 Regulations Governing Cycle-Fill and Pharmacy Notification for Long-Term Care Facilities 1-1-22

Only oral solid medications may be cycle-filled. However, if an oral solid medication meets one (1) of the categories below, then that oral solid medication **may not** be cycle-filled.

- A. PRN or "as needed" medications;
- B. Controlled drugs (CII – CV);
- C. Refrigerated medications;
- D. Antibiotics; or
- E. Anti-infectives.

When a facility notifies a pharmacy in writing of any change of condition that affects the medication status of a resident, the pharmacy shall immediately amend the filling of the prescription to conform to the changed medication requirement of the resident.

For purposes of this section, *change of condition* includes death, discharge, or transfer of a resident as well as medical changes of condition that necessitate a change to the medication prescribed or the dosage given.

216.300 Pharmacy Drug Distribution Systems for Long-Term Care Facility Residents 10-13-03

Generally, there are two (2) types of drug distribution systems used in long-term care facilities. They are the traditional packaging system and unit-dose system. The Pharmacy Program does not utilize a different dispensing fee to calculate reimbursement for various types of drug distribution systems.

Pharmacy providers for long-term care facilities must supply 24-hour service to their patients regardless of the drug distribution system used.

217.000 Federal Public Health Service's 340B Drug Pricing Program 4-1-23

All covered entities that participate in the Federal Public Health Service's 340B Drug Pricing Program that carve Arkansas Medicaid into the 340B program are required to bill Arkansas Medicaid using their 340B Actual Invoice Price for drugs.

- A. Covered entities that bill Arkansas Medicaid for physician administered drugs, including specialty drugs, are required to bill Arkansas Medicaid using their 340B Actual Invoice Price.
- B. Pharmacies are required to bill Arkansas Medicaid using their 340B Actual Invoice Price for Covered Legend and non-legend drugs, including specialty drugs, purchased through the Federal Public Health Service's 340B Drug Pricing Program. The 340B covered entity pharmacies that carve Medicaid into the 340B Drug Pricing Program will be reimbursed the lesser of the 340B Actual Invoice Price, or the 340B ceiling price [provided or calculated by Average Manufacturer Price (AMP) minus Unit Rebate Amount (URA)] plus the established professional dispensing fee, minus the beneficiary's copayment. The 340B actual invoice price for each drug reimbursement covered under this program must be submitted to the Department prior to any claims being processed. The 340B pharmacies will identify on claim submission using the National Council for Prescription Drug Programs (NCPDP) indicator for drugs purchased through the 340B program. Drugs purchased outside the 340B program shall be submitted without the NCPDP 340B claim indicator and will be reimbursed using the lesser of methodology plus the established professional dispensing fee minus the beneficiary's copayment. All applicable federal and state supplemental rebates will be applied to claims submitted without the NCPDP 340B claim indicator. The State will not recognize 340B contract pharmacies. The 340B contract pharmacies are required to carve Medicaid claims out of the 340B Drug Pricing Program. Claims exceeding the 340B ceiling price as published or calculated by Average Manufacturer Price (AMP) minus Unit Rebate Amount (URA) will be subject to audit and may reject at point of sale.

Pharmacy providers who submit NCPDP claims to the Arkansas Medicaid Program on or after January 1, 2012, will be required to send Value 07, 08, or 13 in the Basis of Cost Determination field (423-DN). The 340B providers have contractual agreements with federally qualified 340B entities, enabling special purchase of medication at federal bid pricing. These medications are reserved for only beneficiaries meeting the federal definition of 340B patients. Claims for prescriptions filled with medications purchased through the 340B program will carry the 08 value (340B Pricing) in the Basis of Cost Determination Field. Claims submitted with usual and customary pricing will carry the 07 value (Usual and Customary Pricing) in this field. Claims for

prescriptions filled with non-340B purchased medication AND given a special price will carry the 13 value (Special Pricing) in this field.

218.000 Participating Manufacturer/Distributor Listing 8-1-21

Due to the importance of maintaining accurate prices in the drug master file, it is necessary that drug companies keep various drug pricing contractors informed of all product and price revisions. The Arkansas Medicaid Program's fiscal agent contracts with a national compendia to provide pricing information. It is the pharmacists' responsibility to contact the DHS contracted Pharmacy Vendor's Help Desk to determine if a manufacturer's products are listed in the national compendia drug file. [View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.](#)

219.000 Use of Generic Drugs 4-1-17

When a pharmacist receives a prescription for a brand- or trade-name drug, the pharmacist must

- A. Dispense the lower-cost generically equivalent drug product, when available. However, this does not prevent the beneficiary from purchasing the brand- or trade-name product if they choose to pay for the prescription.

OR

- B. If the brand-name drug has a federal upper limit (FUL), State Actual Acquisition Cost (SAAC) or generic NADAC rate, the pharmacist may dispense the brand-name product but will only be reimbursed at the applicable FUL, SAAC or generic NADAC rate.

220.000 Utilization Review 3-14-15

Drug utilization review procedures have been established for program control. It is expected that with the cooperation of provider pharmacists, high standards of patient care may be achieved through the promotion of rational drug therapy.

The pharmacist assumes professional responsibility in dispensing drugs to eligible beneficiaries under the Medicaid Program. He or she may refuse to dispense any prescription that appears to be improperly executed or, in his or her professional judgment, is unsafe as presented. He or she may refuse to dispense drugs to known addicts or to persons known to "shop" for prescribing providers or pharmacies in an effort to obtain more drugs than one prescriber would authorize.

Prospective Drug Utilization Review (ProDUR) alerts will provide for a review of drug therapy at the point of sale where each prescription is filled to allow the pharmacist to make sound professional judgment decisions concerning any potential drug therapy problems. The pharmacist may override the ProDUR alert, after professional consideration of the information, if an override is necessary for the health and well-being of the beneficiary. All information pertaining to ProDUR overrides is retained on file with Medicaid.

221.000 Record-Keeping Requirements 11-1-09

- A. Medicaid requires that drug records (e.g., purchase invoices, official dispensing records, prescriptions and inventory records) must be kept in a manner that is readily retrievable and retained for at least five (5) years or until all issues are resolved regarding audits, litigations, appeals, etc. Although the Arkansas State Board of Pharmacy requires record retention for at least two (2) years, the record-retention requirement is expanded to five (5) years for Medicaid providers. See Section 140.00 for additional details for record keeping requirements.
- B. Pharmacy providers furnishing any Medicaid-covered service, for which a prescription is required by law, by Medicaid rule, or both, must have a copy of the prescription for such

good or service. Unless required earlier by other rule or law, the provider must obtain a copy of the prescription within five (5) business days of the date the prescription is written.

- C. The Pharmacy provider must maintain a copy of each relevant prescription in the Medicaid beneficiary's records and follow all prescriptions and care plans.

221.100 Auditing Procedures

3-14-15

Each Medicaid-enrolled pharmacy provider will be subject to an audit of their records at any time. Providers must make available to the representatives of the Division of Medical Services, or their designated agents, all required records at the time of an audit. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, pharmacies must present any dispute of the findings within thirty (30) days after the date of the recoupment notice.

Auditors will make announced or unannounced audits of providers. Pharmacies are encouraged to develop and maintain record-keeping standards to ensure the accessibility of required records by any member of the pharmacy staff. The absence of the pharmacy owner or manager is not a valid reason for unavailability of records. Documentation provided to the State after the audit is complete is too late for consideration. To avoid imposition of sanctions due to failure to provide requested records, pharmacies must ensure that the auditors receive the following information within a timely manner:

A. Accommodations and Records Provided to Auditors

The pharmacist on duty shall disclose the following information in whatever medium it is maintained upon request to the auditor including but not limited to:

1. Working space
2. Daily logs of all Medicaid and non-Medicaid prescriptions
3. Access to computer terminal
4. Working demonstration of computer system used by the pharmacy
5. Original prescriptions ("hard copies") of Medicaid and non-Medicaid customers (for purposes of confirming billed information, pricing and brand medically necessary documentation)
6. A completed questionnaire regarding pharmacy pricing/discount policies, services, staffing, and computer capabilities
7. Signature logs signed by the persons picking up or accepting delivery of Medicaid prescriptions and
8. Third party explanation of benefits (EOB's) to document claim denial by the third party

B. Pricing Documentation

Routine audits consist of the following:

1. Verification of the claim information, including but not limited to:
 - a. Beneficiaries name
 - b. Dates of service
 - c. Drug dispensed
 - d. Drug description
 - e. Drug strength
 - f. Quantity dispensed
 - g. Directions by prescriber, and

- h. Brand and package size of drug dispensed
- 2. Verification that the pharmacy's usual and customary charges are consistent with the Medicaid Program and the general public. Items that must be considered include but are not limited to:
 - a. Verification that the pricing method used for at least 90% of the private-pay prescriptions is consistent with charges to the Medicaid Program.
Price variations in individual drugs and quantity will be noted. When a price for a prescription varies more than 10% within a given time frame, auditors will select the most prevalent price as usual and customary.
Auditors may request certain documentation regarding pricing to private-pay customers (e.g., paid prescription histories in computer-generated form).
 - b. Verification of the shelf price of over-the-counter items.
 - c. Verification that all available prescription discounts are extended to the Medicaid Program.

The Medicaid Program will recoup any overpayment made as a result of a pharmacy's violation of the usual and customary billing requirement. Refer to Section 251.000 for the usual and customary charge.

C. Coupons

All providers who offer coupon discounts must provide written notification to the Arkansas Division of Medical Services within 30 days before the coupon's effective date. [View or print the Arkansas Division of Medical Services address.](#)

Auditors will check to ensure that the prescriptions filled during the effective period of the coupon are in compliance with Pharmacy Program regulations. Refer to Section 251.101 for discounts and other promotions.

D. Purchase Verification

Auditors will verify that the pharmacy has purchased the drug products (actual National Drug Codes) that have been billed to the Arkansas Medicaid Program. Pharmacies will, upon request, order purchase histories from their major wholesale vendors.

Pharmacies must make available all invoices for the requested period to facilitate auditor verification of drug purchases. Refer to section 254.000 for information relating to claims with incorrect National Drug Code (NDC) numbers.

240.000 PRIOR AUTHORIZATION

1-1-23

Prescription drugs may be reimbursed under the Arkansas Medicaid Program pursuant to an order from an authorized prescriber.

The prescriber must initiate the prior authorization (PA) for prescription drugs that require PA. The PA request must be completed and submitted by the prescriber. All PA documentation must remain in the patient's chart and will be subject to audit by the Division of Medical Services or its authorized representatives.

In addition, clinical edits will be established through a system modification enhancement, as well as limits placed on drugs based on age, gender, quantity, and dosage, as approved by our Drug Utilization Review Board. Lists of all drugs, subject to clinical editing and the criteria for reimbursement, are maintained by DHS or its contracted Pharmacy Vendor. [View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.](#)

Arkansas Medicaid Pharmacy Program will maintain a Preferred Drug List based on comparative evidence-based data from Clinical Evidence Reports (CER). Arkansas Medicaid Pharmacy

Program will use the CER to identify drug class or drug classes of medications that have similar indications, efficacy, and safety. Arkansas Medicaid will negotiate state supplemental rebates with manufacturers for the identified medication(s), pursuant to a CMS approved State Supplemental Rebate Agreement. A Drug Cost Committee (DCC) will review both State Supplemental and Federal rebates to determine the final net cost to the State. The Drug Utilization Review (DUR) Board will review the CER to determine safety and efficacy of the identified medication(s). The DCC and DUR Board will provide recommendations to the State for preferred and non-preferred status for the identified medication(s). Arkansas Medicaid will use these recommendations to establish and maintain a Preferred Drug List.

In an emergency, for those drugs for which a five-day supply can be dispensed, an Arkansas Medicaid enrolled pharmacy may dispense up to a five-day supply of a drug that requires prior authorization. This provision applies only in an **emergency** situation when the DHS Contracted Pharmacy Vendor Help Desk and the State Medicaid Pharmacy Program offices are closed, and the pharmacist is not able to contact the prescribing provider to change the prescription. The Emergency Supply Policy does not apply to drugs that are not covered by the State. Frequency of the emergency override is limited to one (1) time per year per drug class for non-LTC beneficiaries and one (1) time per sixty (60) days per drug class for LTC beneficiaries. To file a claim using this emergency provision, the pharmacy provider will submit a "03" in the Level of Service (418-DI) field.

Prior Authorization information is maintained by DHS or its contracted Pharmacy Vendor. [View or print the DHS Contracted Pharmacy Vendor Help Desk contact information.](#)

The following information is available:

- A. Prescription Drug Clinical Edits
- B. Prescription Drug Claim Edits
- C. Prescription Drug PA Forms
- D. VRS System Brochure, and
- E. Evidence-Based Prescription Drug Program.

241.000 Coverage of Tobacco Cessation Products

2-1-20

Effective for claims with dates of service on or after January 1, 2020, coverage of tobacco cessation products either prescribed or initiated through statewide pharmacist protocol is available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the [DHS Contracted Pharmacy Vendor website](#) or in the [Prescription Drug Program Prior Authorization Criteria.](#)

Coverage and Limitations

- A. Reimbursement for tobacco cessation products is available for all prescription and over the counter (OTC) products, and subject to be within FDA prescribing and dosing limitations.
- B. Additional prescription benefits are allowed per month for tobacco cessation products and will not count against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.
- C. OTC as well as any prescription products are eligible for reimbursement. OTC products are not covered for long-term care residents.
- D. Arkansas Medicaid will provide coverage of prescription and OTC smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence - 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

250.000 REIMBURSEMENT**251.000 Method of Reimbursement**

4-1-23

- A. Payment for ingredient cost for covered outpatient legend and non-legend drugs for all pharmacy and medication types that are not otherwise identified within this section shall be based upon the lesser of methodology.

Lesser of Methodology:

1. Brand Drugs

- a. The usual and customary charge to the public or submitted ingredient cost;
- b. The National Average Drug Acquisition Cost (NADAC), as defined in B, plus the established professional dispensing fee;
- c. The ACA Federal Upper Limit (FUL) plus the established professional dispensing fee; **OR**
- d. The calculated State Actual Acquisition Cost (SAAC), as defined in C, plus the established professional dispensing fee.

2. Generic Drugs

- a. The usual and customary charge to the public or submitted ingredient cost;
- b. The National Average Drug Acquisition Cost (NADAC), as defined in B, plus the established professional dispensing fee;
- c. The ACA Federal Upper Limit (FUL) plus the established professional dispensing fee; **OR**
- d. The calculated State Actual Acquisition Cost (SAAC), as defined in C, plus the established professional dispensing fee.

3. Backup Ingredient Cost Benchmark

If NADAC is not available, the allowed ingredient cost, unless otherwise defined, shall be the lesser of Wholesale Acquisition Cost (WAC) plus zero percent (+0%), State Actual Acquisition Cost (SAAC) or ACA Federal Upper Limit.

4. Limited Access and Specialty Drugs

Limited Access Drugs, defined as drugs not available for dispensing in all retail pharmacies based on price or separate agreements between manufacturer and pharmacy, and Specialty Drugs, will be reimbursed at the Lesser of Methodology plus the established professional dispensing fee. If NADAC is not available, then the Backup Ingredient Cost Benchmark will apply, which will use the lesser of Wholesale Acquisition Cost (WAC) plus zero percent (+0%) or State Actual Acquisition Cost (SAAC).

5. 340B Drug Pricing Program

- a. Covered Legend and non-legend drugs, including specialty drugs purchased through the Federal Public Health Service's 340B Drug Pricing Program by pharmacies that carve Medicaid into the 340B Drug Pricing Program, shall be reimbursed the lesser of the 340B Actual Invoice Price or the 340B ceiling price [provided or calculated by Average Manufacturer Price (AMP) minus Unit Rebate Amount (URA)] plus the established professional dispensing fee. The 340B actual invoice price for each drug reimbursement covered under this program must be submitted to the Department prior to any claims being processed. Drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies are not covered.
- b. Physician administered drugs, including specialty drugs, purchased through the 340B Program, will be reimbursed the lesser of the 340B Actual Invoice Price

or the 340B ceiling price [provided or calculated by Average Manufacturer Price (AMP) minus Unit Rebate Amount (URA)]. The 340B actual invoice price for each drug reimbursement covered under this program must be submitted to the Department prior to any claims being processed. Physician administered drugs include outpatient drugs and drugs used in connection with an inpatient or outpatient service provided by a hospital. Covered entities must also identify all 340B drug claims using the medical modifiers JG or TB. Medical drug claims from covered 340B entities, without the modifiers JG or TB, will be considered non-340B drug claims and will be subject to rebate invoicing.

6. Federal Supply Schedule (FSS) and FQHC

Facilities purchasing drugs, specialty drugs, and physician administered drugs through the Federal Supply Schedule (FSS) or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B Drug Pricing Program, shall be reimbursed no more than the Federal Supply Schedule price. The addition of the established professional dispensing fee for pharmacies will apply, except in the cases of physician administered drugs. Federally Qualified Health Centers (FQHC) that purchase drugs through the 340B program, and carve in Medicaid, will be reimbursed by the encounter rate except in the case of implantable contraceptive capsules, intrauterine devices, and contraceptive injections in which case reimbursement will be no more than the 340B ceiling price. Federally Qualified Health Centers (FQHC) that do not participate in the 340B program, or carve out Medicaid, will be reimbursed by the encounter rate except in the case of implantable contraceptive capsules, intrauterine devices, and contraceptive injections in which case reimbursement will be at the actual acquisition cost.

7. Clotting Factor

- a. Pharmacies dispensing Antihemophilic Factor products will be reimbursed at the lesser of methodology plus the established professional dispensing fee. The lesser of methodology for the allowed ingredient cost shall be the Wholesale Acquisition Cost (WAC) plus zero percent (+0%) or State Actual Acquisition Cost (SAAC).
- b. Pharmacies dispensing Antihemophilic Factor products purchased through the Federal Public Health Service's 340B Drug Pricing Program by pharmacies that carve Medicaid into the 340B Drug Pricing Program shall be reimbursed at the lesser of the 340B actual invoice price or the 340B ceiling price {provided or calculated by Average Manufacturer Price (AMP) minus Unit Rebate Amount (URA)] plus the established professional dispensing fee. The 340B actual invoice price for each drug reimbursement covered under this program must be submitted to the Department prior to any claims being processed.

8. Drugs Purchased at Nominal Price

Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) shall be reimbursed by their actual acquisition cost.

- B. The National Average Drug Acquisition Cost (NADAC) is a pricing benchmark published by CMS that calculates ingredient average acquisition costs experienced by retail community providers across the country. When Brand and Generic NADACs are available for the same ingredient, reimbursement will be based on the Generic NADAC except in the case of Preferred Brand Drugs. The allowed ingredient cost for Preferred Brand Medications shall be reimbursed on the lesser of the Brand NADAC, WAC, or SAAC.
- C. State Actual Acquisition Cost shall apply to certain drugs identified administratively, judicially, or by a federal agency as having a published price exceeding the ingredient cost. The calculated SAAC shall be obtained from actual acquisition costs from multiple resources, if available. Depending on the variance, either the highest acquisition cost, an average of the acquisition costs, or invoice price shall be used in determining a SAAC. When Brand and Generic drugs are available for the same ingredient, reimbursement will

be based on the Generic State Actual Acquisition Cost (SAAC). The SAAC was previously referred to as State Upper Limit (SUL), Generic Upper Limit (GUL), Maximum Allowed Cost (MAC), and Cap Upper Limit (CAP).

- D. Investigational drugs are excluded from coverage.
- E. The Professional Dispensing Fee for covered outpatient legend and non-legend drugs shall take into consideration the State's Preferred Drug List status, for the drug being dispensed, and equals the average professional dispensing fee in the aggregate:
 1. Brand and Non-preferred Brand = Nine Dollars (\$9.00); or
 2. Brand Preferred and Generic Medication drug = Ten Dollars and Fifty Cents (\$10.50).

Drug pricing files are updated weekly.

251.100 Usual and Customary Charge

10-13-03

Audits of pharmacies will be conducted to determine whether the usual and customary charge is being accurately billed to Medicaid.

The Arkansas Medicaid Pharmacy Program requires that the amount a pharmacy bills to the Medicaid Program be consistent with the pharmacy's usual and customary charge to the general public. The usual and customary charge is defined as the price that is charged for 90% of the prescriptions for private pay customers for the same product and quantity. Stores may choose the pricing method they desire, and must apply the same pricing formula to prescriptions filed with the Arkansas Medicaid Program that is applied to prescriptions for private pay customers.

Medicaid reimbursement will be based upon the submitted usual and customary billed amount and will be subject to audit verification of the usual and customary price. Stores found in violation of the usual and customary billing provisions will be subject to recoupment of any identified overpayment. Variations in excess of 10% from the usual and customary charge will invariably result in recoupment. Individual drug and/or quantity price variations will be noted. If the prices on more than 10% of the prescriptions for a given drug and/or quantity are found to vary in a given time frame, auditors will select the most prevalent price as the usual and customary charge. Items that must be considered when determining usual and customary charges include:

- A. The usual and customary charge or billed amount for any drug, legend or over-the-counter (OTC) that is available as an OTC drug will be limited to the lowest shelf price of the product available to customers and covered by the Arkansas Medicaid Program.
- B. All special prices, including but not limited to prices given to family members or other select customers, must be indicated (e.g., "special" or "SP") on all prescriptions. If special prices are not clearly identifiable on private-pay prescriptions, auditors will use these prices to determine the pharmacy's usual and customary charge.

The provider's usual and customary charge shall be recorded on all submitted claim forms. For any claim submitted to the Medicaid Program, the charge submitted therein shall be documented by the pharmacy provider as its usual and customary charge. For verification purposes, program auditors shall have access to providers' non-Medicaid prescription files.

251.101 Discounts and Other Promotions

9-1-05

Discrimination against Medicaid beneficiaries is prohibited. No Medicaid beneficiary shall be excluded from any temporary or promotional discount or price reduction available to persons who are not Medicaid beneficiaries. If a temporary or promotional discount or price reduction is targeted to a specific population by a characteristic such as age, only Medicaid beneficiaries who are similarly situated to persons to whom the promotion is directed are entitled to the discount or

reduced price. Amounts billed to the Medicaid Program must be adjusted to reflect temporary or promotional discounts or price reductions irrespective of coupon or card presentation. If it is determined, by audit or otherwise, that one or more Medicaid beneficiaries was excluded from any temporary or promotional discount or price reduction, the difference between the reduced or discounted price and the price paid will be recouped from the Medicaid provider.

This section applies only to price reductions and discounts, not to the provider's usual and customary charges or to rates paid by other third-party payers. Nothing in this section shall be construed in any manner that is inconsistent with any other provision in this manual, or with 42 U.S.C. § 1320a-7b.

251.200 Brand Medically Necessary Override

8-1-21

The prescriber must determine whether the Medicaid beneficiary meets the required conditions to override an Upper Limit (FUL, SAAC, Generic NADAC). The prescriber must also complete the required MedWatch (see below) documentation to allow a prior authorization (PA) for a "Brand Medically Necessary" override of the Upper Limit to reimburse at the brand name reimbursement rate.

MedWatch is the Food and Drug Administration (FDA) Safety Information and Adverse Event Reporting Program that allows healthcare professionals to report serious problems that they suspect are associated with certain drugs they prescribe.

The following criteria must be met to override the Upper Limit when calculating the allowable amount of reimbursement:

- A. For MedWatch drugs, the following conditions are required for approval of a Brand Medically Necessary override:
 1. The prescriber shall establish that the beneficiary's condition meets the definition provided for the medical necessity of dispensing any brand name drug when a generic equivalent is available.

In the context of this policy, "Brand Medically Necessary" is defined as the necessity to prescribe and dispense a brand name medication when use of a generic product has resulted in adverse reaction(s) to the generic, allergic reaction(s) to the generic or therapeutic failure of the generic.

 - a. Adverse reaction caused by a generic must meet one of the following criteria:
 - i. Life threatening
 - ii. Hospitalization
 - iii. Disability
 - iv. Required intervention to prevent impairment or damage
 - b. Allergic reaction is defined as when an allergen is present in a generic drug that is not present in a brand drug resulting in a hypersensitive reaction.
 - c. Therapeutic failure is defined as, clinical failure due to the beneficiary's suboptimal plasma drug concentration for the generic drug when compared to published full pharmacokinetic profiles for the brand name drug.
 2. The prescriber shall submit documentation to the [DHS Contracted Pharmacy Vendor](#) using the FDA MedWatch and the MedWatch Patient Information Request forms to support dispensing a brand name medication instead of the generic equivalent.
 3. When a MedWatch drug is approved for a Brand Medically Necessary override, the [DHS Contracted Pharmacy Vendor](#) Help Desk will contact the pharmacy provider to inform them of the prior authorization number and the date range of the approved PA.

The PA is given for up to one year for MedWatch Drugs.

All prescriptions must be on file for review by auditors from the Division of Medical Services or their designated agents.

If the criteria stated above are met and the pharmacy claim is submitted with a code of "1" in the dispense as written (DAW) field, the prescription will be priced using the Brand NADAC (or WAC when applicable) for the specific product dispensed rather than the Upper Limit rate.

- B. Pharmacy providers can request a review of a specific SAAC associated to a paid claim by completing the AR Medicaid Price Research Request Form and faxing it to the number listed on the form. This form can be found on the [DHS Contracted Pharmacy Vendor website](#).

252.000 Dispensing Fee Reimbursement for Long-Term Care Beneficiaries 9-1-05

Only one dispensing fee per month per drug strength will be reimbursed by the Medicaid Program for certified long-term care beneficiaries. This applies even if various brands of the same generic drug or chemical entity are dispensed during the month. The provider must bill the National Drug Code number for the generic drug or chemical entity actually dispensed.

253.000 Compounded Prescriptions 9-1-05

Compounded prescription claims may be submitted to the Program when multiple ingredients are used in the preparation of the medication provided to the Arkansas Medicaid beneficiary. Up to twenty-five (25) National Drug Codes (NDCs) may be submitted for compounded prescription claims. The provider must indicate the metric decimal quantity of each submitted NDC. The metric decimal quantity field at the header level should reflect the total quantity of the final compounded prescription. A prescription is only considered a compounded prescription if two or more NDCs are submitted as ingredients on the claim. If one or more of the ingredients is not payable by the Program, the cost of those non-covered products will not be included in the payment for the claim. If the pharmacist opts to provide a compounded prescription in spite of the non-coverage of one or more ingredients, the beneficiary is not responsible for the cost of any non-covered ingredients used to prepare the prescription, but only for the applicable co-payment. The provider may submit a Prescription Clarification Code of 08 (in field 420-DK) to accept payment for only the covered ingredients of the compound. If the Prescription Clarification Code of 08 is not submitted, the program will reject the claim with an error message informing the provider of the non-covered status of one or more ingredients. The compounded prescription claim, with two to twenty-five ingredients, will count as one claim against the Medicaid beneficiary's prescription drug benefit limit.

Due to provisions set forth in the Omnibus Budget Reconciliation Act (OBRA 90), only the NDC that is dispensed and the quantity of the NDC that is dispensed can be submitted to Medicaid. If a pharmacy provider is unable to bill according to these guidelines due to software limitations, the vendor should be notified of these requirements immediately. Any pharmacy that continues to bill compounded prescription claims improperly will be subject to recoupment of the **total paid amount** of those claims.

254.000 Claims with Incorrect National Drug Code (NDC) Numbers 9-1-05

On each claim submitted for payment, the pharmacy provider must accurately record the NDC number for the drug product. The NDC number must be for the drug and package size actually dispensed. The entire 11-digit NDC number must be billed properly for the NDC to be correct. **When an audit determines that the incorrect NDC number was billed, providers are not allowed to reverse and file the claim again.** Instead, the state will recoup 20% of the paid amount for claims with incorrect NDC numbers. For example, if a pharmacy has claims with incorrect NDCs in the amount of \$464.33, the following amount will be recouped:

\$464.33 X 20% = \$92.87.

255.000 **Rate Appeal Process** **10-13-03**

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

261.000 **Introduction to Billing** **7-1-20**

For paper billing of non-NCPDP claims (including immunosuppressant drug crossover claims or vaccine claims), pharmacy providers use the CMS-1500 form to bill the Arkansas Medicaid Program for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary. The Arkansas Medicaid fiscal agent provides the ability for electronic claim submissions through the Provider Portal to providers for Non-NCPDP billing. Please contact the Provider Assistance Center for any questions or assistance with this software. [View or print the Provider Assistance Center contact information.](#)

The Arkansas Medicaid Pharmacy Program does not accept NCPDP paper claim forms for covered outpatient medications. Vendor systems are widely available for incorporation of electronic claims submission in the pharmacy practice.

262.000 **CMS-1500 Billing Procedures**

262.200 **National Place of Service Codes for Influenza Virus, Pneumococcal Polysaccharide Vaccines, and Any Other Services Provided in the Pharmacy Location** **8-1-21**

Electronic and paper claims now require the same national place of service code.

Place of Service (POS)	POS Code
Pharmacy	01

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 CMS-1500 Form

9-1-14

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	

Field Name and Number	Instructions for Completion
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.
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.
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.

Field Name and Number	Instructions for Completion
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	<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>
15. OTHER DATE	<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>
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for Pharmacy services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.

Field Name and Number	Instructions for Completion
20. OUTSIDE LAB? \$ CHARGES	Not required. Not required.
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	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	<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	Two-digit national standard place of service code. See Section 262.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	<p>CPT/HCPCS</p> <p>One CPT or HCPCS procedure code for each detail.</p> <p>MODIFIER</p> <p>Not applicable to Pharmacy claims.</p>

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in the Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	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 payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or Arkids First-B co-payments.
30. RESERVED	Reserved for NUCC use.

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

262.400 Special Billing Procedures

10-13-03

Not applicable to this program.