

# New Provider Workshop

Karen Young

Training and Program Developer, MMIS, AFMC



# New Provider Workshop Webinar Disclaimer

The New Provider Workshop is designed for ALL Provider types and specialties. We will only cover the items listed on the Agenda. In addition, we will not cover any specific provider types during this workshop. The Medicaid program has over 50 provider types and we invited all provider types to attend this workshop. Therefore, the information during this session will vary depending on the most relevant and immediate information.

If you have specific questions, please contact the Provider Assistance Center at 1-800-457-4454. Please pay close attention, as the options have changed for Electronic Data Interchange(EDI and Provider Enrollment.

There are also job aids that will give you step-by-step instructions on: How to check eligibility, How to check status of a claim, How to submit and review a claim, How to register for the portal, and more. In addition, we now have Quick Track Training Videos to assist with Portal Password Reset, Eligibility Verification and Files Exchange for Health Care Innovation Documentation, How to Adjust/Edit a Claim, How to Access a PA Letter, Timely Filing and How to Void a Claim located on the DHS and AFMC websites.

If you have escalated issues or would like to discuss specific issues, please contact your provider outreach specialists at 501-906-7566 to set up a virtual or on-site visit. A map to contact your rep is located at [afmc.org](https://afmc.org) and the DHS website <https://humanservices.arkansas.gov>

For the latest information surrounding COVID-19 please visit the DHS websites at <https://humanservices.arkansas.gov>



# QR Code to Access Training Resources

Use your IOS, Android or any device to access all our MMIS Tools and Resources for your convenience.



# Agenda

Introduction – MMIS Outreach Team	Program Overview	Who's Who at Medicaid	Provider Enrollment	Provider Information	Fee Schedule & Policy Manuals
Eligibility	Claims	Medicare	Third-Party Liability	Prior Authorization	Healthcare Portal
Training Opportunities	Things to Remember	Eblast	Evaluations	Questions	Live Demonstration (Portal, Websites, Manuals, Procedure Code Linking)



# MMIS Outreach Team

**MMIS OUTREACH SPECIALISTS**

**HOURS OF OPERATION:**  
Monday–Friday • 8 A.M.–5 P.M.

**MMIS Manager**  
Becky Andrews .....501-212-8738  
[bandrews@afmc.org](mailto:bandrews@afmc.org)

**MMIS Supervisor**  
Andrea Allen  
Pulaski County .....501-906-7566 Ex. 1  
[pulaskibilling@afmc.org](mailto:pulaskibilling@afmc.org)

**Outreach Specialists**

Christy Owens  
NW—Northwest .....501-906-7566 Ex. 2-2  
[northwestbilling@afmc.org](mailto:northwestbilling@afmc.org)

Rose Bruton  
NE—Northeast .....501-906-7566 Ext. 2-1  
[northeastbilling@afmc.org](mailto:northeastbilling@afmc.org)

Mary Riley  
EC—East Central .....501-906-7566 Ext. 4-1  
[eastcentralbilling@afmc.org](mailto:eastcentralbilling@afmc.org)

Kristie Williams  
SE—Southeast .....501-906-7566 Ext. 3-1  
[southeastbilling@afmc.org](mailto:southeastbilling@afmc.org)


Angie Riggan  
SW—Southwest .....501-906-7566 Ext. 3-2  
[southwestbilling@afmc.org](mailto:southwestbilling@afmc.org)

Renee Smith  
WC—West Central .....501-906-7566 Ext. 5-1  
[westcentralbilling@afmc.org](mailto:westcentralbilling@afmc.org)






# MMIS Outreach Team Map



**ARKANSAS DEPARTMENT OF HUMAN SERVICES**

**gainwell** 


## MMIS Outreach Specialists Information Sheet

1020 W. 4th St., Suite 400 • Little Rock, AR 72201 • Toll free: 1-877-650-2362 • [afmc.org/mmis](http://afmc.org/mmis)


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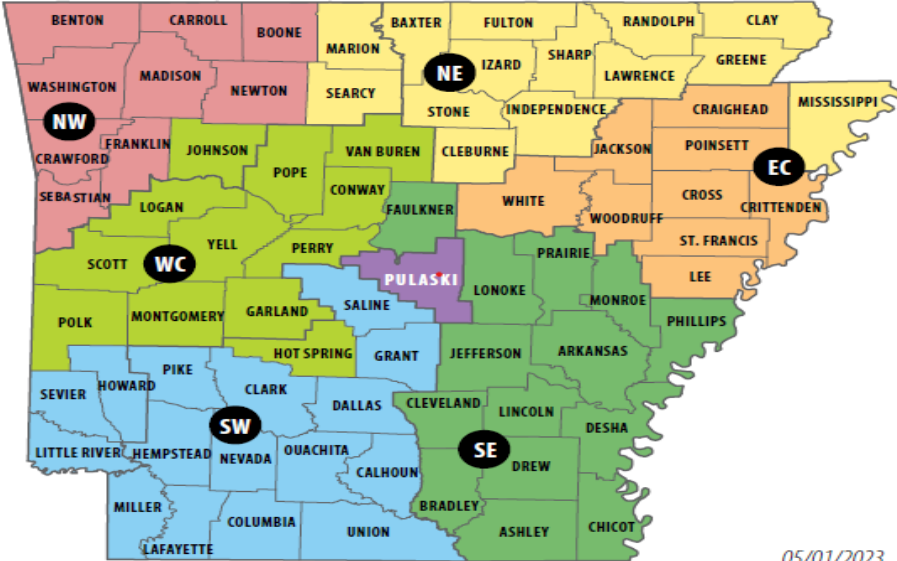
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 Kristie Williams  
SE—Southeast .....501-906-7566 Ext. 3-1  
[southeastbilling@afmc.org](mailto:southeastbilling@afmc.org)

 Angie Riggan  
SW—Southwest .....501-906-7566 Ext. 3-2  
[southwestbilling@afmc.org](mailto:southwestbilling@afmc.org)

 Renee Smith  
WC—West Central .....501-906-7566 Ext. 5-1  
[westcentralbilling@afmc.org](mailto:westcentralbilling@afmc.org)



05/01/2023

### ARKANSAS DEPARTMENT OF HUMAN SERVICES, DMS

**ARKIDS FIRST/MEDICAID**  
<https://humanservices.arkansas.gov/>  
ARKids First Enrollment Information..... 888-474-8275

**CONNECTCARE**  
Toll free..... 800-275-1131

**MEDICAID FRAUD CONTROL UNIT (PROVIDERS)**  
Central Arkansas ..... 501-682-8349

**ARKANSAS MEDICAID MANAGED CARE VOICE INFORMATION SERVICES**  
Toll free..... 800-805-1512

**PHARMACY**  
Magellan Medicaid Administration Help Desk .....800-424-7895

**TPL INFORMATION**  
Local .....501-537-1070  
Fax.....501-682-1644  
DHS Division of Medical Services,  
TPL Unit • P.O. Box 1437, Slot S296  
Little Rock, AR 72203-1437

### GAINWELL TECHNOLOGIES (Claims Processing)

**Gainwell Provider Assistance Center**  
In-state toll free .....800-457-4454  
Local and out-of-state .....501-376-2211

**Gainwell Provider Services Manager**  
Cynthia Bogard.....469-830-6768

**CLAIMS**  
P.O. Box 8034  
Little Rock, AR 72203

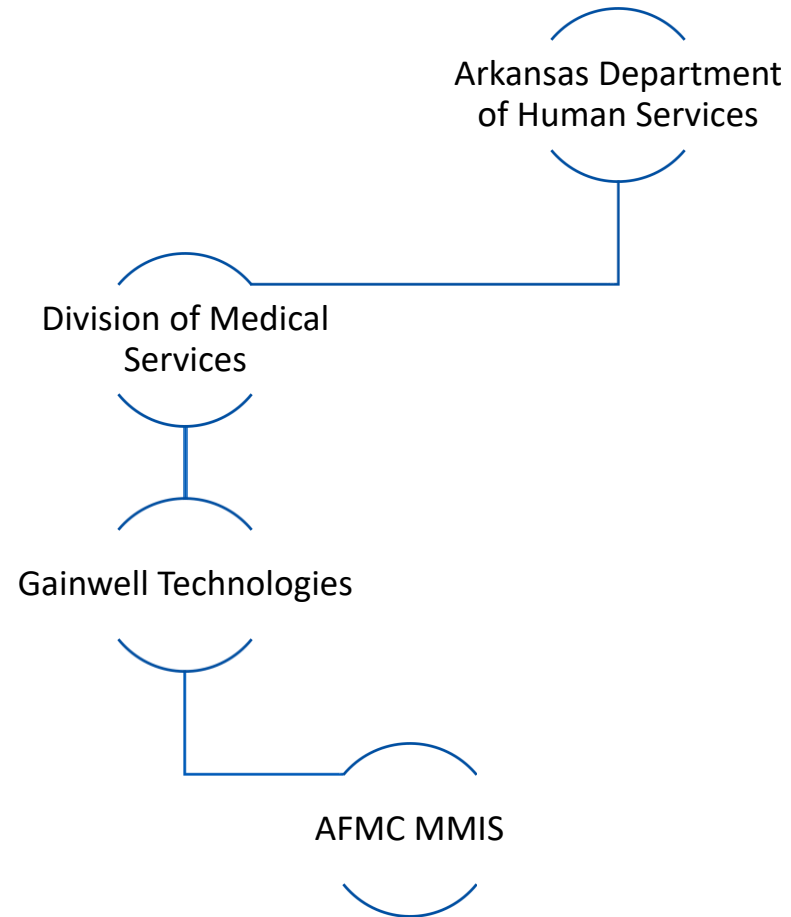
**SPECIAL CLAIMS**  
ATTN: Research Analysts  
P.O. Box 8036  
Little Rock, AR 72203

**CROSSOVER CLAIMS**  
P.O. Box 34440  
Little Rock, AR 72203

**PROVIDER ENROLLMENT**  
P.O. Box 8105  
Little Rock, AR 72203  
Fax: 501-374-0746



# Organizational Chart



# Who's Who at Medicaid

- Division of Medical Services (DMS)  
<https://humanservices.arkansas.gov/offices>
- County offices (DCO)  
<https://humanservices.arkansas.gov/find-a-county-office/>
- AFMC  
[afmc.org](http://afmc.org)
  - MMIS outreach specialists - 501-906-7566, [afmc.org/mmis](http://afmc.org/mmis)
  - ConnectCare - 1-800-275-1131, [seeyourdoc.org](http://seeyourdoc.org)
  - Provider relations outreach specialists -  
[afmc.org/providerrelations](http://afmc.org/providerrelations)
  - AFMC review department - 479-649-8501
- eQHealth: Prior authorization and extension of benefits -  
<https://www.kepro.com/eqsuite-portal-access>  
[Ar.pr@eqhs.com](mailto:Ar.pr@eqhs.com) or 1-888-660-3831
- Health Management Systems (HMS) <https://www.hms.com/our-solutions/payment-integrity/> or 1-877-HMS-0184
- Office of Medicaid Inspector General (OMIG) 1-855-527-6644
- Magellan Medicaid Administration pharmacy help desk  
1-800-424-7895, Option 2 for prescribers
- Gainwell Technologies 1-800-457-4454
- PASSE-DHS PASSE provider call center 1-888-889-6451
- MCNA Dental 1-800-494-MCNA
- Delta Dental Smiles Customer Service 1-866-864-2499





# DHS Division of Medical Services (DMS) – Administers Arkansas Medicaid

- DMS establishes policy for all Medicaid programs
- Provider reimbursement establishes reimbursement rates
- TPL validates third-party liability information
- Program development and quality assurance distributes Medicaid policy and monitors waiver programs
- Utilization review assists with claims and makes coverage determinations
- Medical assistance manages program communications plus dental and visual programs
- Pharmacy makes coverage determination and manages all drug-related issues

Webpage: <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/>

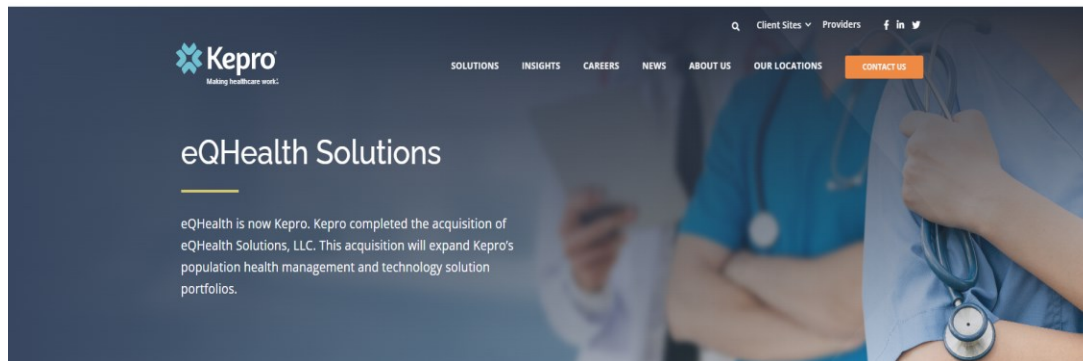


# DHS County Offices

- Work directly with clients
- Determine eligibility, plan description and eligibility time frame
- Assist with primary care physician (PCP) selection

Webpage: <https://humanservices.arkansas.gov/offices>

# eQHealth Solutions



Webpage:

<https://www.kepro.com/eqsuite-portal-access>

Email:

[Ar.pr@eqhs.com](mailto:Ar.pr@eqhs.com)

Phone Number: 1-888-660-3831



# Health Management Systems (HMS) – Third-party Recovery

Health management systems (HMS) provides services that identify third-party payment sources (such as commercial insurance and health plans, Medicare and TRICARE) and recovers public health plan expenditures when third-party liability exists

Phone number: 1-877-HMS-0184

Webpage: <https://www.hms.com/our-solutions/payment-integrity/>



# Office of Medicaid Inspector General – Program Integrity

- OMIG detects schemes of fraud, curbs unacceptable practices, and improves quality of care as it relates to Medicaid fraud, waste and abuse. **Medicaid fraud can be reported by calling:**
  - Arkansas Medicaid Inspector General's Hotline: 1-855-5AR-OMIG (1-855-527-6644), or
  - Report on the website: <http://omig.arkansas.gov/>

# Magellan Medicaid Administration (MMA)

## Prescription Drug Information

For questions and concerns please contact:

- Magellan Pharmacy Call Center: (800) 424-7895
  - Pharmacy Support — Option 1
  - Prescriber Support — Option 2
  - Beneficiary Support — Option 3
  - Web Support — Option 4, then Option 1
- Magellan Fax Number: (800) 424-7976
- PDL Call Center: (800) 424-7895
  - Pharmacy Support — Option 1
  - Prescriber Support — Option 2
  - Beneficiary Support — Option 3
  - Web Support — Option 4, then Option 1
- PDL Fax Number: (800) 424-5739
- Call Center hours are Monday — Friday 8AM — 5PM CST excluding state holidays.
- Web Support hours are Monday — Friday 7AM — 7PM CST.

Magellan Medicaid Administration (MMA) processes Arkansas Medicaid pharmacy claims.

MMA performs the following functions:

- Claims processing
- Operations support for the pharmacy program
- Call center operations for providers and members
- Clinical consultation services
- Education and outreach for providers

Webpage:

<https://arkansas.magellanrx.com/provider/documents/>





# Gainwell Technologies

Gainwell Technologies is the fiscal agent for Arkansas Medicaid. They provide the following services:

- Provider enrollment

GAINWELL TECHNOLOGIES SERVICES (Claims Processing) • 500 President Clinton Ave., Suite 400 • Little Rock, AR 72201		
<b>Gainwell Provider Assistance Center</b> <ul style="list-style-type: none"><li>• In-state toll free ..... <b>800-457-4454</b></li><li>• Local and out-of-state ..... <b>501-376-2211</b></li></ul>	<b>CLAIMS</b> P.O. Box 8034 Little Rock, AR 72203	<b>CROSSOVER CLAIMS</b> P.O. Box 34440 Little Rock, AR 72203
<b>Gainwell Provider Services Manager</b> Courtney Tipple ..... <b>512-319-3823</b>	<b>SPECIAL CLAIMS</b> ATTN: Research Analysts P.O. Box 8036 Little Rock, AR 72203	<b>PROVIDER ENROLLMENT</b> P.O. Box 8105 Little Rock, AR 72203 Fax: 501-374-0746

- Electronic Data Interchange (EDI)

Monday through Friday 8 a.m. – 5 p.m.



# PASSE | Provider-Led Arkansas Shared Savings Entity

- Arkansas Total Care  
Phone Number: 866-282-6280  
Webpage: [arkansastotalcare.com](http://arkansastotalcare.com)
- Empower Healthcare Solutions:  
Phone Number: 855-429-1028  
Webpage: [getempowerhealth.com](http://getempowerhealth.com)
- Summit Community Care:  
Phone Number: 844-462-0022  
Webpage: [summitcommunitycare.com](http://summitcommunitycare.com)
- DHS PASSE Provider Call Center  
888-889-6451



# Dental Managed Care

## Delta Dental

- Victoria Martin, Manager  
501-992-1714 or 501-804-8648  
[vmartin@deltadental.com](mailto:vmartin@deltadental.com)
- Whitney Roundtree, Provider Network Coordinator  
501-607-3331 or 501-992-1750  
[wroundtree@deltadental.com](mailto:wroundtree@deltadental.com)
- Briana Sparks, Provider Network Coordinator  
501-607-3803 or 501-992-1718  
[bsparks@deltadental.com](mailto:bsparks@deltadental.com)

## MCNA

- MCNA Dental  
800-494-MCNA  
[contactus@mcna.net](mailto:contactus@mcna.net)



# Who's Who at Medicaid - AFMC

- MMIS outreach specialists
- Provider relations outreach specialist
- Provider relations - DPSQA
- DPSQA - Inspections of Care
- AFMC review department
- ConnectCare
- Non-Emergency Transportation (NET)
- AFMC service center
- Medicaid Quality Improvement (MQI)



# AFMC

AFMC is a nonprofit organization engaged with clients and health care providers in all settings to improve overall health and consumers' experience of care, while reducing health care costs. We accomplish this through education, outreach, data analysis, information technology, medical case review and marketing/communications services.

Webpage: [afmc.org](http://afmc.org)



# AFMC | MMIS Outreach Specialist

AFMC's MMIS outreach specialists are available to help Arkansas providers with questions about:

- Program policies and procedures
- Claim submissions
- Provider portal training
- Understanding remittance advice
- Virtual and on-site training

***Note: If you would like a one-on-one meeting to answer specific questions after this training, please contact your outreach specialist.***

You can find your provider outreach specialist at [afmc.org/mmis](https://afmc.org/mmis) or on the [DHS Website](#) under

- Divisions and Shared Services
- Medical Services
- Helpful Information for Providers
  - Support for Providers
- AFMC outreach specialists
  - Choose the option for Meet the AFMC billing outreach specialists
- You may contact your outreach specialist by calling 501-906-7566 and choosing the region where your organization resides.





# AFMC | Provider Relations Outreach Specialists

- Provider relations outreach specialists are policy experts and educators who work with health care providers. They help practices navigate the Medicaid system and stay up-to-date on policy and procedures. During visits, the specialists will educate on state initiatives, provide educational tools to implement best practices and gather feedback for the state. Some of the current initiatives include:
    - Patient-centered Medical Home (PCMH)
    - PASSE
- You can find your provider outreach specialist at [afmc.org/providerrelations](https://afmc.org/providerrelations) or on the [DHS Website](#) under
- Divisions and Shared Services
  - Medical Services
  - Helpful Information for Providers
    - Support for Providers
  - AFMC outreach specialists
    - Choose the option for “Meet the AFMC policy and education outreach specialists”

# AFMC | Provider Relations - DPSQA

AFMC's DPSQA outreach specialists serve as the link between the Division of Provider Services and Quality Assurance (DPSQA) and the Medicaid provider community. The specialists help ensure providers understand applicable DHS programs, program requirements and operations, new initiatives, Medicaid policy changes and best-practice guidelines.

They assist providers with the following:

- Adult Developmental Day Treatment (ADDT)
- ARChoices waiver
- Early Intervention Day Treatment (EIDT)
- Home and Community Based Services (HCBS)
- Independently licensed practitioners

- Inpatient Psychiatric Services for U21
- Living Choices waiver
- Long Term Services and Supports (LTSS)
- Outpatient Behavioral Health Services (OBHS)
- PASSE
- Personal Care

Webpage: <https://afmc.org/health-care-professionals/arkansas-medicaid-providers/dpsqa/>

# AFMC | Inspections of Care (IOC)

AFMC's Inspections of Care (IOC) team, through a contract with the Department of Human Services (DHS) Division of Provider Services and Quality Assurance (DPSQA), conducts annual and random on-site health and safety licensure/certification reviews, inspection of care and quality of care reviews for the following providers:

- Outpatient Behavioral Health Services (OBHS) Fee for Service (FFS) Behavioral Health Agencies (BHA) and Independently Licensed Practitioners (ILP)
- Additionally Certified BHA programs:
  - Therapeutic Communities
  - Acute Crisis Units
  - Partial Hospitalization
  - Residential Community Reintegration
- Alcohol and Other Drug Abuse Treatment Providers (AODATP)
- Community Services Support Program (CSSP)
- Inpatient Psychiatric Services for the Under Age 21 (U21)
- Division of Youth Services

- These unannounced, on-site reviews and quality of care desk reviews are designed to monitor for compliance with certification/licensure, program standards, and any contractual agreements.

Webpage: <https://afmc.org/health-care-professionals/arkansas-medicaid-providers/dpsqa/inspections-of-care/>



# AFMC | Review Services

AFMC provides health utilization management reviews for public and private health plans to ensure all health care services reimbursed are provided in the most efficient manner and are medically necessary. Review staff also help providers deliver the highest quality of care while at the same time preventing fraud and abuse.

Review services are as follows:

- [Emergency room](#)
- [Concurrent inpatient review](#)
- [Retrospective review of inpatient admissions](#)
- Reconsideration reviews
- [Extension of benefits](#) for outpatient, lab and imaging
- [Hyperalimentation](#)
- [Medicaid Utilization Management Program](#)
- [Prosthetics and durable medical equipment](#)

- [Inpatient utilization management](#)
- Solid organ and bone marrow transplant
- Medical necessity for surgical procedures and use of [assistant surgeons](#)
- Private peer review
- Web-based review through [Arkansas Medicaid Healthcare Portal](#) for inpatient continued stay

Find out more about [AFMC's Review Services](#).

Phone Number: 479-649-8501

Webpage: [ClinicalServices@afmc.org](mailto:ClinicalServices@afmc.org)



# AFMC | ConnectCare Helpline

- Assigns and changes client's PCP
- Educates clients about Medicaid
- Emails confirmation notices, PCP lists and outreach materials to clients
- Processes PCP dismissals
- Coordinates with caseworkers to assign PCPs for foster children
- Phone Number: 1-800-275-1131
- Webpage: [seeyourdoc.org](https://seeyourdoc.org)



# AFMC | Non-Emergency Transportation (NET)

## What providers should know about the Non-Emergency Transportation Program

The Arkansas Medicaid Non-Emergency Transportation (NET) program provides eligible Medicaid clients with transportation for medical services. Clients who are ineligible for this service include:

- Nursing home facility residents
  - Those in intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
  - Qualified Medicare Clients (QMB)
  - ARKids First B recipients
- Clients who have traditional Medicaid can only utilize NET if their appointment is with an enrolled Arkansas Medicaid provider. No co-payments are required and there are no limits on the number of trips and no mileage cap.
  - Clients enrolled in Arkansas Works may be transported to any health care provider within their network plan. The client must have a valid Medicaid number. There is a limit of eight legs/units per calendar year. The client may apply for an extension of transportation services when the eight legs/units have been exhausted.





# Non-Emergency Transportation(NET) cont'd

## What is the Transportation Helpline?

The toll-free Non-Emergency Transportation Helpline (1-888-987-1200, option 1) takes client's questions, comments, complaints and suggestions about the NET program. **The NET Helpline will not arrange transportation;** clients should call their local Medicaid transportation broker 48 hours before the scheduled appointment.

Webpage: [afmc.org/net](https://afmc.org/net)



# AFMC | Client Service Center

AFMC provides an Arkansas Medicaid and Arkansas Health Care Independence Program (AHCIP) service center to assist clients with a variety of functions related to their health insurance coverage as well as Arkansas Medicaid and other stakeholders. Service center services include:

- Ordering Medicaid cards for the medically frail population
  - Serving as a liaison between HP and qualified health plans to assist with Arkansas Health Care Independence Program policy issues
  - Researching state computer systems, such as CURAM, DocuShare, Arkansas Medicaid Provider Portal, ANSWER, and MMIS
  - Linking Medicaid accounts in MMIS
  - Submitting opt-out requests to the <https://humanservices.arkansas.gov/offices> on behalf of clients
  - Training for state projects and initiatives
  - Editing info in MMIS to match the CURAM record
  - Editing demographic information in CURAM
  - Providing accurate information to clients regarding their current coverage or lack thereof
  - Providing an onsite Spanish interpreter
  - Collecting data and creating reports
  - Coordinating with stakeholders and providing assistance for client-related issues through a research specialist located onsite
- For more information, contact 501-212-8600

Webpage: <https://afmc.org/services/provider-outreach/beneficiary-service-center/>



# Medicaid Quality Improvement (MQI)

AFMC's Medicaid Quality Improvement (MQI) team works directly with health care providers on specific projects to improve patient care and compliance. Projects are selected for each state fiscal year in conjunction with Arkansas Medicaid and are based on data analysis and research that demonstrates improvement in the project area can be achieved through provider/patient education and awareness. Once the project is selected, tools and materials are developed for both patients and health care professionals. Team members meet with providers to assess the provider/practice's needs and offer real-world guidance and assistance.

## Active MQI projects

- [Maternal Mortality](#)
- [Long-acting reversible contraception \(LARC\)](#)
- [Breastfeeding promotion](#)
- [Opioid prescribing](#)
- [Alcohol use disorder](#)



# Gainwell Technologies | Provider Enrollment



# Provider Enrollment

<https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/>

## Provider Enrollment

Drop Down ▼

## Application Information

- [Instructions for how to complete your application](#)
- [Video instruction for how to complete your application](#)
- [Required Documents Finder](#)
- [Start your application](#)

# Provider Enrollment Updates

## ARMedicaid

[Home](#) [Eligibility](#) [Claims](#) [Care Management](#) [Provider Functions](#) [Files Exchange](#) [Resources](#)

[PCP Information](#) | [Provider LTC Census](#) | [Search Update Requests](#) | [Submit an Update Request](#)

Provider Functions

**Provider Name** PCP PROVIDER

**Role IDs**

Provider - In Network - 111111112 (NF ▼)



### Provider Functions

- ▶ [PCP Information](#)
- ▶ [Provider LTC Census](#)
- ▶ [Search Update Requests](#)
- ▶ [Submit an Update Request](#)





# Provider Re-validation on the Healthcare Portal

The screenshot displays the ARMedicaid Healthcare Portal interface. At the top, the 'ARMedicaid' logo is on the left, and 'Contact Us | Logout' links are on the right. A navigation bar contains links for Home, Eligibility, Claims, Care Management, Provider Functions, Files Exchange, and Resources. Below this, a header section shows the 'Provider Name' as 'HORIZONS OF HOPE INC' and 'Role IDs' as 'Provider - In Network'. The main content area is divided into three columns. The left column has a sidebar with sections: 'User Details' (Welcome, My Profile, Manage Accounts), 'Provider' (Name, Provider ID, Revalidation Date: 08/11/2019, License: 396 (Expiration Date: 06/30/2020)), 'Characteristics', 'Re-Validation', and 'Provider Services' (Search Payment History). The middle column features a 'Welcome Health Care Professional!' message, a photo of two healthcare professionals, and a commitment statement about making it easier for providers to perform their business. The right column includes 'Contact Us' and 'Secure Correspondence' links, followed by claim inquiry instructions and a specific address: 'Claims, DXC Technology, PO BOX 8034, LITTLE ROCK, AR 72203'. A feedback link is at the bottom of the middle column.

**ARMedicaid** [Contact Us](#) | [Logout](#)

[Home](#) [Eligibility](#) [Claims](#) [Care Management](#) [Provider Functions](#) [Files Exchange](#) [Resources](#)

Home

**Provider Name** HORIZONS OF HOPE INC **Role IDs** Provider - In Network

**User Details**  
Welcome  
▶ [My Profile](#)  
▶ [Manage Accounts](#)

**Provider**  
Name  
**Provider ID**  
⚠ **Revalidation Date** 08/11/2019  
**License** 396 (Expiration Date: 06/30/2020)  
▶ [Characteristics](#)  
⚠ **Re-Validation**

**Provider Services**  
▶ [Search Payment History](#)

**Welcome Health Care Professional!**

[Contact Us](#)

[Secure Correspondence](#)

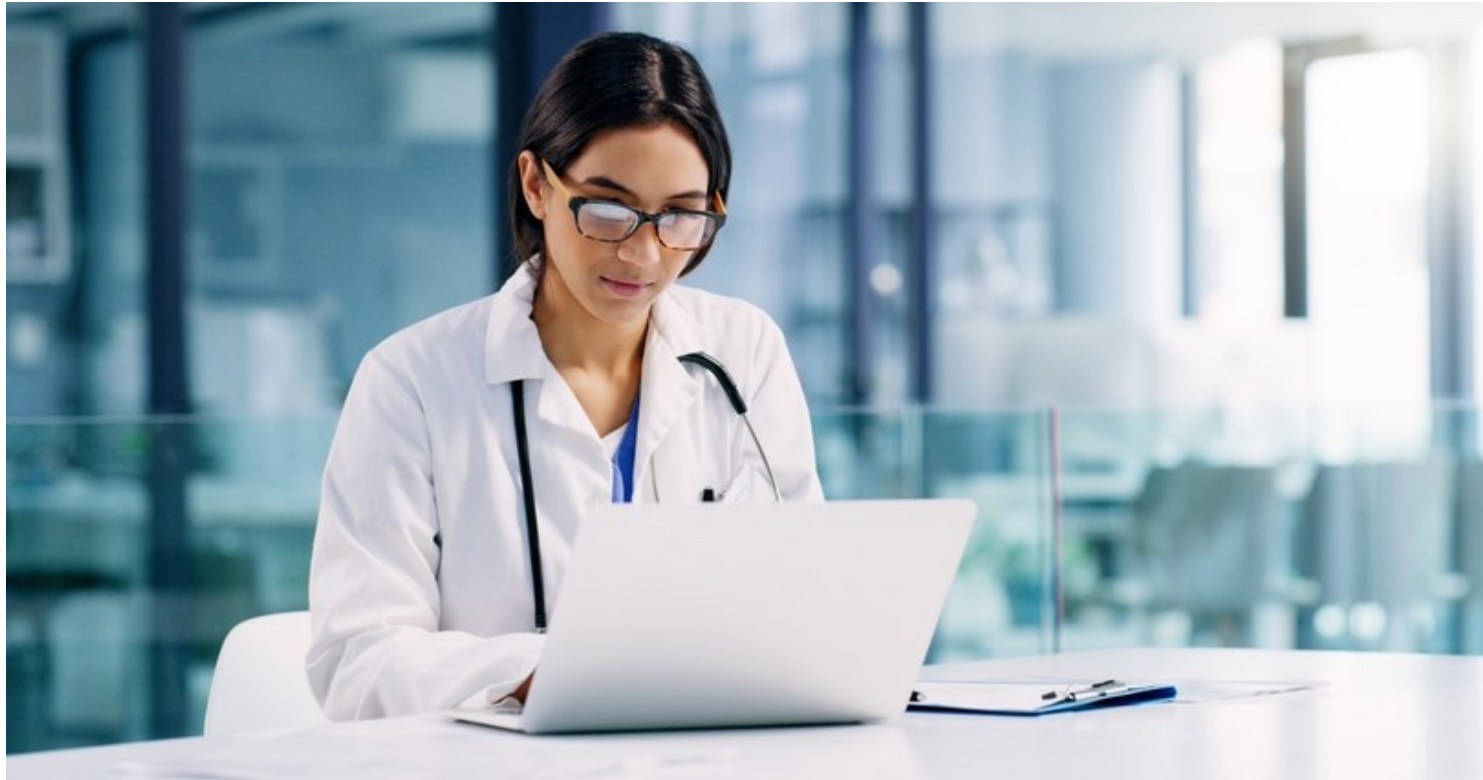
All Claim Inquiries should be submitted to the following Address:

Claims  
DXC Technology  
PO BOX 8034  
LITTLE ROCK, AR 72203

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

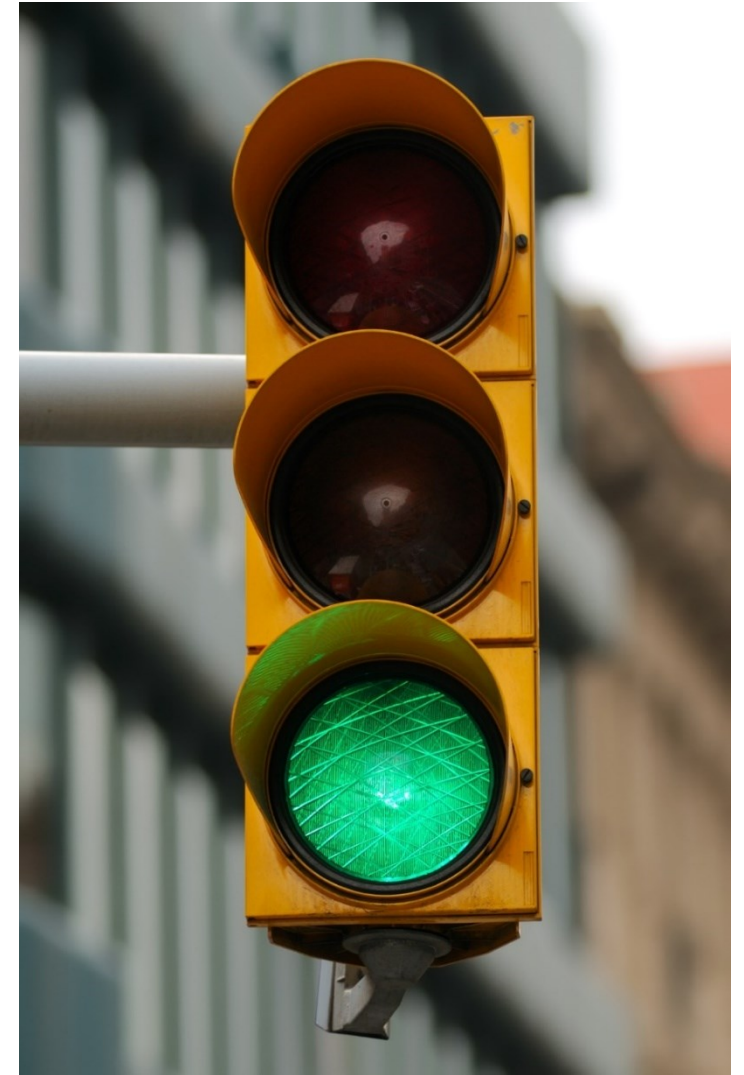
[Help us provide better service to you! Click here to give us your feedback](#)

# Provider Information



# Provider Numbers

- Nine-digit provider ID
- National provider ID (NPI)
- Atypical providers (NPI not required)



# Fee Schedule & Policy Manuals



# Helpful Information for Providers

## Helpful Information For Providers

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- [Billing Manuals](#)
- [Fee Schedules](#)
- [PCMH / PCCM](#)
- [Provider Training Information](#)
- [Rate Reviews](#)
- [Sign-up for MMIS email updates](#)
- [Submit a Claim](#)
- [State Plan \(Medicaid and CHIP\)](#)

## What's New For Arkansas Medicaid Providers



# Arkansas Medicaid Provider Manuals and Updates

- Section I
  - General policy
  - General information, sources, beneficiary eligibility and responsibilities, provider participation, administrative (and noncompliance) remedies and sanctions, PCP case management program, and required services and activities
- **Section II**
  - **Provider manual (varies by provider type)**
  - **Program or provider specific information, program coverage, prior authorization, reimbursement and billing procedures**
- Section III
  - Billing information: general information, remittance advice and status report, adjustment request, additional or other payment sources, pseudo claims and reference books

# Provider Manuals

- Section IV
  - Glossary: Arkansas Medicaid acronyms and terms
- Section V
  - Claim forms, Arkansas Medicaid forms, contacts and links

# Provider Manuals

- Appendix A
- Update log: Update number and effective date (formerly Appendix A)
- Number and release dates for updates
- Program publications/notifications: transmittal letters, official notices, remittance advice messages and notices of rule making



# Procedure Code Linking Tables



1st

- Access to a computer, smartphone, or tablet that is new enough to...

2nd

- Access to the internet...
- With a current web browser...

3rd

- And have Microsoft Excel and Word installed...

# Procedure Code Tables List

Procedure Code Linking Tables	
Academic Medical Center (AMC)	Hospital
Adult Behavioral Health Services for Community Independence (ABHSCI)	Hyperalimentation
Adult Developmental Day Treatment (ADDT)	Independent Laboratory
Ambulatory Surgical Center (ASC)	Independent Radiology
ARKids First-B	Nurse Practitioner (NP)
Autism Waiver	Oral Surgeon (Dental Procedure Codes or Physician Procedure Codes)
Autism EPSDT	Outpatient Behavioral Health Services (OBHS)
Certified Registered Nurse Anesthetist	Physician
Certified Nurse Midwife (CNM)	Podiatrist
Children's Services Targeted Case Management	Portable X-ray
Chiropractic	Private Duty Nursing (PDN)
Critical Access Hospital	Prosthetics (Includes Durable Medical Equipment & Orthotics)
Dental	Radiation Therapy Center
Developmental Therapy Services	Rehabilitative Hospital
Early Intervention Day Treatment (EIDT)	Rural Health Center (RHC)
End-Stage Renal Disease	School-Based Mental Health (SBMH)
EPSDT (Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment)	Therapy (OT, PT, Speech-Language)
Family Planning Clinic	Transportation
Federally Qualified Health Center (FQHC)	Ventilator
Hearing/Audiology	Vision
Home Health	



# Fee Schedules

The fee schedules do not address the various coverage limitations routinely applied by Arkansas Medicaid before final payment is determined (e.g., beneficiary and provider eligibility, benefit limits, billing instructions, frequency of services, third party liability, age restrictions, prior authorization, co-payments/coinsurance where applicable).

**Procedure codes and/or fee schedule amounts listed do not guarantee payment, coverage or amount allowed.**

Although every effort is made to ensure the accuracy of this information, discrepancies may occur. These fee schedules may be changed or updated at any time to correct such discrepancies. The reimbursement rates reflected in these fee schedules are in effect as of the run date for the report. The reimbursement rate applied to a claim depends on the claim's date of service because Arkansas Medicaid's reimbursement rates are date-of-service effective. These fee schedules reflect only procedure codes that are currently payable. Any procedure code reflecting a Medicaid maximum of \$0.00 is manually priced.

Please note that Arkansas Medicaid will reimburse the lesser of the amount billed or the Medicaid maximum. For disclaimers specific to the provider type, please refer to the disclaimer text in each fee schedule file. For a full explanation of the procedure codes and modifiers listed here, refer to your Arkansas Medicaid provider manual.



# 131.000 | Charges that Are Not the Responsibility of the Beneficiary

- A. A claim or portion of a claim denied for lack of medical necessity.
- B. Charges in excess of the Medicaid maximum allowable rate.
- C. A claim or portion of a claim denied due to provider error.
- D. A claim or portion of a claim denied because of errors made by DMS or the Arkansas Medicaid fiscal agent.
- E. A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed.
- F. A claim or portion of a claim denied because a provider failed to obtain prior, concurrent or retroactive authorization for a service.
- G. The difference between the beneficiary Medicaid cost sharing responsibility, if any, and the Medicare or Medicare Advantage co-payments.
- H. Medicaid pays the difference, if any, between the Medicaid maximum allowable fee and the total of all payments previously received by the provider for the same service. Medicaid beneficiaries are not responsible for deductibles, co-payments or coinsurance amounts to the extent that such payments, when added to the amounts paid by third parties, equal or exceed the Medicaid maximum for that service, even if the Medicaid payment is zero. The beneficiary is responsible for paying applicable Medicaid cost share amounts.
- I. The beneficiary is not responsible for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

If an individual who makes payment at the time of service is later found to be Medicaid eligible and Medicaid is billed, the individual must be refunded the full amount of his or her payment for the covered service(s). If it is agreeable with the individual, these funds may be credited against unpaid non-covered services and Medicaid cost-sharing amounts that are the responsibility of the beneficiary.

The beneficiary may not be billed for the completion and submission of a Medicaid claim form.

**Exception: Medicaid does not cover the deductible, co-payments or other cost share amounts levied to Medicare Part D drugs.**

Except for cost sharing responsibilities outlined in Sections 133.000 – 135.000, a beneficiary is not liable for the charges defined in this policy.



# 132.000 | Charges that Are the Responsibility of the Beneficiary

- A. Charges incurred during a time of ineligibility
- B. Charges for non-covered services, including services received in excess of Medicaid benefit limitations, if the beneficiary has chosen to receive and agreed to pay for those non-covered services
- C. Charges for services which the beneficiary has chosen to receive and agreed to pay for as a private pay patient
- D. Spend down liability on the first day of spend down eligibility
- E. The beneficiary is also responsible for any applicable cost-sharing amounts such as premiums, deductibles, coinsurance, or co-payments imposed by the Medicaid Program pursuant to 42 C.F.R. §§ 447.50 – 447.60 (2004). These cost-sharing responsibilities are outlined in Sections 124.210 -124.230 and 133.000 - 135.000 of this manual.

The beneficiary is not responsible for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

Beneficiaries are responsible for the charges defined in this section.



# PCP Referrals & Documentation

## 171.400 | PCP Referrals

- 171.400**      **PCP Referrals**      **1-1-18**      ☐
- A. Referrals may be only for medically necessary services, supplies or equipment.
  - B. Enrollee free choice by naming two or more providers of the same type or specialty.
  - C. PCPs are not required to make retroactive referrals.
  - D. Since PCPs are responsible for coordinating and monitoring all medical and rehabilitative services received by their enrollees, they must accept co-responsibility for the ongoing care of patients they refer to other providers.
  - E. PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. (This requirement varies somewhat in some programs; applicable regulations are clearly set forth in the appropriate Arkansas Medicaid Provider Manuals.)
  - F. There is no limit on the number of times a referral may be renewed, but renewals must be medically necessary and at least every six months (with exceptions as noted in part E, above).
  - G. An enrollee's PCP determines whether it is necessary to see the enrollee before making or renewing a referral.
  - H. Medicaid beneficiaries and ~~ARKids~~ First-B participants are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in Section 172.100.
  - I. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

## 171.410 | PCCM Referrals and Documentation

- 171.410**      **PCCM Referrals and Documentation**      **7-1-05**
- A. Medicaid provides an optional referral form, form DMS-2610, to facilitate referrals. [View or print form DMS-2610.](#)
    - 1. Additionally, PCP referrals may be oral, by note or by letter.
    - 2. Referrals may be faxed.
  - B. Regardless of the means by which the PCP makes the referral, Medicaid requires documentation of the referral in the enrollee's medical record.
    - 1. Medicaid also requires documentation in the patient's chart by the provider to whom the referral is made.
    - 2. Providers of referred services must correspond with the PCP to the extent necessary to coordinate patient care and as requested by the PCP.

# 142.300 | Conditions Related to Record Keeping

## 142.300 Conditions Related to Record Keeping

9-15-09

- A. Each provider must prepare and keep complete and accurate original records that fully disclose the nature and extent of goods, services or both provided to and for eligible beneficiaries. The provider must contemporaneously establish and maintain beneficiary records that completely and accurately explain all evaluation, care diagnoses and any other activities of the provider in connection with the Medicaid beneficiary. The delivery of all goods and services billed to Medicaid must be documented in the beneficiary's medical record. Beneficiary records must support the levels of service billed to Medicaid. Providers furnishing any Medicaid covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the aforementioned prescription, care plan or order within five (5) business days of the date it is written. When verbal orders are properly received, a written prescription must be obtained within fourteen (14) business days of the date the prescription is written or received through verbal order. The provider must maintain a copy of each subsequent, relevant prescription and follow all prescriptions and care plans.
- B. If a provider maintains more than one office in the state, the provider must designate one such office as a home office. Original records must be maintained at the provider's home office. A copy of the records must be maintained at the provider's service delivery site. If the provider changes ownership or ceases doing business in the state, all required original records must be maintained at a site in the state that is readily accessible by DMS and its agents and designees.
- C. Each provider must retain all records for five (5) years from the date of service or until all audit questions or review issues, appeal hearings, investigations or administrative or judicial litigation to which the records may relate are finally concluded, whichever period is later. Failure to furnish medical records upon request may result in sanctions being imposed. Federal legislation further requires that any accounting of private healthcare information (PHI) or Health Insurance Portability and Accountability Act of 1996 (HIPAA) policies or complaints must be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.
- D. Upon request, each provider must furnish all original records in its possession regarding the furnishing or billing of Medicaid goods or services, upon request, to authorized representatives of the Division of Medical Services or their designated representatives,

state Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services, or their designated agents. The request may be made in writing or in person. No advance notice is required for an in-person request. When records are stored off-premise or are in active use, the audited provider may certify, in writing, that the records in question are in active use or off-premise storage and set a date and hour within three (3) working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel. If an audit of records determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation supporting the services will be accepted from the provider for consideration. Additional documentation will not be accepted at a later date.

- E. Each provider must immediately furnish records, upon request, establishing the provider's charges to private patients for services that are the same as or substantially similar to services billed to Medicaid patients.





# Eligibility



# Importance of Checking Eligibility

Coverage Details for Beneficiary ID 4563217101 - PATTI PUFF from 1/1/2020 to 1/10/2020

Verification Response ID 2001000001

Primary Care Provider

PCP Name

PCP NOT REQUIRED

Effective Dates

01/01/2020-01/01/2020

Phone

[Expand All](#) | [Collapse All](#)

Benefit Details

Coverage	Description	County	Effective Date	End Date
25-MCAID	Full Medicaid	604 PULASKI	01/01/2020	01/10/2020
Copayments		Amount		
MCAID	1 (Medical Care) 30 (Health Benefit Plan Coverage) 33 (Chiropractic) 35 (Dental Care) 47 (Hospital) 48 (Hospital - Inpatient) 50 (Hospital - Outpatient) 86 (Emergency) 88 (Pharmacy) 98 (Professional (Physician) Visit - Office) AL (Vision) MH (Mental Health) UC (Urgent Care)	\$0.00		

Limit Details

Managed Care Assignment Details

Tier Level Details

Medicare/TPL

EPSDT Well Child Service Details

ARKIDS B Screening

Adult Dental Service

Demographic Details

[Print Preview](#)



# Review Benefit Plan on Crosswalk

Last Update: 10/16/17

Note: This document is a working document and modifications may be needed to reflect future changes.

Legacy Aid Category Description	Legacy Aid Category	Indicator	Disaster	Federal Poverty Level	Federal Match %	Waiver Inst. Indicator		iC Benefit Plan Code	iC Benefit Plan Description	iC Aid Category Code
ARKids First Program (M-CHIP)	01							AR1	ArKids First CHIP Program	0100
ARKids (M-CHIP2)	01	A						AR1	ArKids First CHIP Program	0101
ARKids (M-CHIP) Katrina AL	01	A	B					AR1	ArKids First CHIP Program	0102
ARKids (M-CHIP) Katrina LA	01	A	L					AR1	ArKids First CHIP Program	0103
ARKids (M-CHIP) Katrina MS	01	A	M					AR1	ArKids First CHIP Program	0104
ARKids (M-CHIP) Rita TX	01	A	T					AR1	ArKids First CHIP Program	0105
Medicaid Eligible (M-CHIP)	01	I						AR1	ArKids First CHIP Program	0106
Children of public employees (M-CHIP)	01	P						AR1	ArKids First CHIP Program	0107
Children of public employees (M-CHIP) Katrina LA	01	P	L					AR1	ArKids First CHIP Program	0108
DCFS non-Medicaid (non-IVE)	02							DCFYS	DCFYS Div of Child Fmly	0200
CMS non-Medicaid	03							TITLV	Children's Med Svcs Respite Care & DDS	0300
DDS non-Medicaid	04							DDS	Developmental Disability	0400
DCFS non-Medicaid IVE	05							DCFYS	DCFYS Div of Child Fmly	0500
Adult Expansion no FPL no FMAP	06							HCIP	Health Care Independence (Private Option)	0600
Adult Expansion no FPL no FMAP	06							IABP	Interim Alternative Benefit Plan	0600
Adult Expansion no FPL no FMAP	06							ABP	Alternative Benefit Plan	0600
Adult Expansion no FPL no FMAP	06							FRAIL	Full Medicaid for Medically Frail	0600
Adult Expansion no FPL A FMAP	06				A			HCIP	Health Care Independence (Private Option)	0601
Adult Expansion no FPL A FMAP	06				A			IABP	Interim Alternative Benefit Plan	0601
Adult Expansion no FPL A FMAP	06				A			ABP	Alternative Benefit Plan	0601
Adult Expansion no FPL A FMAP	06				A			FRAIL	Full Medicaid for Medically Frail	0601
Adult Expansion no FPL B FMAP	06				B			HCIP	Health Care Independence (Private Option)	0602
Adult Expansion no FPL B FMAP	06				B			IABP	Interim Alternative Benefit Plan	0602
Adult Expansion no FPL B FMAP	06				B			ABP	Alternative Benefit Plan	0602
Adult Expansion no FPL B FMAP	06				B			FRAIL	Full Medicaid for Medically Frail	0602
Adult Expansion no FPL N FMAP	06				N			HCIP	Health Care Independence (Private Option)	0603
Adult Expansion no FPL N FMAP	06				N			IABP	Interim Alternative Benefit Plan	0603
Adult Expansion no FPL N FMAP	06				N			ABP	Alternative Benefit Plan	0603



# Benefits (Section II of Provider Manual)

Arkansas Medicaid administers more than **50 programs**. Here are just a few of the many benefits available to eligible clients (see Section II of the Physician Manual):

- Physician services
- Inpatient hospital
- Outpatient hospital
- Lab/X-ray
- Prescription
- Therapy (OT/PT/speech)
- Mental health
- Emergency room
- Long-term care
- Hospice
- Medical equipment

# Tools to Determine Eligibility

- Benefit plan crosswalk **AND** Section 1 (124.000) of your Provider Manual [Aid Category Crosswalks](#)
- Eligibility verification job aid
- [Eligibility Verification](#)

# Claims





# TIME FOR A BREAK

We will be right back!

# Completion of Claim Form

## Professional (1500)

The following are examples of providers who would complete a CMS 1500 form:

- Physicians/Other practitioners
- Transportation providers
- Vision providers
- Surgeons
- Supply providers
- HCBS/Waiver providers

## Institutional (UB-04)

The following are examples of providers who would complete a UB-04 form:

- Inpatient/Outpatient hospital
- Nursing facility
- Home health/PDN
- Hospice
- Dialysis center
- Residential treatment center
- Rural health clinics



# Rendering Versus Billing Provider | Professional (1500)

## **Rendering Provider** (Individual within a group)

- Individual that provides services to an Arkansas Medicaid client.

## **Billing Provider**

- Entity being reimbursed for service

# Attending Versus Billing Provider | Institutional (UB-04)

## **Attending Provider**

- Individual that provides services to an Arkansas Medicaid client

## **Billing Provider**

- Entity being reimbursed for service

# Ways to Submit Claims for Processing

- Arkansas Medicaid Provider Healthcare Portal  
[portal.mmis.arkansas.gov/ARMedicaid](https://portal.mmis.arkansas.gov/ARMedicaid)
- **Vendor specs** are available on the DHS website at: [System Documents - Arkansas Department of Human Services](#)
- **Paper:** Although paper submission is allowed, we **highly** recommend that you only submit a paper claim when you are asked to do so. Paper claims can take up to 30-45 days to process. *Using the paper claim submission could greatly postpone provider's payment*

# Mail Paper Claims To:

## **Gainwell Technologies**

Attn: Claims  
P.O. Box 8034  
Little Rock, AR 72203

## **Special Claims**

Attn: Research Analysts  
P.O. Box 8036  
Little Rock, AR 72203

## **Crossover Claims**

Gainwell Technologies  
P.O. Box 34440  
Little Rock, AR 72203

*Please do not send claims to AFMC*



# What is a Timely Claim?

## Section 302.000 of the AR Medicaid Manual Defines Timely Claims

The *Code of Federal Regulations* states “The Medicaid agency *must require* providers to submit all claims *no later than 12 months from the date of service.*” The 12-month (365 days) filing deadline applies to **all** claims, including:

- Claims for services provided to beneficiaries with joint Medicare/Medicaid eligibility
- Adjustment requests and resubmissions of claims previously considered
- Claims for services provided to individuals who acquire Medicaid eligibility retroactively

**There are no exceptions to the 12-month filing deadline policy.** The definitions and additional federal regulations in Section 3 will permit some flexibility for those who adhere closely to them.

All providers must submit claims within the 12-month (365 days) filing deadline to meet timely filing policy.

# Claims with Retroactive Eligibility

- Retroactive eligibility does not constitute an exception to the filing deadline policy.
- If a claim is denied for client ineligibility, the provider may resubmit the claim when the patient becomes eligible.
- Occasionally, a Medicaid eligibility determination cannot be completed in time for service providers to file timely claims.

# Claims with Retroactive Eligibility

- Arkansas Medicaid considers the pseudo client identification number **9999999999** to represent the client. Therefore, a claim containing that number is a clean claim if it contains all other information necessary for correct processing.
- Providers have **12 months** from the *approval* date of the patient's Medicaid eligibility to resubmit a clean claim *after* filing a pseudo claim.
- Providers may not *electronically* transmit any claims for dates of service *over 12 months* in the past to the Arkansas Medicaid fiscal agent.

# Pseudo Claims

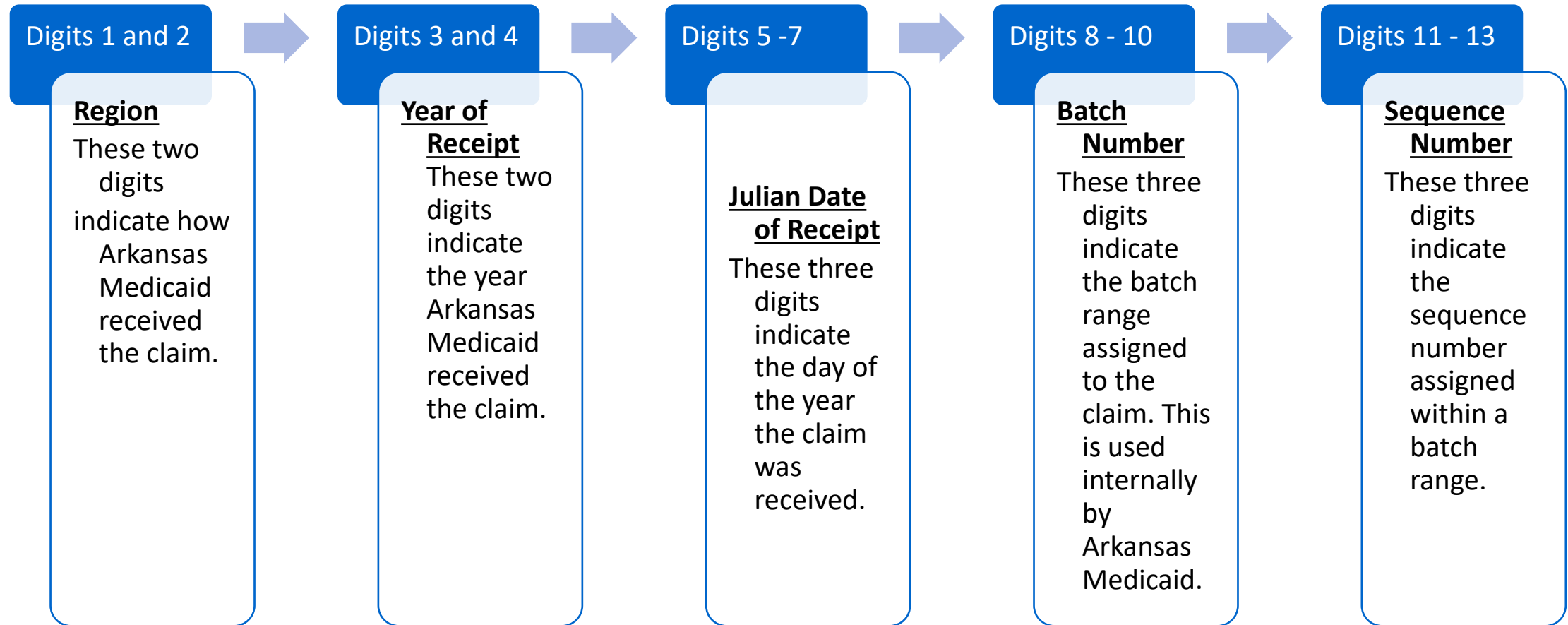
- To submit a claim for services provided to a patient who is not yet eligible for Medicaid, enter, on the claim form or on the electronic format (Portal or billing vendor/trading partner), a pseudo Medicaid client identification number, **9999999999**. Medicaid will deny the claim. Retain the denial or rejection for proof of timely filing if eligibility determination occurs more than 12 months after the date of service.
- Providers have 12 months from the approval date of the patient's Medicaid eligibility to re-submit a *clean* claim after filing a pseudo claim.
- When submitting the new claim after member has received eligibility, please ensure you submit this claim exactly as you submitted the pseudo claim. All provider numbers and procedure code/modifier information must match the original claim submitted.



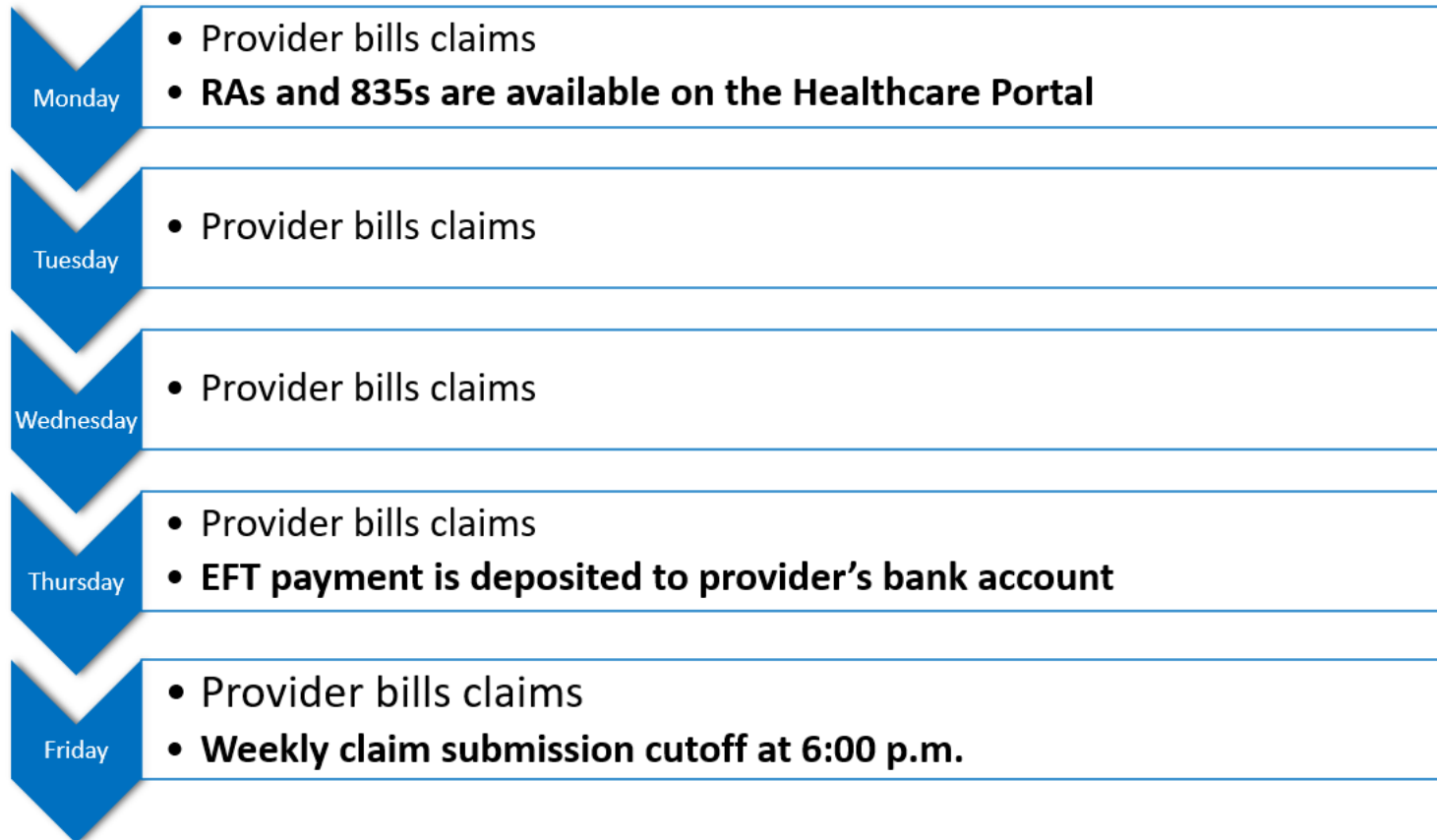
# Pseudo Claims

- Submit a paper claim to **Gainwell Technologies Research, PO Box 8036, Little Rock, AR 72203**
  - A copy of the Remittance Advice (RA) report page, documenting a denial of the claim dated within 12 months after the beginning date of service, or
  - A copy of the error response to an electronic transmission of the claim, computer-dated within 12 months after the beginning date of service, and
  - Any additional documentation necessary to explain why the error has prevented re-filing the claim until more than 12 months have passed after the beginning date of service

# Internal Control Number



# Payment Processing Schedule



# Remittance Advice

## 313.100 Descriptions and Samples of Remittance Advice Reports

11-1-17

Samples of each type of remittance advice report and descriptions of the fields are described to help in reading the RA.

View or print Remittance Advice samples for the following claim types: [Dental](#), [Institutional](#), [Pharmacy](#) or [Professional](#).

View or print Remittance Advice field names and descriptions for the following claim types: [Dental](#), [Institutional](#), [Pharmacy](#) or [Professional](#).

## 314.000 Explanation of the Remittance and Status Report

11-1-17

There are three different claim types for remittance advice reports issued by the fiscal agent: Institutional, Professional, Pharmacy and Dental. The remittance advice a provider receives will depend upon the claim types submitted. Each remittance type contains the same categories of information. These categories are described in the following subsections. Detailed descriptions of each remittance type, as well as samples of each type, [are located in Section 313.100](#).



# Common Terms for Claims Processing

## Denied

Claim processed and denied based on the rules in the processing system. Some denied claims can be resubmitted for payment after corrections have been made. Denied claims may **not** be adjusted.

However, they can be resubmitted as a clean claim for payment if it is within the timely filing guidelines.

## Paid

Claim processed and paid based on the rules in the processing system.

\*Note: If a claim pays \$0.00 due to lower of pricing, it is considered a paid claim.

# Common Terms for Claims Processing

## **Adjustment**

Modifying claims that paid but are still within the timely filing guidelines.

## **Rebill**

Bill a claim that was denied.

# Common Terms for Claims Processing

## **Suspend**

Claim must be manually reviewed before it can be processed (adjudicated).

## **Void**

Terminating a paid claim.

# Adjustments

- If the fiscal agent has *incorrectly* paid a clean claim and the error has made it impossible to adjust the payment before 12 months have passed since the beginning date of service, a completed Adjustment Request Form (AR-004) must be submitted to the address specified on the form. Attach the documentation necessary to explain why the error has prevented re-filing the claim until more than 12 months have passed after the beginning date of service.
- Adjustment Request Form – Medicaid XIX AR 004 ([print Adjustment Request Form-Medicaid XIX AR-004](#)), available in Section V of the Arkansas Medicaid Manual
- Mail to:

**Adjustments**  
**Gainwell Technologies**  
**P.O. Box 8036**  
**Little Rock, Arkansas 72203**





# Refund Checks

Service Details													
#	From Date	To Date	Place Of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount	Allowed Amount	Co-pay Amount
<u>1</u>	01/01/2018	01/01/2018	11	N	99214		1	1.00 Unit	<input type="checkbox"/>	<input type="checkbox"/>	\$100.00		
No Adjudication Errors exist for this claim													
No Other Insurance Details exist for this claim													
No Attachments exist for this claim													
<a href="#">Edit</a> <a href="#">Copy</a> <a href="#">Void</a> <a href="#">Print Preview</a> <a href="#">Inquiry</a>													



# Top Denials

1100	Multiple Service Locations For Provider Specialty
1018	Invalid Replacement/Void- Original Claim Denied/Suspended
0355	NO CO-INSURANCE OR DEDUCTIBLE DUE BY MEDICAID
0011	MEDICARE PAID DATE MISSING OR INVALID.
1094	THE MEDICARE CLAIM HAS A MEMBER WHO IS ENROLLED IN PASSE MGD CARE. PLEASE SUBMIT



# 1100-Multiple Service Locations for Provider Specialty

If the NPI is shared with more than one Medicaid Provider number, the system looks at the taxonomy then the address with zip+4

- Update the NPI, taxonomy or the address with zip+4
- Updating the address, the provider needs to update it with the legal zip+4 per the post office.
- Provider Medicaid IDs share the same address, then the provider only has the option to update the NPI or primary taxonomy on file in order to bill electronically.

***Questions about updating the NPI, taxonomy or address, contact the Provider Enrollment Unit at Gainwell***



# 1018-INVALID REPLACEMENT/VOID- ORIGINAL CLAIM DENIED/SUSPENDED

## Method of Correction

You cannot Adjust/Edit a claim unless it's in a Paid status

- Don't select the edit/adjust button. You can copy the previous claim. Make sure to include the modifiers if on original claim

*Please note: If you electronically post your RA, the original claim number is referenced on the claim. You will need to delete the denied claim number and resubmit the claim. Or you can resubmit the claim on the portal.*



## 0355-NO CO-INSURANCE OR DEDUCTIBLE DUE BY MEDICAID

### Method of Correction

This is a Crossover Claim-This means there was no reference on the claim to indicate Coinsurance or Deductible due by Medicaid.

Please review the claim and make sure all fields are filled out correctly. Meaning the Co-insurance and/or Deductible fields needs to be populated and re-submit the claim.



# 0011-MEDICARE PAID DATE MISSING OR INVALID.

Providers can get this denial due to the following reasons:

1) If the Medicare paid date is keyed with a date later than the date the claim was submitted or if the claim is a paper claim the date populated on the creation date field.

2) The Medicare payment date cannot be before or equal to the From DOS on the claim.

3) The Medicare paid date is not present or it is not a valid date.



# 1094-THE MEDICARE CLAIM HAS A MEMBER WHO IS ENROLLED IN PASSE MGD CARE

This denial is self explanatory, but we wanted to stress how important it is to check the **Managed Care** panel when you check eligibility to verify if the member is in a PASSE.

The Managed Care panel will also tell you which PASSE the member has and that PASSE's contact information.

Arkansas Total Care

Empower Healthcare Solutions

Summit Community Care

CareSource



# Medicare

MEDiCARE





# Medicare/Medicaid Crossover Claims

- The *Medicare* claim will establish timely filing for Medicaid, if the provider **files** with Medicare during the 12-month Medicaid filing deadline. Section 302.100 of the AR Medicaid Manual states that federal regulations permit Medicaid to pay its portion of the claim within **six** months after the Medicaid “agency or the provider receives notice of the disposition of the Medicare claim.”
- To submit a Medicare/Medicaid crossover claim that exceeds the timely filing conditions, enclose a **signed cover memo** or Medicaid Claim Inquiry Form requesting payment for the Medicaid portion of a Medicare claim filed to Medicare within 12 months of the date of service and adjudicated by Medicare more than 12 months after the date of service.
- **Mail the cover letter, DMS-600, claim form and EOMB to:**

**Gainwell Technologies**

**PO Box 34440**

**Little Rock, AR 72203**



# Medicare-Medicaid Crossover Claim Filing Procedures

- If medical services are provided to a patient who is entitled to and is enrolled with coverage within the original Medicare plan under the Social Security Act and also to Medicaid benefits, it is necessary to file a claim only with the original Medicare plan. The claim must be filed according to Medicare's instructions and sent to the Medicare intermediary. The claim should automatically cross to Medicaid if the provider is properly enrolled with Arkansas Medicaid and indicates the beneficiary's dual eligibility on the Medicare claim form. According to the terms of the Medicaid provider contract, a provider must "accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any appropriate deductible or coinsurance which may be due and payable under Title XIX (Medicaid)." See Section 142.700 for further information regarding Medicare/Medicaid mandatory acceptance of assignment for providers.
- When the original Medicare plan intermediary completes the processing of the claim, the payment information is automatically crossed to Medicare's Coordination of Benefits Agreement (COBA) process and from there crossed to Arkansas Medicaid and the claim is processed in the next weekend cycle for Medicaid payment of applicable coinsurance and deductible. The transaction will usually appear on the provider's Medicaid RA within four (4) to six (6) weeks of payment by Medicare. If it does not appear within that time, payment should be requested according to the instructions below.
- Claims for Medicare beneficiaries entitled under the Railroad Retirement Act **do not** cross to Medicaid. The provider of services must request payment of co-insurance and deductible amounts through Medicaid according to the instructions below, after Railroad Retirement Act Medicare pays the claim.
- Medicare Advantage/Medigap Plans (like HMOs and PPOs) are health plan options that are available to beneficiaries, approved by Medicare, but run by private companies. These companies bill Medicare and pay directly through the private company for benefits that are a part of the Medicare Program, as well as offering enhanced coverage provisions to enrollees. Since these claims are paid through private companies and not through the original Medicare plan directly, these claims **do not** automatically cross to Medicaid; and the provider must request payment of Medicare covered services co-insurance and deductible amounts through Medicaid according to the below instructions after the Medicare Advantage/Medigap plan pays the claim.

# Medicare-Medicaid Crossover Claim Filing Procedures

- If medical services are provided to a patient who is entitled to and is enrolled with coverage within the original Medicare plan under the Social Security Act and also Medicaid benefits, it is necessary to file a claim only with the original Medicare plan. The claim must be filed according to Medicare's instructions and sent to the Medicare intermediary. The claims with Arkansas Medicaid and indicates the beneficiary's dual eligibility on the Medicare claim form. According to the terms of the Medicaid provider contract, a provider must "accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any appropriate deductible or coinsurance should automatically cross to Medicaid if the provider is properly enrolled which may be due and payable under Title XIX (Medicaid)." See Section 142.700 for further information regarding Medicare/Medicaid mandatory acceptance of assignment for providers.
- When the original Medicare plan intermediary completes the processing of the claim, the payment information is automatically crossed to Medicare's Coordination of Benefits Agreement (COBA) process and from there crossed to Arkansas Medicaid and the claim is processed in the next weekend cycle for Medicaid payment of applicable coinsurance and deductible. The transaction will usually appear on the provider's Medicaid RA within four (4) to six (6) weeks of payment by Medicare. If it does not appear within that time, payment should be requested according to the instructions below.
- Claims for Medicare beneficiaries entitled under the When a provider learns of a patient's Medicaid eligibility only after filing a claim to Medicare, the instructions below should be followed after Medicare pays the claim.
- **Instructions:** The Arkansas Medicaid fiscal agent provides software and web-based technology with which to electronically bill Medicaid for crossover claims that do not cross to Medicaid. Additional information regarding electronic billing can be located in this Sections 301.000 through 301.200. Providers are strongly encouraged to submit claims electronically or through the Arkansas Medicaid website. Front-end processing of electronically and web-based submitted claims ensures prompt adjudication and facilitates reimbursement.
- Providers without electronic billing capability must mail the appropriate National Standard Claim Form (CMS-1500 or CMS-1450) to the fiscal agent (currently Gainwell Technologies), PO Box 34440, Little Rock, AR 72203. (See Section V of this manual for examples of CMS-1500 and CMS-1450). Along with the National Standard Claim Form, providers must submit attachment DMS-600. ([View or print attachment DMS-600.](#)) Providers must also submit the Medicare Explanation of Benefits (EOMB). Claims must be submitted in the following order:
  - A. National Standard Claim Form
  - B. DMS-600
  - C. Medicare Explanation of Benefits (EOMB)
  - D. Other supporting or applicable documentation
- Paper claims will be returned to the provider if not submitted in the above order.
- Railroad Retirement Act **do not** cross to Medicaid. The provider of services must request payment of co-insurance and deductible amounts through Medicaid according to the instructions below, after Railroad Retirement Act Medicare pays the claim.
- Medicare Advantage/Medigap Plans (like HMOs and PPOs) are health plan options that are available to beneficiaries, approved by Medicare, but run by private companies. These companies bill Medicare and pay directly through the private company for benefits that are a part of the Medicare Program, as well as offering enhanced coverage provisions to enrollees. Since these claims are paid through private companies and not through the original Medicare plan directly, these claims **do not** automatically cross to Medicaid; and the provider must request payment of Medicare covered services co-insurance and deductible amounts through Medicaid according to the below instructions after the Medicare Advantage/Medigap plan pays the claim.

# Medicare Denial or Adjustment

## Denial of Claim by Medicare

- Any charges denied by the original Medicare plan, a Medicare Advantage/Medigap plan, or Railroad Retirement will not be automatically forwarded to Medicaid for reimbursement. An appropriate Medicaid claim form must be completed and a copy of the Medicare denial statement attached. Claims under these circumstances must be forwarded to the Provider Assistance Center (PAC) for processing. [View or print PAC contact information.](#)
- **\*\*Please note, you must submit your claim on an official red and white claim form along with your EOB. Claims should be submitted to ATTN: Research Analyst P.O. Box 8036 Little Rock AR 72203.**

## Adjustments by Medicare

- Any adjustment made by the original Medicare plan, a Medicare Advantage/Medigap plan, or Medicare Railroad Retirement, **will not** be automatically forwarded to Medicaid. If any Medicare payment source makes an adjustment that results in an overpayment or underpayment by Medicaid, the provider must submit in the following order:
  - A. Adjustment Request Form – Medicaid XIX AR 004 ([View or print Adjustment Request Form-Medicaid XIX AR-004](#)), available in Section V of this manual
  - B. National Standard Claim Form (CMS-1500 or CMS-1450)
  - C. Copy of the Medicare Explanation of Benefits (EOMB) reflecting Medicare's adjustment and other supporting documentation
- Enter the provider identification number and the patient's Medicaid identification number on the face of the Medicare EOMB and mail all documents to the address located on the Adjustment Request Form (AR-004).
- **\*\*Please note that claims that are within 365 days of the DOS can be adjusted electronically.**

# How To File A Claim for A Client That Has TPL, Medicare And Medicaid

## Medicare Denies And TPL Pays

If Medicare denies the claim and the patient also has **Medicare-supplement or private insurance**, bill the charges to Medicaid on an original red-ink claim form (CMS-1500 or CMS-1450), attaching both the Medicare denial and the insurance company's Explanation of Benefits form. Submit the claim to the Gainwell Technologies research analyst as shown above.

## Medicare And TPL Denies

If both Medicare and Medicare-supplement or private insurance deny the claim, then bill the charges to Medicaid on an original red-ink claim form (CMS-1500 or CMS-1450), attaching both denials. Submit the claim to the Gainwell Technologies research analyst as shown above.

## Medicare Pays And TPL Denies

If Medicare pays the claim but Medicare-supplement or private insurance denies it, bill the claim to Arkansas Medicaid on the paper crossover invoice, attaching the insurance company's denial. Submit the claim to the Gainwell Technologies research analyst as shown above.



# Submitting a Crossover Claim on the Portal

## Submit Professional Claim: Step 1



The \* (in red) indicates required fields when the ADD button is selected.

Claim Type

Professional  
Crossover Professional

### Medicare Crossover Details

Allowed Medicare Amount

0.00

Co-insurance Amount

0.00

Deductible Amount

0.00

Medicare Payment Amount

0.00

\*Medicare Payment Date ⓘ

Continue

Cancel



# Summary

- The *Medicare* claim will establish timely filing for Medicaid if the provider files with Medicare during the 12-month Medicaid filing deadline
- Providers have six months from date of Medicare paid date to submit their Medicare Crossover claim, if it was not submitted directly by Medicare Intermediary. **From the Medicare Crossover Provider Manual** “Federal regulations permit Medicaid to pay its portion of the claim within six (6) months after the Medicaid “agency or the provider receives notice of the disposition of the Medicare claim.”
- **Mailing address for claims past the timely filing deadline:**

**Gainwell Technologies Research**

**PO Box 8036**

**Little Rock, AR 72203**



# Third-Party Liability





# TPL Documentation/Billing Guidelines

- If you are a provider of services to a Medicaid-eligible member, but the services you provide are not covered by the member's primary insurance company, please see below for documentation and billing guidelines:
  - A provider can use either a certificate of benefits or a denial letter from insurance company (EOB with no payment to provider) or a payment to the provider (EOB with payment). They will need to keep this in the client file for auditing purposes.
  - It will be good for one year for either the Certificate of Benefits or Denial EOB.
  - Example: Get certificate or denial dated 01/01/2021. The provider could use it through 12/31/2021. They would say "yes" they billed the insurance using a denial date of, in this example, 01/01/2021 and \$0.00 payment amount. Be sure to include Claim Filing Indicator.

# Submitting a Third-Party Liability (TPL) Claim on the Portal

## Submit Professional Claim: Step 1



The \* (in red) indicates required fields when the ADD button is selected.

Claim Type **Professional**  
Crossover Professional

#	Carrier Name	Carrier ID	Policy ID	Paid Amount	Paid Date	Action
1	SOUTHWIRE AND AFFILIATES	CI1	321654		—	<a href="#">Remove</a>

Refresh Other Insurance

Carrier Name

SOUTHWIRE AND AFFILIATES

Carrier ID

CI1

Policy Holder is

Person

Policy Holder Last Name

PUFF

First Name

PATTI

MI

—

Policy Holder Address

1234 MAIN STREET

City

LITTLE ROCK

State

ARKANSAS

Zip Code

72255

Policy Holder ID

Policy ID

321654

Group Name

Responsibility

U-Unknown

Patient Relationship to Insured

18-Self

Paid Amount

\*Paid Date

\*Claim Filing Indicator

Release of Information

Assignment of Benefits

Save Insurance

Cancel Insurance

Click to add a new other insurance.

# Prior Authorization



# AFMC Prior Authorization Process Types on the Portal

- Anesthesia
- Assistant Surgeon
- Hyperalimentation
- Hyperbaric Oxygen Therapy
- Inpatient Services
- Lab and Radiology
- Lab Molecular Pathology
- Orthotics and Prosthetics
- Physician Administered Drugs
- Professional Services
- Ventilators and Equipment
- Viscosupplementation

*Note: These process types are processed by AFMC*

# State Medical Prior Authorization Process Types on the Portal

- Augmentative Communication
- Device Evaluation
- DDS services
- Developmental Rehab Services
- Disposable Medical Supplies
- Eye Prosthetics
- First Connections
- Hearing Services
- Home Health Visit Extensions
- Private Duty Nursing
- Special Procedure Codes
- Targeted Case Management
- Title V
- Vision

*Note: These process types are processed by the State*

# State Dental Prior Authorization Process Types on the Portal

- Adult dental
- Child dental
- Orthodontics

*Note: These process types are  
processed by the State*

# How To Access PA Letters



# Prior Authorizations/EOB Not Requested In The Healthcare Portal

- eQHealth



# Healthcare Provider Portal

Secure | <https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx>

**ARMedicaid** [Contact Us](#) | [Login](#)  
[Español](#) | [Other](#)

Home

Home Thursday 01/04/2018 10:33 AM CST

**Login**

\*User ID

[Log In](#)


[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)

**What can you do in the Provider Portal**

Through this secure and easy to use internet portal, healthcare providers can submit claims and inquire on the status of their claims, inquire on a patient's eligibility, upload files containing 837 transactions, and search for another provider. In addition, healthcare providers can use this site to locate claim forms, provider participation materials and other health plan information and resources.



[FAQs](#) [Links and Tools](#) [Learn More About](#)

[Help us provide better service to you! Click here to give us your feedback.](#)

[Website Requirements](#)

[Provider Manual](#)

[DOWNLOAD PES \(Full Version\)](#)

[DOWNLOAD PES Upgrade \(from version 2.24 to 2.25\)](#)

**Broadcast Messages**

Providers must now utilize electronic fund transfer (EFT), which allows your Medicaid payments to be directly deposited into your bank account. If you already receive your Medicaid payments by EFT, then no further action is required. If you DO NOT receive EFT payments for Medicaid services you provide, you must take action NOW to ensure that you continue to receive Medicaid payments. [more...](#)

[Privacy Notice](#)



# Healthcare Portal Features

- Online provider enrollment application
- Eligibility verification
- Submit all claim types (professional, institutional, dental, crossover and third-party)
- Ability to edit (adjust), void and copy claims
- View status of claims
- Attachments for claims and prior authorizations
- Prior authorization request and status check
- Real-time claims processing
- Remittance advise held up to seven years
- Secure correspondence

# Healthcare Portal Enhancements

- Treatment History panel
- Dental Claim Diagnosis Code no longer required
- Tooth#/Letter, Oral Cavity not required for D9248
- Provider Affiliation
- File size increased for attachments
- Files exchange – documentation list

# Training



# Training Opportunities

## Quick Track Training

AFMC proudly announces the quick track training series featuring short videos and corresponding handouts to get you up to speed — quickly! Each short episode in this series will instruct you on a particular skill so you can master what you need right now.

Video Links	Guides
<a href="#">Eligibility Verification Video</a>	<a href="#">Eligibility Verification Guide</a>
<a href="#">Files Exchange for HCI Video</a>	<a href="#">Files Exchange for HCI Guide</a>
<a href="#">How to Adjust/Edit a Claim Video</a>	<a href="#">How to Adjust/Edit a Claim Guide</a>
<a href="#">How to Access a PA Letter Video</a>	<a href="#">How to Access a PA Letter Guide</a>
<a href="#">How to Submit a Medicare/Medicaid Claim Video</a>	<a href="#">How to Submit a Medicare/Medicaid Claim Guide</a>
<a href="#">How to Submit a Claim with Third Party Liability Video</a>	<a href="#">How to Submit a Claim with Third Party Liability Guide</a>
<a href="#">Portal Password Reset Video</a>	<a href="#">Portal Password Reset Guide</a>
<a href="#">Timely Filing Video</a>	<a href="#">Timely Filing Guide</a>
<a href="#">How to Void a Claim Video</a>	<a href="#">How to Void a Claim Guide</a>



# Training Tools and Resources

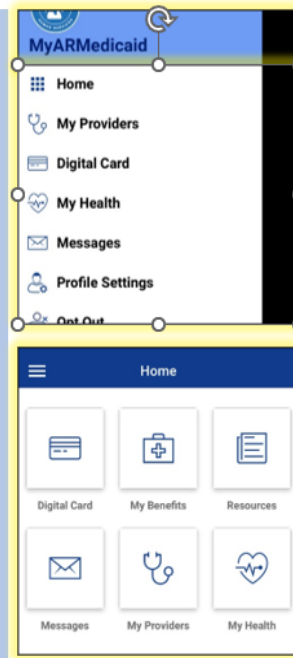
- DHS Website: <https://humanservices.arkansas.gov>
- Provider manuals
- FAQs
- Vendor specs
- Fee schedule
- Training Materials
- *MyARMedicaid Application (New)*



## Download the MyARMedicaid App

### BENEFITS

- View claims that Medicaid has paid for you
- View doctors or providers you have seen
- View medical visits or procedures you have had
- View your prescriptions and immunization records
- Access your digital Medicaid Card
- Search for providers
- Receive important notifications



### HOW TO SIGN UP

- On your smartphone
  - Go to the Apple App Store or Google Play and download the MyARMedicaid app.
  - Create an account and log in to see the benefits.



- Through the web
  - Go to the MyARMedicaid website at <https://mdp.mmis.arkansas.gov/>.
  - Create an account and log in to see the benefits.

Donaghey Plaza, P.O. Box 1437, Little Rock, AR 72203

501.682.1001

HUMAN SERVICES.ARKANSAS.GOV



# Things to Remember

- Claims submitted electronically must be entered by 6 p.m. on Friday
- Medicaid 101 webinar conducted the last Tuesday of each month (unless otherwise noted)
- Always check manuals, official notices, remittance advice banners and fee schedules for up-to-date information



# Eblast Sign-up Link

Sign-up for MMIS email updates

**Name \***

First

Last

**Email \***

Submit

[AFMC MMIS Eblast Sign Up Link](#)



# Evaluations

***Your feedback is important to us!***

Please take time to complete the evaluation that will be emailed to you.  
Attendance certificate will be available to print.

Thank you for attending today!

# Trainer Led Portal Training



