Housekeeping Rules

• Please make sure your phone is on mute.
• Questions will be answered during the webinar by our panelists.
• PHI should not be entered in the Q & A panel. For specific questions that contain PHI, please email your AFMC MMIS outreach specialist.
• New Provider Workshop presentation is available on the Medicaid and AFMC website at Medicaid.mmis.arkansas.gov under Training and afmc.org under Resources.
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 option 2. If you have technical issues please choose option 1, for Provider Enrollment option 3.

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 located on the Medicaid 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 and the Medicaid website www.Medicaid.mmis.arkansas.gov

For the latest information surrounding COVID-19 please visit the Medicaid and DHS websites at Medicaid.mmis.arkansas.gov and https://humanservices.arkansas.gov/resources/response-covid-19
New Provider Workshop

Karen Young
Training and Program Developer, MMIS, AFMC
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
MMIS Outreach Team

AFMC/MMIS OUTREACH SPECIALISTS

HOURS OF OPERATION:
Monday–Friday • 8:30 a.m.–5 p.m.

• AFMC/MMIS Manager
  Becky Andrews ……. 501-212-8738

• Supervisor/Outreach Specialist
  Andrea Rowlett-Allen
  Pulaski County ……. 501-906-7566
  pulaskibilling@afmc.org

• Outreach Specialists
  Christy Owens
  NW—Northwest ……. 501-906-7566
  northwestbilling@afmc.org

  Jose Britton
  NE—Northeast ……. 501-906-7566
  northeastbilling@afmc.org

  Mary Riley
  EC—East Central ……. 501-906-7566
  eastcentralbilling@afmc.org

  Kristie Williams
  SE—Southeast ……. 501-906-7566
  southeastbilling@afmc.org

  Angie Hagan
  SW—Southwest ……. 501-906-7566
  southwestbilling@afmc.org

  Renee Smith
  WC—West Central ……. 501-906-7566
  westcentralbilling@afmc.org

AFMC

Healthy People. Healthy Businesses.
Healthy Communities.

Gainwell

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Who’s Who at Medicaid

- Division of Medical Services (DMS)  
  https://humanservices.arkansas.gov/offices
- County offices (DCO)  
  https://humanservices.arkansas.gov/offices/dhs-county-office-map
- AFMC afmc.org  
  - MMIS Outreach Specialists 501-906-7566 afmc.mmis
  - ConnectCare seeyourdoc.org 1-800-275-1131
  - Provider Relations Outreach Specialists-afmc.providerrelations
  - AFMC-Review Department 479-649-8501
- eQHealth prior authorization and extension of benefits-  
  https://eqhs.com  
  Ar.pr@eqhs.com or 1-888-660-3831
  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/offices
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/dhs-county-office-map
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://hms.com
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) 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 is the fiscal agent for Arkansas Medicaid. They provide the following services:

- Provider enrollment
- Claims processing
- Remittance advice
- Provider Assistance Center (PAC)
- Electronic Data Interchange (EDI)

Monday through Friday 6 a.m. – 6 p.m.
PASSE | Provider-Led Arkansas Shared Savings Entity

- Arkansas Total Care
  - Phone Number: 866-282-6280
  - Webpage: arkansastotalcare.com

- Empower Healthcare Solutions:
  - Phone Number: 855-429-1028
  - Webpage: getempowerhealth.com

- Summit Community Care:
  - Phone Number: 844-462-0022
  - Webpage: summitcommunitycare.com

- DHS PASSE Provider Call Center
  - 888-889-6451
Dental Managed Care

Delta Dental
- Victoria Martin, Manager
- Whitney Palmer
  501-607-3331 or 501-992-1750
  wpalmer@deltadentalar.com
- Tondelayo Wayne
  501-607-3803 or 501-992-1748
  twayne@deltadentalar.com

MCNA
- MCNA Dental
  800-494-MCNA
  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
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
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 or on the Arkansas Medicaid Website under

- What do you need?
  - Provider information
  - Support
- AFMC outreach specialists
  - Choose the option for Medicaid Management Information System (MMIS) outreach specialists
- You may contact your outreach specialist by calling 501-906-7566 and choosing the region where your organization resides.
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:

- Episodes of Care
- Patient-centered Medical Home (PCMH)
- PASSE

You can find your provider outreach specialist at [afmc.org/providerrelations](https://afmc.org/providerrelations) or on the [Arkansas Medicaid Website](https://www.arkansasmedicaid.gov) under:

- **What do you need?**
  - Provider information
  - Support

- **AFMC outreach specialists**
  - Choose the option for Medicaid Managed Care Services (MMCS) outreach specialists
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’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 reviews and quality of care/service reviews for the following Medicaid providers:

- ARChoices
  - Attendant Care
  - Respite Care
  - Home Delivered Meals
  - Environment Modification
  - PERS
  - Targeted Case Management

- Division of Youth Services (DYS) Secure Residential Treatment Facilities, Specialized Residential Treatment (including group homes) and Community-Based Youth Services

- Inpatient Psychiatric Services for the Under Age 21 (U21)

- Outpatient Behavioral Health Services (OBHS) Fee-for-Service (FFS) including dually credentialed Substance Abuse Treatment Facilities

- Substance Abuse Residential Facilities

The unannounced reviews are designed to monitor and survey/review for compliance with licensure, program standards as well as any contractual agreements.

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
Fax: 479-649-0799
Webpage: afmc.org/review
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
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
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 Division of County 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/
Provider Enrollment

https://medicaid.mmis.arkansas.gov/Provider/Enroll/Enroll.aspx
Provider Enrollment Information

- Instructions for how to complete your application (PDF, new window)
- Required Documents Finder (Excel, new window)
- Video instruction for how to complete your application (MP4, new window)
- Start your application now (HTML, new window)
Provider Re-validation on the Healthcare Portal
Provider Information
Provider Numbers

- Nine-digit provider ID
- National provider ID (NPI)
- Atypical providers (NPI not required)
Fee Schedule & Policy Manuals
What’s New for Arkansas Medicaid Providers

Content updated March 5, 2019

View system status.

Jump to

- Provider-led Arkansas Shared Savings Entity (PASSE) UPDATE
- IMPORTANT UPDATE: Entry of Electronic PAs Using AFMC ReviewPoint Portal to Continue
- Provider-led Arkansas Shared Savings Entity (PASSE) Will Go Live on March 1, 2019
- PI/MU Deadline for 2018 Attestations
- Electronic Funds Transfer Required for All Providers Billing All Claims
- New Provider Manual Updates
- New RA Messages

Provider-led Arkansas Shared Savings Entity (PASSE) UPDATE

Added 3/4/19
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
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

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 -124.250 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.
PCP Referrals & Documentation

171.400 | PCP Referrals

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

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

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 of 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

**Benefit Details**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Description</th>
<th>County</th>
<th>Effective Date</th>
<th>End Date</th>
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<tbody>
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<td>21-MCAO</td>
<td>Full Medicaid</td>
<td>804 PHL/ASK</td>
<td>01/01/2020</td>
<td>01/10/2020</td>
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</tbody>
</table>

**Copayments**

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<th>Description</th>
<th>Amount</th>
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</thead>
<tbody>
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<td>Health Benefit Plan Coverage</td>
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<td>33</td>
<td>Maternity</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Dental Care</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Hospital - Inpatient</td>
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<tr>
<td>50</td>
<td>Hospital - Outpatient</td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>Urgent Care</td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Professional (Physician Visit - Office)</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Inpatient</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Outpatient</td>
<td></td>
</tr>
</tbody>
</table>

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[AFMC logo]

[Arkansas Department of Human Services logo]
Review Benefit Plan on Crosswalk
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
- Section I (124.000) of your Provider Manual
  - https://medicaid.mmis.arkansas.gov/Download/provider/provdocs/Manuals/SectionI/Section_I.doc
- Eligibility verification job aid
  - MMIS_JobAid_Eligibility.pdf
Claims
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

- Vendor specs are available on the Medicaid website at
  https://medicaid.mmis.arkansas.gov/Provider/hipaa/compan.aspx

- 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

Digits 1 and 2
Region
These two digits indicate how Arkansas Medicaid received the claim.

Digits 3 and 4
Year of Receipt
These two digits indicate the year Arkansas Medicaid received the claim.

Digits 5 - 7
Julian Date of Receipt
These three digits indicate the day of the year the claim was received.

Digits 8 - 10
Batch Number
These three digits indicate the batch range assigned to the claim. This is used internally by Arkansas Medicaid.

Digits 11 - 13
Sequence Number
These three digits indicate the sequence number assigned within a batch range.
Payment Processing Schedule

- Monday: Provider bills claims
- RAs and 835s are available on the Healthcare Portal

- Tuesday: Provider bills claims

- Wednesday: Provider bills claims

- Thursday: Provider bills claims
- EFT payment is deposited to provider's bank account

- Friday: Provider bills claims
- Weekly claim submission cutoff at 6:00 p.m.
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 filling 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

<table>
<thead>
<tr>
<th>#</th>
<th>From Date</th>
<th>To Date</th>
<th>Place Of Service</th>
<th>EMG</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Diag Code Ptrs</th>
<th>Units</th>
<th>EPSDT</th>
<th>Family Plan</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>01/01/2018</td>
<td>01/01/2018</td>
<td>11</td>
<td>N</td>
<td>99214</td>
<td>1</td>
<td>1.00 Unit</td>
<td></td>
<td></td>
<td></td>
<td>$100.00</td>
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<td></td>
</tr>
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</table>

No Adjudication Errors exist for this claim

No Other Insurance Details exist for this claim

No Attachments exist for this claim
<table>
<thead>
<tr>
<th>EOB Code</th>
<th>EOB Code Desc</th>
</tr>
</thead>
<tbody>
<tr>
<td>1100</td>
<td>MULTIPLE SERVICE LOCATIONS FOR PROVIDER SPECIALTY. PLEASE CALL PROVIDER ENROLLMENT</td>
</tr>
<tr>
<td>0978</td>
<td>IN RELATION TO EFFECTIVE DOS OF PROV SPEC, PROV IS INELIG TO RENDER THIS SERVICE</td>
</tr>
<tr>
<td>0319</td>
<td>INCORRECT PROVIDER NUMBER SUBMITTED - PAYMENT DELAYED</td>
</tr>
<tr>
<td>0252</td>
<td>MEDICAID ID NUMBER SUBMITTED DOES NOT MATCH MEMBERS NAME ON MEDICAID ID CARD</td>
</tr>
<tr>
<td>0098</td>
<td>SERVICE NOT PROVIDED UNDER THE MEDICAID PROGRAM.</td>
</tr>
<tr>
<td>0250</td>
<td>MEMBER NOT LISTED UNDER ID # SUBMITTED. CORRECT ID # AND RESUBMIT</td>
</tr>
<tr>
<td>0070</td>
<td>NOT IN ACCORD WITH MEDICAL POLICY GUIDELINES.</td>
</tr>
<tr>
<td>0355</td>
<td>NO CO-INSURANCE OR DEDUCTIBLE DUE BY MEDICAID</td>
</tr>
<tr>
<td>0077</td>
<td>THERAPY SERVICES INDICATOR AND/OR SCHOOL DISTRICT LEA CODE MISSING/INVALID</td>
</tr>
<tr>
<td>0092</td>
<td>THERAPY SERVICES INDICATOR INVALID FOR PROVIDER TYPE</td>
</tr>
<tr>
<td>0237</td>
<td>RENDERING PROVIDER NUMBER IS INVALID, MISSING, OR CANCELLED</td>
</tr>
<tr>
<td>1036</td>
<td>DIAGNOSIS CODE NOT ALLOWED FOR DATE OF SERVICE</td>
</tr>
<tr>
<td>1062</td>
<td>THE MDCD BILLING PROVIDER ID SUBMITTED ON THE CLAIM MUST BE THE NPI</td>
</tr>
<tr>
<td>1046</td>
<td>AMOUNT BILLED MISSING OR INVALID</td>
</tr>
<tr>
<td>0011</td>
<td>MEDICARE PAID DATE MISSING OR INVALID</td>
</tr>
<tr>
<td>1154</td>
<td>THE MEDICARE COINSURANCE AMOUNT MAY NOT BE GREATER THAN THE MEDICARE PAID AMOUNT</td>
</tr>
<tr>
<td>1063</td>
<td>THE MDCD RENDERING PROVIDER ID SUBMITTED ON THE CLAIM MUST BE THE NPI</td>
</tr>
<tr>
<td>0228</td>
<td>THE PROVIDER IS NOT ELIGIBLE FOR DATE(S) OF SERVICE</td>
</tr>
<tr>
<td>0007</td>
<td>TOTAL DAYS NOT EQUAL TO THE DIFFERENCE BETWEEN THE &quot;FROM&quot; AND &quot;TO&quot; DATES</td>
</tr>
<tr>
<td>0184</td>
<td>ACCOMMODATION UNITS DO NOT EQUAL COVERED DAYS</td>
</tr>
<tr>
<td>1093</td>
<td>EFT IS REQUIRED FOR BILLING PROVIDER TO RECEIVE PAYMENT</td>
</tr>
<tr>
<td>0863</td>
<td>PROC CODE IS OUTSIDE AGREED UPON CONTRACT</td>
</tr>
<tr>
<td>0046</td>
<td>ED SUPPL, DRUGS, INJECT NOT ALLOWED W/O ED ROOM CHARGE ON SAME DATE</td>
</tr>
<tr>
<td>1018</td>
<td>INVALID REPLACEMENT/VOID-ORIGINAL CLAIM DENIED/SUSPENDED</td>
</tr>
</tbody>
</table>
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 Research  
  PO Box 8036  
  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 DXC Technology, 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 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.

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.
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

<table>
<thead>
<tr>
<th>Allowed Medicare Amount</th>
<th>Co-insurance Amount</th>
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</thead>
<tbody>
<tr>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
</tr>
</tbody>
</table>

*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 the 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**

<table>
<thead>
<tr>
<th>#</th>
<th>Carrier Name</th>
<th>Carrier ID</th>
<th>Policy ID</th>
<th>Paid Amount</th>
<th>Paid Date</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
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<td>SOUTHAWAY AND AFFILIATES</td>
<td>C31</td>
<td>321494</td>
<td></td>
<td></td>
<td>Remove</td>
</tr>
</tbody>
</table>

- **Carrier Name**: SOUTHAWAY AND AFFILIATES
- **Carrier ID**: C31
- **Policy ID**: 321494
- **Paid Amount**: 
- **Paid Date**: 
- **Action**: Remove

**Fields Without Insurance**

- **Carrier Name**: SOUTHAWAY AND AFFILIATES
- **Carrier ID**: C31
- **Policy Holder First Name**: PATRIC
- **Policy Holder Last Name**: FULTON
- **Policy Holder Address**: 1234 MAIN STREET
- **City**: LITTLE ROCK
- **State**: ARKANSAS
- **Zip Code**: 72209
- **Policy Holder ID**: 
- **Group Name**: 
- **Responsibility**: Unknown
- **Patient Relationship**: Insured
- **Paid Amount**: 

**Claim Filing Indicator**: 

**Release of Information**: 

**Assignment of Benefits**

- **Save Insurance**
- **Cancel Insurance**

*Click to add a new other insurance.*
Prior Authorization

PRIOR AUTHORIZATION FORM
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
- Personal care – under age 21
- Physician-administered drugs
- Professional services
- Targeted case management
- Ventilators, 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
- First Connections
- Hearing services
- Home health visit extensions
- Independent Choices
- Other medical service
- Other prosthetics
- Private duty nursing
- Specialized service
- Title V

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
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 Coming Soon!

- Provider affiliation display panel
- Treatment history panel
- ARKids B co-pay information
- File size increased for attachments
- Files exchange – documentation list
Training
Training Opportunities

Provider Training Information

Jump to
- DXC / AFMC Virtual Annual Billing Workshops
- Recorded Webinars
- Training Materials for Download
- MMIS Job Aids
- Contact AFMC
- Archived Training Resources
Training Tools and Resources

- Medicaid website: https://medicaid.mmis.arkansas.gov
- Provider manuals
- FAQs
- Vendor specs
- Fee schedule
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

The following path can be used to sign up for the AFMC MMIS eblast:

- Navigate to the Arkansas Medicaid website ([https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx](https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx))
- Under “What do you need?” choose the option for “Provider”
- Choose “Support” from the left side of the page
- Choose the first option for “AFMC MMIS eblast sign-up”
Eblast Sign-up Link

Sign-up for MMIS email updates

Name *

First

Last

Email *

Submit

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