Housekeeping Rules for Attendees

- All attendee microphones will remain muted throughout the webinar.
- Please make sure you type your questions in the Q&A box. Questions will be answered during the presentation.
- To customize your presentation view, click the Layout button in the top right corner.
- If you do not have the presentations, you can email mmisteam@afmc.org to request a link to access a copy.
How to Access Training Materials During the Presentation

Open the Multimedia Viewer Panel and click “Continue.”

You should see the AFMC MMIS webpage which will allow you to download the presentation and any additional training resources.
Medicaid 101 Webinar Disclaimer

The Medicaid 101 Webinar 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. We invited all provider types to attend this webinar. Therefore, the information during this session will vary depending on the most relevant and immediate information.

If you have specific questions, technical issues or need Provider Enrollment, contact them at 1-800-457-4454. Please pay close attention to the options, as they have changed.

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, Timely Filing, How to Adjust/Edit a Claim, How to Void a Claim, and Files Exchange for Health Care Innovation Documentation located on the DHS and AFMC websites.

If you have escalated issues or would like to discuss specific issues, please contact your AFMC MMIS Outreach Specialist at 501-906-7566 to set up a virtual or on-site visit. A map to contact your AFMC MMIS Outreach Specialist is located at afmc.org and the DHS/DMS website https://humanservices.arkansas.gov

For the latest information surrounding COVID-19 please visit the DHS websites at

Updates for Providers - Arkansas Department of Human Services
Agenda

- Introduction – MMIS Outreach Team
- Who’s Who at Medicaid
- Provider Enrollment
- Provider Information
- Policy Manuals & Fee Schedule
- Eligibility
- Claims
- Third Party Liability

- Prior Authorization
- Healthcare Portal
- Things to Remember
- Medicaid Tools and Resources
- Eblast Sign-up
- Evaluations
- Questions
- Procedure Code Linking Tables
MMIS Outreach Team

AFMC/MMIS OUTREACH SPECIALISTS

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

- **AFMC/MMIS Manager**
  Becky Andrews · 501-212-8738

- **Supervisor/Outreach Specialist**
  Andrea Allen · Pulaski County · 501-906-7566
  pulaskibilling@afmc.org

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

  Rose 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 Riggin · SW—Southwest · 501-906-7566
  southwestbilling@afmc.org

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

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# Out of State Providers

<table>
<thead>
<tr>
<th>WY</th>
<th>West Central</th>
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<tbody>
<tr>
<td>Northwest towns in MO/OK</td>
<td>Northeast towns in MO</td>
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<tr>
<td>Anderson, MO</td>
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<td>Gainsville, MO</td>
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<td>Joplin, MO</td>
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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.org/mmis
  - ConnectCare - 1-800-275-1131, seeyourdoc.org
  - Provider relations outreach specialists - afmc.org/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
- 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

Webpage: https://eqhs.com
Email: 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
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
- Claims processing
- Remittance advice
- Provider Assistance Center (PAC)
- 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
- 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 Line
  888-889-6451
Dental Managed Care

Delta Dental
- Victoria Martin, Manager
  501-992-1714 or 501-804-8648
  vmartin@deltadentalar.com
- Whitney Roundtree, Provider Network Coordinator
  501-607-3331 or 501-992-1750
  wroundtree@deltadentalar.com
- Briana Sparks, Provider Network Coordinator
  501-607-3803 or 501-992-1718
  bsparks@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

You can find your provider outreach specialist at afmc.org/mmis or on the DHS/DMS Website

- 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.

Note: If you would like a one-on-one meeting to answer specific questions after this training, please contact your outreach specialist.
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 or on the DHS/DMS Website

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 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.

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: 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 clients

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 clients’ 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](http://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 Updates

Provider Functions

- PCP Information
- Provider LTC Census
- Search Update Requests
- Submit an Update Request
Provider Information
Provider Numbers

• Nine-digit provider ID
• National provider ID (NPI)
• Atypical providers (NPI not required)
Policy Manuals and Fee Schedule
Helpful Information for Providers

- Access the Provider Portal (check eligibility, submit a PA request, or submit claims)
- Billing Manuals
- Fee Schedules
- PCMH / PCCM
- Provider Training Information
- Rate Reviews
- Sign-up for MMIS email updates
- State Plan (Medicaid and CHIP)
Provider Manuals

- **Section I**
  - General policy
  - General information, sources, client eligibility and responsibilities, provider participation, administrative (and non-compliance) 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
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 Linking Tables

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

The fee schedules do not address the various coverage limitations routinely applied by Arkansas Medicaid before final payment is determined (e.g., client and provider eligibility, benefit limits, billing instructions, frequency of services, third party liability, age restrictions, prior authorization, and 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.
Importance of Checking Eligibility
Review Benefit Plan on Crosswalk
Tools to Determine Eligibility

- Benefit Plan Crosswalk
- Section I (124.000) of your Provider Manual
  - https://medicaid.mmis.arkansas.gov/Download/providers/provdocs/Manuals/SectionI/Section_I.doc
- Eligibility Verification Job Aid
  - MMIS_JobAid_Eligibility.pdf
Claims
Completion of Claim Form

**Professional (CMS 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 (CMS 1450 or 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 Claim (CMS 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 Claim (CMS 1450 or 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:** Specifications are available on the Medicaid website at:
  [System Documents - Arkansas Department of Human Services](https://systemdocuments.arkansastreasurer.com/

- **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 clients 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

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A copy of today’s presentation is available at: services.arkansas.gov/wp-content/uploads/Medicaid101.pdf

TIME FOR A BREAK
We will be right back!
How to Access Training Materials During the Presentation

Open the Multimedia Viewer Panel and click “Continue.”

You should see the AFMC MMIS webpage which will allow you to download the presentation and any additional training resources.
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 cont’d

- 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 cont’d

- 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
Voided Claims

Section 314.130 of the AR Medicaid Manual Defines how to adjust by Voiding

Payment errors, such as underpayments and overpayments as well as payments for the wrong procedure code, wrong dates of service, wrong place of service, etc., can be adjusted by canceling ("voiding") the incorrectly adjudicated claim and processing the claim as if it were a new 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 refiling 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

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# Refund Checks

## Service Details

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</table>

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No Adjudication Errors exist for this claim

No Other Insurance Details exist for this claim

No Attachments exist for this claim

---

![Refund Check Image]
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

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Arkansas Medicaid Manual

Please refer to Section 3 of the Arkansas Medicaid Manual for additional information related to timely claims

• Section 302.000 Timely Filing
• Section 302.100 Medicare/Medicaid Crossover Claims
• Section 302.400 Claims With Retroactive Eligibility
• Section 302.510 Adjustments

Gainwell Technologies Provider Assistance Center (PAC)

PO Box 8036
Little Rock, AR 72203
1-800-457-4454

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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 01/01/2022. The provider could use it through 12/31/2022. They would say “yes” they billed the insurance using a denial date of, in this example, 01/01/2022 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

<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>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SOUTHWADE AND AFFILIATES</td>
<td>C01</td>
<td>321894</td>
<td></td>
<td></td>
<td>Remove</td>
</tr>
</tbody>
</table>

Carrier Name: SOUTHWADE AND AFFILIATES
Policy Holder: Person
Policy Holder Last Name: MATTI
Policy Holder Address: 1234 MAIN STREET
City: LITTLE ROCK
State: ARKANSAS
ZIP Code: 72203
Policy Holder ID: 121694
Group Name: 
Responsibility: Unknown
Patient Relationship: 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
State Medical/State Dental Prior Authorization Process Types on the Portal

Only the following PA types are available on the HealthCare Provider Portal:

State Medical
- 108 – Augmentative Communication Device Evaluation
- 151 – DDS services
- 152 – Developmental Rehab Services
- 109 – Disposable Medical Supplies
- 111 – Eye prosthetics
- 154 – First Connections
- 107 – Hearing Services
- 110 – Home Health Visit Extensions
- 102 – Private Duty Nursing
- 114 – Special Procedures Codes
- 130-Targeted Case Management
- 153 – Title V
- 116 – Vision

State Dental
- 103 – Adult Dental
- 104 – Child Dental
- 105 – Orthodontics
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
Welcome Healthcare Professional!

We are committed to making 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.

Security Correspondence

All Claim Inquiries should be submitted to the following address:

Claims
DIXC Technology
PO BOX 8034
LITTLE ROCK, AR 72203

We hope you provide better service to your! Click here to give us your feedback.
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 advice held up to seven years
- Secure correspondence

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Eligibility Strip

Coverage Details for Beneficiary ID: 05022173101 - PRT07 PMPP from 1/16/2019 to 1/14/2019

Verification Response ID: 1991600002

Primary Care Provider:
- PCP Name: PCP NOT REQUIRED
- Effective Date: 01/16/2019 to 01/14/2019
- Phone: ___

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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</thead>
<tbody>
<tr>
<td>25-RCAD1</td>
<td>Full Medicaid</td>
<td>604 FLA, GA, AL</td>
<td>01/16/2019</td>
<td>01/14/2019</td>
</tr>
</tbody>
</table>

Copayments

<table>
<thead>
<tr>
<th>Copayments</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Medical Care)</td>
<td>$0.00</td>
</tr>
<tr>
<td>30 (Health Benefit Plan Coverage)</td>
<td></td>
</tr>
<tr>
<td>33 (Chiropractor)</td>
<td></td>
</tr>
<tr>
<td>35 (Dental Care)</td>
<td></td>
</tr>
<tr>
<td>47 (Hospital)</td>
<td></td>
</tr>
<tr>
<td>48 (Hospital - Inpatient)</td>
<td></td>
</tr>
<tr>
<td>50 (Hospital - Outpatient)</td>
<td></td>
</tr>
<tr>
<td>96 (Emergency)</td>
<td></td>
</tr>
<tr>
<td>88 (Pharmacy)</td>
<td></td>
</tr>
<tr>
<td>98 (Professional (Physician) Visit - Office)</td>
<td></td>
</tr>
<tr>
<td>AL (Vision)</td>
<td></td>
</tr>
<tr>
<td>MH (Mental Health)</td>
<td></td>
</tr>
<tr>
<td>VC (V begins)</td>
<td></td>
</tr>
</tbody>
</table>

Limit Details

Managed Care Assignment Details

Medicare/TPL

EPSDT Well Child Service Details

ARDEX & Screening

Adult Dental Service

Demographic Details

Print Preview

Other Insurance Detail Information

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Arkansas Department of Human Services
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

Allowed Medicare Amount: 0.00
Deductible Amount: 0.00
Medicare Payment Amount: 0.00

Co-insurance Amount: 0.00

*Medicare Payment Date

Continue  Cancel
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

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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SOUTHWIRE AND AFFILIATES</td>
<td>CII</td>
<td>221654</td>
<td>-</td>
<td></td>
<td>Remove</td>
</tr>
</tbody>
</table>

- Carrier Name: SOUTHWIRE AND AFFILIATES
- Carrier ID: CII
- Policy ID: 221654
- City: LITTLE ROCK
- State: ARKANSAS
- Zip Code: 72201

- Policy Holder is: Person
- Policy Holder Last Name: SURF
- Policy Holder First Name: PATTI
- Policy Holder Address: 1234 MAIN STREET
- Group Name: 023894
- Relationship to Insured: 18-Self
- Paid Amount: 
- *Paid Date: 

*Click to add a new other insurance.
Things to Remember

- Claims submitted electronically must be entered by 6 p.m. on Friday
- New Provider Workshops are conducted quarterly
- Always check manuals, official notices, remittance advice banners and fee schedules for up-to-date information
Medicaid Tools and Resources

DHS/DMS website: https://humanservices.arkansas.gov

• Provider manuals
• Frequently asked questions (FAQs)
• Vendor specifications
• Fee schedule
• Training materials
• MyARMedicaid Application (New)
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!
How to Access Training Materials During the Presentation

Open the Multimedia Viewer Panel and click “Continue.”

You should see the AFMC MMIS webpage which will allow you to download the presentation and any additional training resources.