Frequently Asked Questions

Retroactive Eligibility

This document is subject to frequent modifications. Please check the revision date to ensure you are reading the most current information.

Instructions: Please **Click** on the question being asked to locate the appropriate **Answer** within this document. You may also use **CTRL + F** for faster searching. Also, **Click** the "Back to the Top" links on each page to return to first page of questions.

Overview

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To verify retroactive claims will be processed in a timely manner.

- Providers will submit claims electronically, unless other rules apply for paper filing. Providers have from October 17, 2016 until April 15, 2017 to submit retroactive claims.
- Providers must verify recipient eligibility prior to claim submission. If eligibility is not determined, you CANNOT BILL.
    - All pending Medicaid applications should be completed by December 31, 2016.
    - Keep checking eligibility.
- Retroactive claims are applicable for dates of service on or after October 1, 2013. It is the provider's responsibility to validate eligibility coverage and billing policy related to the effected dates of service.
- Providers must verify the Primary Care Physician for the claims dates of service. Contact ConnectCare at **855-266-0628** for *providers only* for PCP assistance. The hours are 8:00 am to 4:30 pm Monday – Friday.
- PA issue – All services requiring a PA must follow established processes. PAs must be obtained before filing the claim.
- For benefit limited or duplicated services: The billing provider that submits a clean claim first is the provider that will be paid.
- Claims are subject to established benefit limits; extension of benefit limit rules apply.
- Providers must use the correct diagnosis and procedure codes for the dates of service. See Question 7 for the correct codes.

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Claim Criteria

- A claim must meet the following criteria in order to qualify for the exception of bypassing the 365-day timely filing period:
    - Retroactive Eligibility Segments
    - ASC claims for AR Medicaid covered procedure codes with a rate change retroactive to date of service 8/1/2015 and newly payable ASC procedure codes that are retroactively effective for dates of service on and after 8/1/2015.
    - Inpatient Hospitalizations
        - Adult Medicaid patients have 24 inpatient days from 10/1/13 - 12/31/15
        - Adult Medicaid patients have 24+ days of inpatient stay after 1/1/16
        - Alternative Benefit Plan beneficiaries have 24+ days of inpatient stay from 10/1/13 to present
    - J-code – AR Medicaid payable drug procedure codes for the billed date of service that rejected/denied for procedure code-to-NDC mismatch even though the rebatable NDC for the procedure code was billed.
    - Department of Corrections Inpatient Claims
- Note that Paid claims will be audited. **Claims that are processed and paid that do not meet the exception criteria will be subject to recoupment.**
- Due to the anticipated influx of claims, claims processing may be slower than normal.
- Providers who submit more than 49 claims per week/per recipient (need clarification per recipient or claims detail or only 49), will set for those claims that are over 49. No action is needed because these claims will process through the coming week's cycles.
- Email arxixtimelyfiling@hpe.com

NOTE: Due to the amount of data being requested, providers may experience increased response times while submitting both real-time claims/eligibility transitions and batch claims/eligibility transactions.

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Answer #1

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1. What if my bill dates are before 10-1-2013?

Answer:

If your bill dates or dates of service are **before 10-1-2013**, then your claim will deny for timely filing and will not be processed.

The date of service must be on or **after 10-1-2013** to qualify for the timely filing exception.

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Answer #2

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2. Will retroactive eligibility require PCP referrals on DOS before the approved beneficiary eligibility was added to the claims processing system?

Answer:

According to Section I of your provider policy manual, retroactive eligibility does not require a PCP.

However, if your claim is rejected for this issue, then please contact the Provider Assistance Center to request further research at 800-457-4454. Please be sure to tell the Call Center Representative that you are calling regarding a Timely Filing claim.

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Answer #3

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3. How will benefit limits and extension of benefits be addressed for my claim that denies for exceeding the benefit limit (i.e. lab/x-ray, office visits)?

Answer:
Interim Alternative Benefits Plan:

Below is an example of what will show on the provider portal for a client who is AID Category 06, and has not been determined medically frail, and has not moved into a Qualified Health Plan with a Private Carrier. There is no PCP requirement, no limits on lab services, no limits on physician office visits, and no limits on pharmacy. This eligibility is temporary during the transition period to a QHP or Medically Frail category of fee-for-service.

Extended Eligibility or Benefit Information

Eligibility or Benefit Information	R (Other or Additional Payer)
Service Type Code	30 (Health Benefit Plan Coverage)
Insurance Type Code	C1 (Commercial)
Plan Coverage Description	00 ()
Member Identification Number	
Insurance Policy Number	00000AR0000001-00
Group Number	
Group or Policy Number	
Date Time Period	20160101-20161231
Last Or Organization Name	ALTERNATIVE BENEFIT PLAN INTRM
Identification Code	00000

Qualified Health Plan through Private Insurance Carrier:

Below is an example of what will show on the provider portal for a client who is AID Category 06, and is currently in a Qualified Health Plan with a private insurance carrier. Displayed on the provider portal is specific carrier information related to the client, including a phone number for the provider to reach the carrier. There is no Medicaid PCP requirement for clients in a Qualified Health Plan, but the provider will need to contact the carrier to determine if there are PCP requirements by the carrier.

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Extended Eligibility or Benefit Information

Eligibility or Benefit Information	R (Other or Additional Payer)
Service Type Code	30 (Health Benefit Plan Coverage)
Insurance Type Code	C1 (Commercial)
Plan Coverage Description	00 ()
Member Identification Number	
Insurance Policy Number	75293AR0280001-32
Group Number	
Group or Policy Number	
Date Time Period	20160101-20161231
Last Or Organization Name	ARKANSAS BLUE CROSS AND BLUE S
Identification Code	75293
Communication Number	8008004298

Alternative Benefit Plan Full:

Below is an example of what will show on the provider portal for a client who is AID Category 06, and has been determined Medically Frail, and has chosen the Alternative Benefits Plan in fee-for-service Medicaid. A PCP is required for services in this category, and there are no limits on lab services, no limits on physician office visits, and no limits on pharmacy. There are no benefits in ABP for long-term care services or home health.

Extended Eligibility or Benefit Information

Eligibility or Benefit Information	R (Other or Additional Payer)
Service Type Code	30 (Health Benefit Plan Coverage)
Insurance Type Code	C1 (Commercial)
Plan Coverage Description	00 ()
Member Identification Number	
Insurance Policy Number	00000AR0000002-00
Group Number	
Group or Policy Number	
Date Time Period	20160101-20161231
Last Or Organization Name	ALTERNATIVE BENEFIT PLAN FULL
Identification Code	00000

Standard Medicaid Plan

Below is an example of what will show on the provider portal for a client who is AID Category 06, and has been determined Medically Frail, and has chosen Standard Medicaid. Standard Medicaid does require a PCP assignment. Standard Medicaid has traditional Medicaid benefit limits on lab services, physician's visits, and pharmacy. Standard Medicaid will have benefits for long term care as well as home health.

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Extended Eligibility or Benefit Information

Eligibility or Benefit Information	L (Primary Care Provider)
Coverage Level Code	IND (Individual)
Service Type Code	30 (Health Benefit Plan Coverage)
Insurance Type Code	MC (Medicaid)

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Answer #4

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4. Where can I find Fee Schedules for all provider programs for 2013, 2014, 2015, and 2016?

Answer:

Fee schedules from 2011 through 2016 have been pulled from electronic archives and are linked below. Please select the date of the needed fee schedule and click the link to view or print the file.

A | C | D | E | F | H | I | L | N | O | P | R | S | T | V

Alternatives for Adults with Physical Disabilities Waiver

2011 / 2012	2013	2014	2015	2016
10/25/12		7/15/14		1/15/16 5/17/16

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Ambulatory Surgical Center

2011 / 2012	2013	2014	2015	2016
5/15/12	4/16/13 8/7/13	8/19/14	6/18/15 6/24/15	

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ARChoices

2011 / 2012	2013	2014	2015	2016
				1/12/16

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ARKids First-B Screenings / SCHIP Vaccines

2011 / 2012	2013	2014	2015	2016
5/23/12	6/19/13	7/1/14	8/27/15	1/19/16

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Autism Waiver

2011 / 2012	2013	2014	2015	2016
		3/19/14 6/25/14		1/14/16 4/27/16

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Certified Nurse-Midwife

2011 / 2012	2013	2014	2015	2016
5/18/12	4/16/13	6/26/14	2/6/15 5/27/16	1/6/16 4/26/16 5/17/16

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Child Health Management Services

2011 / 2012	2013	2014	2015	2016
5/18/12	4/22/13 7/22/13	6/25/14		1/15/16

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Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

2011 / 2012	2013	2014	2015	2016
5/18/12	6/19/13	7/11/14 10/29/14		1/19/16

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Chiropractic

2011 / 2012	2013	2014	2015	2016
5/22/12		7/11/14		1/6/16 4/27/16

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Dental

2011 / 2012	2013	2014	2015	2016
5/17/12	9/12/13	7/14/14		1/13/16 5/18/16 9/13/16

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Developmental Day Treatment Clinic Services

2011 / 2012	2013	2014	2015	2016
5/23/12		7/15/14		1/15/16 2/17/16 5/25/16

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ElderChoices

2011 / 2012	2013	2014	2015	2016
5/23/12		7/1/14		1/12/16

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End-Stage Renal Disease

2011 / 2012	2013	2014	2015	2016
5/18/12	9/12/13	7/15/14		1/7/16

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Federally Qualified Health Center

2011 / 2012	2013	2014	2015	2016
5/18/12		6/27/14		1/7/16 9/26/16

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Hearing Services

2011 / 2012	2013	2014	2015	2016
5/17/12		6/25/14		1/12/16

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Home Health

2011 / 2012	2013	2014	2015	2016
10/12/12	9/12/13	7/15/14		1/6/16

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Hospice

2011 / 2012	2013	2014	2015	2016
12/20/12		2/27/14 11/20/14		1/6/16

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Hospital

2011 / 2012	2013	2014	2015	2016
5/15/12	3/28/13	1/31/14	4/22/15	1/6/16
	4/12/13	9/29/14	11/12/15	5/25/16
	7/22/13	11/12/14		9/12/16
	8/23/13			9/20/16
	9/4/13			

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Hyperalimentation

2011 / 2012	2013	2014	2015	2016
5/22/12				1/7/16

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Independent Lab

2011 / 2012	2013	2014	2015	2016
5/18/12	6/24/16	1/8/14		1/7/16
		6/25/14		9/13/16
				9/21/16

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Independent Radiology

2011 / 2012	2013	2014	2015	2016
5/18/12	6/24/13	7/15/14		1/13/16
	9/17/13			9/13/16

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Licensed Mental Health Practitioner

2011 / 2012	2013	2014	2015	2016
5/23/12	4/19/13	7/18/14		1/12/16

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Living Choices Assisted Living

2011 / 2012	2013	2014	2015	2016
11/29/12		6/23/14		1/7/16

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Nurse Practitioner

2011 / 2012	2013	2014	2015	2016
5/18/12	4/12/13	9/29/14		1/12/16
	8/6/13			4/20/16
				5/9/16
				9/13/16
				9/20/16

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Occupational, Physical, and Speech Therapy Services

2011 / 2012	2013	2014	2015	2016
5/23/12		7/25/14	7/7/15	1/15/16

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Oral Surgeon

2011 / 2012	2013	2014	2015	2016
5/17/12	9/12/13	7/14/14		1/13/16

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Personal Care Services

2011 / 2012	2013	2014	2015	2016
5/22/12	9/12/13	8/13/14		1/4/16
				1/26/16

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Physician

2011 / 2012	2013	2014	2015	2016
5/15/12	3/28/13	3/17/14	4/15/15	1/6/16
	6/28/13	9/29/14	9/11/15	4/21/16
	7/22/13		10/2/15	9/13/16
	8/16/13		10/18/15	9/20/16
	9/3/13		11/12/15	10/18/16
	12/17/13			

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Podiatrist

2011 / 2012	2013	2014	2015	2016
5/18/12		6/26/14		1/7/16

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Portable X-Ray

2011 / 2012	2013	2014	2015	2016
5/13/11		7/18/14		1/28/16

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Private Duty Nursing

2011 / 2012	2013	2014	2015	2016
10/01/12		6/26/14	10/19/15	1/6/16

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Prosthetics (includes Durable Medical Equipment and Orthotics)

2011 / 2012	2013	2014	2015	2016
10/1/12	3/28/13	6/25/14		1/6/16
	9/5/13	10/27/14		8/15/16

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Radiation Therapy Center

2011 / 2012	2013	2014	2015	2016
5/23/12	2/8/13	7/17/14		1/12/16

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Rehabilitative Hospital

2011 / 2012	2013	2014	2015	2016
5/18/12		7/18/14		1/15/16

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Rehabilitative Services for Persons with Mental Illness

2011 / 2012	2013	2014	2015	2016
5/18/12	3/28/13	1/22/14		4/20/16
	4/18/13	1/31/14		
	8/16/13	7/22/14		
	10/3/13			

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Rehabilitative Services for Youth and Children

2011 / 2012	2013	2014	2015	2016
5/23/11		7/25/14		

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Rural Health Clinic

2011 / 2012	2013	2014	2015	2016
5/18/12		7/18/14		1/7/16

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School-Based Mental Health Services

2011 / 2012	2013	2014	2015	2016
5/23/12		6/23/14		1/7/16

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Substance Abuse Treatment Services

2011 / 2012	2013	2014	2015	2016
5/21/12		7/23/14		1/19/16

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Supplemental Payments to Physician, Primary Care Physician and Family Planning Clinic

2011 / 2012	2013	2014	2015	2016
	1/1/13	10/17/14		

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Targeted Case Management

2011 / 2012	2013	2014	2015	2016
5/23/12	3/19/13	7/25/14		1/6/16

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Transportation

2011 / 2012	2013	2014	2015	2016
5/23/12		7/25/14		1/7/16 9/21/16

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Ventilator Equipment

2011 / 2012	2013	2014	2015	2016
5/21/12		7/23/14		1/7/16
				9/13/16

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Visual Care

2011 / 2012	2013	2014	2015	2016
5/17/12	12/27/13	7/23/14		1/7/16

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Answer #5

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5. Are there other exceptions to allow timely filing exemptions other than those reasons already stated in the overview?

Answer:

- ASC claims for AR Medicaid covered procedure codes with a rate change retroactive to date of service 8/1/2015 and newly payable ASC procedure codes that are retroactively effective for dates of service on and after 8/1/2015.
- Inpatient Hospitalizations
    - Adult Medicaid patients have 24 inpatient days from 10/1/13 – 12/31/15
    - Adult Medicaid patients have 24+ days of inpatient stay after 1/1/16
    - Alternative Benefit Plan beneficiaries have 24+ days of inpatient stay from 10/1/13 to present
- J-code – AR Medicaid payable drug procedure codes for the billed date of service that rejected/denied for procedure code-to-NDC mismatch even though the rebateable NDC for the procedure code was billed.
- Office of Medicaid Inspector General (OMIG) – During this open timely filing period, OMIG may present cases involving providers with extenuating circumstances.

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Answer #6

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6. How do I find the correct procedure and diagnosis codes for my claim and date of service?

Answer:

Neither the State nor HPE can code a provider's claims. The following provider notices may be useful to consider depending on the date of service being billed. The CPT, HCPCS, and ICD conversion notices below may be useful.

Provide Publication	Effective Date	Description
NOTICE-001-13	3-15-13	2013 Current Procedure Terminology (CPT®) Code Conversion
NOTICE-002-13	3-15-13	2013 Healthcare Common Procedural Coding System Level II (HCPCS) Code Conversion
NOTICE-002-14	6-15-14	2014 Current Procedure Terminology (CPT®) Code Conversion
NOTICE-003-14	6-15-14	2014 Healthcare Common Procedural Coding System Level II (HCPCS) Code Conversion
NOTICE-001-15	10-1-15	International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
NOTICE-002-15	12-18-15	2015 Current Procedure Terminology (CPT®) Code Conversion
NOTICE-003-15	12-18-15	2015 Healthcare Common Procedural Coding System Level II (HCPCS) Code Conversion
NOTICE-001-16	8-26-16	Current Procedural Terminology (CPT®) Code Conversion
NOTICE-002-16	8-26-16	2016 Healthcare Common Procedure Coding System Level II (HCPCS) Code Conversion and Code on Dental Procedures and Nomenclature (CDT) Conversion

ABP effective date was January 1, 2014.

For more information, also see the specific program manual information on the AR Medicaid website: https://www.medicaid.state.ar.us/Provider/docs/docs.aspx.

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Answer #7

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7. How do I verify an eligibility segment for claim(s) with retroactive dates of service?

Answer:

Eligibility information will be available for up to three years past. The provider will need to key in the specific date of service to be verified. Example: Physician saw the beneficiary for an office visit on 01/14/2014. Beneficiary's application for Medicaid was approved retroactively to 01/01/2014 on 08/01/2016 and is now available for billing. The physician's billing personnel will need to run an eligibility verification for the 01/01/2014 date of service before submitting the claim to ensure the Medicaid number is active within the Medicaid claims system.

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Answer #8

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8. What if a claim is submitted that was not related to the particular issue at hand?

Answer:

The only claims that qualify for bypassing the 365 day timely filing exception are those with dates of services on or after 10-01-2013. Paid claims will be audited. Claims that are processed and paid that do not meet the criteria will be subject to recoupment.

Claims filed by providers that do not qualify under the identified listing will be reviewed and recouped.

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Answer #9

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9. How do I verify if a Primary Care Physician (PCP) is needed? Who is responsible for assigning a PCP?

Answer:

Connect care phone number: PCP assistance to **855-266-0628** for *providers only*. The hours are 8-4:30pm M-F.

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Answer #10

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10. Who do I call to verify if a beneficiary has exceeded the benefit limitation?

Answer:

Please call the Provider Assistance Center at 800-457-4454.

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Answer #11

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11. Our billing system is not set up to bill timely claims due to our internal system edits. How can we bill these claims?

Answer:

You must bill these retroactive claims electronically. Arkansas Medicaid strongly suggests that modifications be made to your system to process these claims correctly.

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Answer #12

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12. How many claims can be submitted at one time for each beneficiary? What happens if I submit more than the amount?

Answer:

A maximum of 49 claims per recipient will be processed weekly. Claims in excess of 49 claims per recipient will be suspended and will automatically be processed on the following weekend.

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Answer #13

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13. Will providers receive back pay for PMPM payments, Episodes of Care, PCMH, etc.?

Answer:

Incentive payments will not be paid retroactively. Adjustments may be considered based on claim volume and will be reviewed after the timely filing bypass period ends on or about April 17, 2017.

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Answer #14

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14. How many times am I allowed to resubmit a claim?

Answer:

A claim may be corrected and resubmitted as many times as needed within the six-month window between October 17, 2016 and April 15, 2017. Once the window closes, any claims resubmitted will be rejected for timely filing.

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Answer #15
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15. Is there a list of contacts if my question is still not answered?

Answer:

AFMC:

- Karla Batey: AFMC Review process and education
  - 479-573-7756
  - kbatey@afmc.org
- Ami Winters: AFMC Review process and education
  - 479-573-7746
  - awinters@afmc.org
- Sheryl Hurt: AFMC Outreach - policy and education
  - 501-212-8688
  - shurt@afmc.org

Beacon:

- Nicole May:
  - 501-707-0951
  - Nicole.May@beaconhealthoptions.com
- Melissa Ortega:
  - 501-707-0970
  - Melissa.Ortega@beaconhealthoptions.com
- Jennifer Daniel Brezee:
  - 501-707-0964
  - Jennifer.Daniel-Brezee@beaconhealthoptions.com

HPE Provider Assistance Center:

In-State: 1-800-457-4454
Local / Out of State: 501-376-2211

Magellan Pharmacy Help Desk:

1-800-424-7895

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