

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-200 Medicaid Coverage Periods

A-210 Retroactive Eligibility

A-210 Retroactive Eligibility

MS Manual 05/01/18

The State is required to provide retroactive eligibility for up to three full months prior to the date of application to applicants who:

1. Received medical services in the retroactive period; and
2. Were eligible in the month the medical services were received.

Retroactive eligibility will be provided to applicants who were otherwise eligible in the month services were received regardless of whether they were ineligible at other times during the retroactive period. Retroactive eligibility is separate and apart from current eligibility, i.e., applicants not eligible for the current period may be eligible for the retroactive period.

Retroactive eligibility determinations are required for all categories, except ALF, ARChoices, Autism, DDS Waiver, QMB and PACE.



NOTE: Retroactive coverage for Newborns will not be given prior to the date of birth.



NOTE: Beginning May 1, 2018, Adult Expansion Group recipients may be eligible for retroactive coverage 30 days prior to the date of application. Retroactive coverage for the Adult Expansion Group is date specific.

EXAMPLE: James is approved for coverage in the Adult Expansion Group with an application date of September 15. He asks for retroactive coverage for a doctor bill with a service date of August 1. He is not eligible for retroactive coverage because his bill is for August 1 and retroactive coverage can only begin August 16.

EXAMPLE: James is approved for coverage in the Adult Expansion Group with an application date of December 31. He asks for retroactive coverage for a doctor bill with a service date of December 1. His regular coverage will begin December 1. As the 30th day is included in his regular coverage period, no coverage will be given for the previous month.

An application for retroactive eligibility may be made on behalf of deceased persons and eligibility will be provided if they were eligible when the services were received.

For cases in which an applicant has not resided in Arkansas for three full months prior to the date of application, the retroactive period begins with the date the individual established residency in Arkansas. The "previous state" is responsible for the retroactive period prior to the time the applicant established residency in Arkansas. The caseworker is responsible for

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MEDICAL SERVICES POLICY MANUAL, SECTION A MARKUP

A-200 Medicaid Coverage Periods

A-210 Retroactive Eligibility

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MS Manual 0531/01/187

The State is required to provide retroactive eligibility for up to three full months prior to the date of application to applicants who:

1. Received medical services in the retroactive period; and
2. Were eligible in the month the medical services were received.

Retroactive eligibility will be provided to applicants who were otherwise eligible in the month services were received regardless of whether they were ineligible at other times during the retroactive period. Retroactive eligibility is separate and apart from current eligibility, i.e., applicants not eligible for the current period may be eligible for the retroactive period. Retroactive eligibility determinations are required for all categories, except ALF, ARChoices, Autism, DDS Waiver, QMB and PACE.

NOTE: Retroactive coverage for Newborns will not be given prior to the date of birth.

NOTE: Retroactive coverage for Former Foster Care and the Adult Expansion Group cannot begin prior to January 1, 2014. Medicaid will provide retroactive coverage for services received prior to approval for the Adult Expansion Group and prior to the individual's enrollment in a private insurance plan. Beginning May 1, 2018 January 1, 2017, Adult Expansion Group recipients may will be eligible for retroactive coverage 30 days one month prior to the date month of application. will not be given to the Adult Expansion Group participants.

EXAMPLE: James is approved for coverage in the Adult Expansion Group with an application date of September 15. He asks for retroactive coverage for a doctor bill with a service date of August 1. He is not eligible for retroactive coverage because his bill is for August 1 and retroactive coverage can only begin August 16.

EXAMPLE: James is approved for coverage in the Adult Expansion Group with an application date of December 31. He asks for retroactive coverage for a doctor bill with a service date of December 1. His regular coverage will begin December 1. Therefore, retroactive coverage will not be processed because the 30 days prior to the date of application is December 1 which is in the regular coverage period. As the 30th day is included in his regular coverage period, no coverage will be given for the previous month.

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MEDICAL SERVICES POLICY MANUAL, SECTION B

B-500 Emergency Medicaid Services for Aliens

B-500 Emergency Medicaid Services for Aliens

B-500 Emergency Medicaid Services for Aliens

MS Manual 05/01/18

This group consists of:

- Nonqualified aliens living in the U.S or
- Qualified aliens living in the U.S. for less than 5 years.

Medicaid benefits are available to pay for the cost of emergency services for aliens who do not meet the Medicaid citizenship or alien status requirements or Social Security Number requirements. However, they must meet the financial and categorical eligibility requirements and state residency requirements for the category in which they apply, such as Parent Caretaker Relative, Medically Needy, Adult Expansion, ARKids A or B.



NOTE: Emergency Medicaid applicants, if eligible in the Adult Expansion Group, may be approved for retroactive coverage 30 days prior to the date of application. Retroactive coverage for the Adult Expansion Group is date specific.

EXAMPLE: James applies for Emergency Medicaid coverage on October 20 and requests coverage for September 15 through September 17. He is not eligible for retroactive coverage because his bill is for September 15 through 17 which is more than 30 days prior to the application date. Retroactive coverage cannot begin prior to September 20.

EXAMPLE: James applies for Emergency Medicaid coverage on October 30 and is found to be medically eligible for the Adult Expansion Group on October 1 through October 2. He asks for retroactive coverage for a medical bill with a service date of October 1. He is eligible for retroactive coverage because his bill for October 1 is within the 30 days prior to the application date.

To be eligible for emergency Medicaid, the applicant must have, or must have had within the last 3 months, an emergency medical condition. For the exception, see NOTE above. Labor and delivery is considered an emergency medical condition.

MEDICAL SERVICES POLICY MANUAL, SECTION B

B-500 Emergency Medicaid Services for Aliens

B-500 Emergency Medicaid Services for Aliens

Emergency medical condition is defined as a medical condition, including labor and delivery, manifesting itself by acute symptoms of such severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in at least one of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any bodily part or organ

To qualify as an emergency, the medical condition must be acute. It must have a sudden onset, a sharp rise and last a short time. If the individual's condition is chronic (ongoing), such as cancer, AIDS, end-stage renal disease, etc., it is not considered acute and does not meet the definition of an emergency. If the chronic condition worsens, it is still not acute and does not qualify for emergency services. Federal policy specifically identifies care and services related to an organ transplant procedure as **not** qualifying under emergency services.

Before eligibility can be determined, the existence of an emergency medical condition must be verified by a physician's statement that the alien met the conditions shown above. A physician's statement that the individual will die without medical treatment does not in and of itself, constitute an emergency. The eligibility determination must include a determination of whether the condition is acute or chronic. Verification that medical expenses were incurred for treatment of the condition must also be presented.

Payment for emergency services is limited to the day treatment was initiated and the following period of time in which the necessity for emergency services existed. The date the alien first sought treatment is considered the first day of the emergency, regardless of the length of time the condition exists. The period of eligibility will be a fixed retroactive period, with the Medicaid begin and end dates entered in the system.

Emergency services are defined as services provided in a hospital, clinic, office or other facility equipped to furnish the required care after the onset of an emergency medical condition. Labor and delivery services are covered, including normal deliveries.

To determine if an applicant's doctor visit, emergency room visit or hospital stay was considered an emergency, the discharge summary for the medical visit will be sent to OPPD, S333 for an emergency medical determination.

MEDICAL SERVICES POLICY MANUAL, SECTION B MARK-UP

B-500 Emergency Medicaid Services for Aliens

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MS Manual ~~01/01/17~~ 05a/01/18

This group consists of:

- Nonqualified aliens living in the U.S or
- Qualified aliens living in the U.S. for less than 5 years.

Medicaid benefits are available to pay for the cost of emergency services for aliens who do not meet the Medicaid citizenship or alien status requirements or Social Security Number requirements. However, they must meet the financial and categorical eligibility requirements and state residency requirements for the category in which they apply, such as Parent Caretaker Relative, **Medically Needy**, Adult Expansion, ARKids A or B.

NOTE: Emergency Medicaid applicants, if eligible, may be approved for retroactive coverage 30 days prior to the date of application in the Adult Expansion Group.

EXAMPLE: James applies for Emergency Medicaid coverage on October 20 and requests coverage for September 15 through September 17. He is not eligible for retroactive coverage because his bill is for September 15 through 17 which is more than 30 days prior to the application date. Retroactive coverage cannot begin prior to September 20.

EXAMPLE: James applies for Emergency Medicaid coverage on October 30 and is found to be medically eligible for the Adult Expansion Group on October 1 through October 2. He asks for retroactive coverage for a medical bill with a service date of October 1. He is eligible for retroactive coverage because his bill for October 1 is within the 30 days prior to the application date.

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To be eligible for emergency Medicaid, the applicant must have, or must have had within the last 3 months, an emergency medical condition. **For the exception, see NOTE above.** Labor and delivery is considered an emergency medical condition.

MEDICAL SERVICES POLICY MANUAL, SECTION B MARK-UP

B-500 Emergency Medicaid Services for Aliens

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Emergency medical condition is defined as a medical condition, including labor and delivery, manifesting itself by acute symptoms of such severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in at least one of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any bodily part or organ

To qualify as an emergency, the medical condition must be acute. It must have a sudden onset, a sharp rise and last a short time. If the individual's condition is chronic (ongoing), such as cancer, AIDS, end-stage renal disease, etc., it is not considered acute and does not meet the definition of an emergency. If the chronic condition worsens, it is still not acute and does not qualify for emergency services. Federal policy specifically identifies care and services related to an organ transplant procedure as not qualifying under emergency services.

Before eligibility can be determined, the existence of an emergency medical condition must be verified by a physician's statement that the alien met the conditions shown above. A physician's statement that the individual will die without medical treatment does not in and of itself constitute an emergency. The eligibility determination must include a determination of whether the condition is acute or chronic. Verification that medical expenses were incurred for treatment of the condition must also be presented.

Payment for emergency services is limited to the day treatment was initiated and the following period of time in which the necessity for emergency services existed. ~~(e.g. the date of admission through the date of discharge from the hospital)~~. The date the alien first sought treatment is considered the first day of the emergency, regardless of the length of time the condition exists. The period of eligibility will be a fixed retroactive period, with the Medicaid begin and end dates entered in the system.

Emergency services are defined as services provided in a hospital, clinic, office or other facility equipped to furnish the required care after the onset of an emergency medical condition. Labor and delivery services are covered, including normal deliveries.

To determine if an applicant's doctor visit, emergency room visit or hospital stay was considered an emergency, the discharge summary for the medical visit will be sent to OPPD, S333 for an emergency medical determination.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-300 State Residency

D-340 Medicaid for the Homeless

6. Publicly operated community residences that serve no more than 16 residents are facilities that provide some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. They cannot be on the grounds of or immediately adjacent to any large institution or multiple purpose complexes such as educational or vocational training institutions, correctional or holding facilities, or hospitals, nursing facilities or intermediate care facilities for individuals with intellectual disabilities.

D-371 Inmates Being Released from Custody

MS Manual 08/01/15

Individuals in the custody of the Arkansas Department of Correction (ADC), Arkansas Department of Community Correction (ADCC), county jail, city jail, juvenile detention facility or Division of Youth Services (DYS) will be allowed to submit an application for Medicaid up to 45 days prior to the individual's scheduled release date. Applications will be submitted online at www.access.arkansas.gov or by paper application, DCO-151, Application for Health Coverage Single Adults, which will be submitted to the local DHS county office.

If eligible, Medicaid will not start until the individual is released from custody. The authorized representative from the facility will notify DHS of the actual release date.

D-372 Inmates Being Released for Inpatient Treatment

MS Manual 05/01/18

An individual in the custody of ADC, ADCC, or a local correctional facility who has been admitted and received treatment at an inpatient facility may be eligible for Medicaid payment provided all eligibility requirements are met. Eligibility will be determined in accordance with [MS Sections D, E and F](#). Only the inmate will be included in the Medicaid household. The coverage period will begin on the hospital admission date and end on the hospital discharge date.



NOTE: Inmates may be approved for retroactive coverage 30 days prior to the date of application in the Adult Expansion Group, if eligible. Retroactive coverage for the Adult Expansion Group is date specific.

EXAMPLE: James applies for medical coverage on September 15. He asks for retroactive coverage for a medical bill with an inpatient hospital begin date of August 1. He is not eligible for retroactive coverage on this date because his bill is for August 1 and retroactive coverage can only begin August 16, thirty (30) days prior to the September 15 application date.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-300 State Residency

D-340 Medicaid for the Homeless

EXAMPLE: James applies for medical coverage on September 20. He asks for retroactive coverage for a medical bill with an inpatient hospital begin date of September 15. He is eligible for retroactive coverage on September 15, as this date is within the 30 days prior to the application date.

D-373 Suspension of Medicaid Coverage for an Inmate

MS Manual 05/01/18

The appropriate correctional facility will notify DHS when a Medicaid or Adult Expansion Group recipient enters the ADC, ADCC, the county jail, city jail, or a juvenile detention facility. When this notification is received, DHS will place that individual's Medicaid coverage in suspended status for up to twelve (12) months from the initial approval or most recent renewal.

When an individual with suspended Medicaid eligibility receives eligible medical treatment off the grounds of the detention facility or is released from custody, the individual's case will be reinstated if the reinstatement date is within the twelve (12) month period from the individual's initial approval or most recent renewal. For those individuals receiving eligible treatment while off the correctional facility grounds, Medicaid will be re-instated for a fixed eligibility period from the date of hospitalization to the date of hospital discharge. The case will be re-suspended following the fixed eligibility period.

D-380 Child(ren) Entering Custody of Division of Youth Services (DYS)

MS Manual 04/29/16

The appropriate juvenile detention facility will notify the designated DYS staff when a Medicaid recipient enters the facility. When this notification is received, DYS designated staff will place that child's Medicaid coverage in suspended status for up to twelve (12) months from the initial approval or most recent renewal.

When a child with suspended Medicaid eligibility receives eligible medical treatment off the grounds of the juvenile detention facility or is released from custody, the child's case will be reinstated if the reinstatement date is within the twelve (12) month period from the individual's initial approval or most recent renewal. For those children receiving eligible treatment while off the correctional facility grounds, Medicaid will be re-instated for a fixed eligibility period from the date of hospitalization to the date of hospital discharge. The case will be re-suspended following the fixed eligibility period.

MEDICAL SERVICES POLICY MANUAL, SECTION D MARKUP

D-300 State Residency

D-340 Medicaid for the Homeless

- Publicly operated community residences that serve no more than 16 residents are facilities that provide some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. They cannot be on the grounds of or immediately adjacent to any large institution or multiple purpose complexes such as educational or vocational training institutions, correctional or holding facilities, or hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities.

D-371 Inmates Being Released from Custody

MS Manual 08/01/15

Individuals in the custody of the Arkansas Department of Correction (ADC), Arkansas Department of Community Correction (ADCC), county jail, city jail, juvenile detention facility or Division of Youth Services (DYS) will be allowed to submit an application for Medicaid up to 45 days prior to the individual's scheduled release date. Applications will be submitted online at www.access.arkansas.gov or by paper application, DCO-151, Application for Health Coverage Single Adults, which will be submitted to the local DHS county office.

If eligible, Medicaid will not start until the individual is released from custody. The authorized representative from the facility will notify DHS of the actual release date.

D-372 Inmates Being Released for Inpatient Treatment

MS Manual 0538/01/185

An individual in the custody of ADC, ADCC, or a local correctional facility who has been admitted and received treatment at an inpatient facility may be eligible for Medicaid payment provided all eligibility requirements are met. Eligibility will be determined in accordance with MS Sections D, E and F. Only the inmate will be included in the Medicaid household. The coverage period will begin on the hospital admission date and end on the hospital discharge date.

Note: Inmates may ~~can~~ be approved for retroactive coverage 30 days ~~one month~~ prior to the date ~~month~~ of application in the Adult Expansion Group, if eligible.

EXAMPLE: James applies for medical coverage on September 15. He asks for retroactive coverage for a medical bill with an inpatient hospital begin date of August 1. He is not eligible for retroactive coverage on this date because his bill is for August 1 and retroactive coverage can only begin August 16, thirty (30) days prior to the September 15 application date.

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MEDICAL SERVICES POLICY MANUAL, SECTION D MARKUP

D-300 State Residency

D-340 Medicaid for the Homeless

EXAMPLE: James applies for medical coverage on September 20. He asks for retroactive coverage for a medical bill with an inpatient hospital begin date of September 15. He is eligible for retroactive coverage on September 15, as this date is within the 30 days prior to the application date.

D-373 Suspension of Medicaid Coverage for an Inmate

MS Manual 0538/01/185

The appropriate correctional facility will notify DHS when a Medicaid or Adult Expansion Group Health Care Independence Program recipient enters the ADC, ADCC, the county jail, city jail, or a juvenile detention facility. When this notification is received, DHS will place that individual's Medicaid coverage in suspended status for up to twelve (12) months from the initial approval or most recent renewal.

When an individual with suspended Medicaid eligibility receives eligible medical treatment off the grounds of the detention facility or is released from custody, the individual's case will be reinstated if the reinstatement date is within the twelve (12) month period from the individual's initial approval or most recent renewal. For those individuals receiving eligible treatment while off the correctional facility grounds, Medicaid will be re-instated for a fixed eligibility period from the date of hospitalization to the date of hospital discharge. The case will be re-suspended following the fixed eligibility period.

~~If the individual is in the correctional facility when a redetermination comes due, the case will be closed due to the individual's incarceration status. If the same individual with a closed case requires overnight medical treatment off the correctional facility grounds, the correctional facility will submit a new application for the individual and once approved, the treatment stay will be approved for a fixed eligibility period and the case will be placed in suspended status for a new 12-month period.~~

~~These individuals with suspended coverage that are being released from custody while their case is in suspended status will have their coverage reinstated on the date of their release from the correctional facility.~~

D-380 Child(ren) Entering Custody of Division of Youth Services (DYS)

MS Manual 04/29/16

The appropriate juvenile detention facility will notify the designated DYS staff when a Medicaid recipient enters the facility. When this notification is received, DYS designated staff will place