



Provider Relations Outreach Specialist

Extension of Benefits

Effective Feb. 1, 2005, AFMC began review of Medicaid EOB requests for clinical, outpatient, laboratory and X-ray services. Requests are considered only after the service(s) have been rendered and a claim is filed and subsequently denied because the patient's benefit limits have been exhausted. Medicaid has a benefit limit per state fiscal year of:

- \$500 for lab and X-ray
- 12 physician visits (in a physician's office, patient's home or nursing home)
- 12 outpatient hospital visits (non-emergency ER visits, therapy services and related physician services)
- Providers have the option of filing the EOB request on behalf of their recipients.

220.000 **Benefit Limits**

7-1-15

Benefit limits are the limits on the *quantity* of covered services Medicaid-eligible beneficiaries may receive. Medicaid-eligible beneficiaries are responsible for payment for services beyond the established benefit limits, unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit

If a service is denied for exceeding the benefit limit, and the Medicaid beneficiary had elected to receive the service by written informed consent prior to the delivery of the service, the Medicaid beneficiary is responsible for the payment, unless that service has been deemed not medically necessary.

Benefit extensions are considered after the service has been rendered and the provider has received a denial for "benefits exhausted." DMS considers requests for benefit extensions based on the medical necessity of the service. If a Medicaid provider chooses to file for an extension of benefits and is denied due to the service not being medically necessary, the beneficiary is not responsible for the payment. Once the extension of benefits request has been initiated on a particular service, the provider cannot abort the process before a final decision is rendered.

Please see Section 229.000 through Section 229.120 and Section 131.000 points A and C for benefit extension request procedures. DMS reviews extension of benefits requests for Home Health, personal care, diapers and medical supplies. AFMC reviews extension of benefits requests for physician, lab, radiology and machine tests, using form DMS-671. All personal care services for beneficiaries under age 21 are reviewed by the contracted Quality Improvement Organization (QIO). [View or print AFMC contact information.](#)



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229.100 **Extension of Benefits for Laboratory and X-Ray, Physician Office and Outpatient Hospital Services** **2-1-05**

- A. Requests for extension of benefits for laboratory and x-ray, physician and outpatient services must be mailed to Arkansas Foundation for Medical Care, Inc. (AFMC), Attention EOB Review. [View or print the Arkansas Foundation for Medical Care, Inc. contact information.](#)
 - 1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
 - 2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.
- B. A request for extension of benefits must be received by AFMC within 90 calendar days of the date of benefits-exhausted denial.
 - 1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
 - 2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. *Do not* send a claim.

229.110 **Completion of Request Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services"** **7-1-07**

Requests for extension of benefits for Clinical Services (Physician's Visits), Outpatient Services (Hospital Outpatient visits), Laboratory Services (Lab Tests) and X-ray services (X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc-), must be submitted to AFMC for consideration. Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). [View or print form DMS-671.](#)

Complete instructions for accurate completion of form DMS- 671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

229.120 Documentation Requirements

2-1-05

- A. To request extension of benefits for any benefit limited service, all applicable records that support the medical necessity of extended benefits are required.
- B. Documentation requirements are as follows.
 - 1. Clinical records *must*:
 - a. Be legible and include records supporting the specific request
 - b. Be signed by the performing provider
 - c. Include clinical, outpatient and/or emergency room records for dates of service in chronological order
 - d. Include related diabetic and blood pressure flow sheets
 - e. Include a current medication list for the date of service
 - f. Include the obstetrical record related to a current pregnancy when applicable
 - g. Include clinical indication for laboratory and x-ray services ordered with a copy of orders for laboratory and x-ray services signed by the physician
 - 2. Laboratory and radiology reports *must* include:
 - a. Clinical indication for laboratory and x-ray services ordered
 - b. Signed orders for laboratory and radiology services
 - c. Results signed by the performing provider
 - d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable