ARKANSAS MEDICAID
EDUCATIONAL CONFERENCE

Retrospective Review and Extension of Benefits

Debbie Chambers, RN, CMCN

Manager, Clinical Review

afmc℠ ARMedicaid ARKANSAS DEPARTMENT OF HUMAN SERVICES

Core Service

- Conduct timely review of medical records/information to determine if health care services requested/rendered to Medicaid beneficiaries are medically necessary, meet professionally recognized standards, and are delivered in the appropriate setting.

Population Served

- AFMC's clinical review division fulfills contracts with the Arkansas Department of Human Services (DHS) Division of Medical Services (DMS) to review cases affecting the population of Arkansas Medicaid beneficiaries. Services are primarily provided from AFMC's Fort Smith location via software – MMIS HealthCare Portal and AFMC ReviewPoint.

Retrospective Reviews

- Perform retrospective reviews of paid claims for emergency room visits on a monthly basis to verify that the services were provided to treat an “emergency medical condition.”

- Perform retrospective reviews of paid claims for inpatient hospital admissions (acute care) on a monthly basis to determine medical necessity of admissions on all paid days, and a review for instances not meeting established standards of care (quality of care concerns).

Retro Review Process

- Each month, a random selection of Medicaid paid claims is generated and sent as a case listing to each facility identifying which claims were selected for a retrospective medical necessity review. The facility has 30 days to submit the emergency services documentation or the entire medical record for inpatient services to AFMC.
- First level of review is performed by a registered nurse. The nurse will compare the chart documentation to established standards of care (McKesson InterQual, Arkansas Medicaid state guidelines and approved guidelines) to determine if the admission and length of stay meets guidelines. If the documentation meets guidelines, the nurse will enter an approval and the review is complete. If the documentation does not meet guidelines, the nurse will write up a case summation and it will be sent for a second level of review to a physician advisor for a medical necessity review. Denials or partial denials will result in a letter stating the case specific rationale and will be sent to the facility, attending physician and the beneficiary. The letter will detail all appeal rights.
- Reconsideration requests received will be sent directly to a physician advisor for a medical necessity determination. Reconsideration requests must be received 35 days from the date of the denial letter.
- During the review process, AFMC will also notify hospitals if a billing error has occurred or any quality concern is found.

Submitting Clinical Documentation

- Options for submission
  - ReviewPoint is the preferred method
    - https://afmc.org/reviewpoint
    - Reduces time and expense associated with paper submissions
    - Providers can access 24/7 to review results
    - Free
    - Secure and HIPAA compliant
    - Records directly attached to request
  - Please call **479-649-8501** to discuss alternative methods of submission

Extension of Benefits

- Extension of Benefit claims are considered after a claim has been denied for exceeding benefits

- Requests must be received within 90 days of the date of the benefits-exhausted denial.

Getting Started

- Provider bills for services provided
  - Arkansas Provider Manual Section III
- Provider receives remittance advice with denial for exceeding benefits
- File for Extension of Benefits prior authorization

Submitting the EOB request

- Options for submission
  - MMIS Interchange is the preferred method
    - https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx
    - Reduces time and expense associated with paper submissions
    - Providers can access 24/7 to review results
    - Free
    - Secure and HIPPA compliant
    - DMS-671 not required
    - Records directly attached to request
  - Please call 479-649-8501 to discuss alternative methods of submission

Required Documentation

- Detailed information on page 2 of the DMS-671 EOB request form
- Remittance Advice (RA) must be from Medicaid – not from clearinghouse
- Order(s)
  - Must be signed by a physician or NP
- Report(s)
  - Must be signed by the requesting provider
  - Must have DOS documented
  - Place of service documented
  - X-ray reports must include the names of the views
  - Should be detailed and include CPT required information

Required Documentation cont.

- Medical Necessity
  - Clinical indication for services ordered (includes but not limited to)
    - Current and two previous office visits
    - ER visits
    - OB - need progress reports, flow chart and all previous US and NST reports

EOB Review Process

- First level of review by a registered nurse. If guidelines are met, the review is approved. If not, the review is sent to a physician advisor for a second level of review to determine medical necessity.
- Approval and/or denial letter generated with the case specific denial rationale.
- IMPORTANT: Read the denial rationales on the letters.
- Reconsiderations must be received within 35 days from the date of the denial letter.
- Appeal options
  - Refer to Arkansas Medicaid Manual Section I

Common Errors

- DMS-671 is not signed.
- Fields 1 and 2 of the DMS-671 have the incorrect provider.
- Date of service requested does not match records.
- No orders.
- No orders signed by a physician.
- No RA. Clearing house RA's are not accepted.
- No physician signature on documentation.
- Signatures must be dated and timed.

Contact Information

Debbie Chambers, RN, CMCN
Manager, Clinical Review
dchambers@afmc.org

Amy Carson, RN, CMCN
Manager, Clinical Review
acarson@afmc.org

Heather Beshoner
Administrative Support
Heather.Beshoner@afmc.org

Ami Winters
Specialist, Review
awinters@afmc.org

Doreen Keefer
Administrative Support
dkeefer@afmc.org

Melissa Kilgore
Administrative Support
mkilgore@afmc.org