



Arkansas Department Of Health and Human Services



Division of Medical Services

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TO: Arkansas Medicaid Health Care Providers – Private Duty Nursing

DATE: July 1, 2006

SUBJECT: Provider Manual Update Transmittal #68

REMOVE

Section	Date
201.100	7-1-05
201.200	7-1-05
203.000	11-1-03
204.000	11-1-03
205.000	11-1-03
211.000	11-1-03
212.000	1-1-05
212.200	1-1-05
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232.000	10-13-03
241.000	7-1-05
242.130	12-5-05
242.200	11-1-03
242.410	11-1-03
242.430	7-1-05

INSERT

Section	Date
201.100	7-1-06
201.200	7-1-06
203.000	7-1-06
204.000	7-1-06
205.000	7-1-06
211.000	7-1-06
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242.130	7-1-06
242.200	7-1-06
242.410	7-1-06
242.430	7-1-06

Explanation of Updates

Sections 201.100 and 201.200 are included to add language regarding participation and enrollment requirements for Private Duty Nursing providers. Language has also been added to comply with the Medicaid Fairness Act of 2005. The Arkansas Department of Health has been changed to the Division of Health.

Section 203.000 has been revised to add new language that sets forth Arkansas Medicaid participation requirements and enrollment procedures for Private Duty Nursing providers in states not bordering Arkansas.

Section 204.000 is included to replace the word “recipient” or “recipients” with “beneficiary” or “beneficiaries”. This has been done throughout most sections of this update.

Section 205.000 is included to add additional information concerning documentation that all providers are required to maintain to comply with the Medicaid Fairness Act of 2005.

Section 226.000 has been renamed, "Appealing an Adverse Action" and a statement referring providers to section I of this manual. This language complies with the Medicaid Fairness Act of 2005.

Section 232.000 is included to change the department name to the Arkansas Department of Health and Human Services and to change the abbreviation from DHS to DHHS.

Section 242.130 is included to add procedure code **A6549** to the list of payable medical supplies as a result of the 2006 HCPCS Procedure Code Conversion. Procedure code **B4100** is also being added as a payable code. It was inadvertently omitted.

Section 242.430 is included to explain that procedure code **A6549** has specific billing instructions.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.



Roy Jeffus, Director

SECTION II - PRIVATE DUTY NURSING SERVICES

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201.100 Private Duty Nursing Services Providers

7-1-06

Providers of Private Duty Nursing Services (PDN) must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

- A. The PDN provider must have either a Class A or Class B license issued by the Arkansas **Division** of Health. It must be designated on the license that the PDN agency is a provider of extended care services.
 1. A copy of the license must accompany the provider application and Medicaid contract.
 2. Subsequent licensure must be provided when issued by the Arkansas **Division** of Health.
 - a. Subsequent license renewal must be forwarded to Provider Enrollment within 30 days of issue. If the renewal documents have not been received within the 30-day deadline, the provider will have an additional and final 30 days to comply.
 - b. Failure to ensure that current licensure is on file with Provider Enrollment will result in termination from the Arkansas Medicaid Program.
 3. For purposes of review under the Arkansas Medicaid Program, agencies enrolled as Class B operators providing private duty nursing services must adhere to those standards governing quality of care, skill and expertise applicable to Class A operators.
- B. The PDN provider must complete a provider application (form DMS-652), Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). [View or print a provider application \(form DMS-652\), a Medicaid contract \(form DMS-653\) and a Request for Taxpayer Identification Number and Certification \(Form W-9\).](#)
- C. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule, are not eligible to enroll, or to remain enrolled as Medicaid providers.
- D. The Private Duty Nursing provider must adhere to all applicable professional standards of care and conduct.

Providers who have agreements with Medicaid to provide other services to Medicaid **beneficiaries** must have a separate provider application and Medicaid contract to provide private duty nursing services. A separate provider number is assigned.

201.200 School District or Education Service Cooperative Private Duty Nursing Services Providers

7-1-06

Arkansas Medicaid will enroll Arkansas school districts and Education Service Cooperatives (ESC) as Private Duty Nursing Services (PDN) providers when the following criteria are met:

- A. The school district or Education Service Cooperative must complete a provider application (form DMS-652), Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). [View or print a provider application \(form DMS-652\), a Medicaid contract \(form DMS-653\) and a Request for Taxpayer Identification Number and Certification \(Form W-9\).](#)
- B. The school district or ESC must be certified by the Arkansas Department of Education (ADE) as a Local Educational Agency (LEA). The ADE will provide verification of LEA

certification to the Provider Enrollment Unit of the Arkansas Division of Medical Services. Subsequent certifications must be provided when issued.

1. Subsequent certifications must be forwarded to Provider Enrollment within 30 days of issue. If the certification has not been received within the 30-day deadline, the provider will have an additional and final 30 days to comply.
 2. Failure to ensure that current certification is on file with Provider Enrollment will result in termination from the Arkansas Medicaid Program.
- C. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule, are not eligible to enroll, or to remain enrolled as Medicaid providers.
- D. The Private Duty Nursing provider must adhere to all applicable professional standards of care and conduct.

203.000 **Private Duty Nursing Service Providers in States Not Bordering Arkansas** **7-1-06**

- A. Providers in states not bordering Arkansas are called limited services providers because they may enroll in Arkansas Medicaid only after they have provided care to an Arkansas Medicaid beneficiary and have a claim to file, and because their enrollment automatically expires.
1. A non-bordering state provider may send a claim to Medicaid Provider Enrollment and Medicaid Provider Enrollment will forward by return mail a provider manual and a provider application and contract. [View or print Medicaid Provider Enrollment Unit contact information.](#)
 2. Alternatively, a non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, www.medicaid.state.ar.us, and then submit the application and claim to the Medicaid Provider Enrollment Unit.
- B. Limited services providers remain enrolled for one year.
1. If a limited services provider treats another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
 2. During the enrollment period the provider may file any subsequent claims directly to EDS.
 3. Limited services providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

204.000 **Records Requirements** **7-1-06**

DHHS requires retention of all records for five (5) years. Providers of Private Duty Nursing Services (PDN) must keep and make available to authorized representatives of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit, representatives of the Department of Health and Human Services and its authorized agents or officials, records which include:

- A. Medicaid contract (form DMS-653) to participate in the Arkansas Medicaid Program.
 - B. Copy of the license of the registered nurse (RN) and/or licensed practical nurse (LPN) providing private duty nursing services.
-

- C. Documentation verifying that RNs or LPNs are CPR certified.
- D. Documentation that the RN or LPN has received in-service training on the particular patient's equipment and care needs.
- E. Written contracts between contract personnel and the agency.
- F. Statistical, fiscal and other records necessary for reporting and accountability.
- G. Copies of the approved Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification (Form DMS-2692). [View or print form DMS-2692 and instructions for completion.](#)
- H. Signed and dated notes on the condition and progress of each patient.
- I. The patient's PDN care plan (Home Health Certification and Plan of Care (form CMS-485), including written justifications of any modification in the PDN care plan or prescription of service by the physician. [View or print form CMS-485.](#)
- J. Any additional or special documentation deemed necessary by the provider or required by DMS.
- K. Documentation of PDN services provided to each eligible **beneficiary**, including the date, the actual time of day each service was delivered and the signature of the person who actually provided the service.

205.000**Retention of Records**

7-1-06

- A. Private Duty Nursing Services providers must maintain all records for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer.
- B. Private Duty Nursing Services providers must contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities in connection with any Medicaid beneficiary.
- C. Private Duty Nursing providers furnishing any Medicaid-covered good or service for which a prescription is required by law, by Medicaid rule, or both, must have a copy of the prescription for such good or service. The provider must obtain a copy of the prescription within five (5) business days of the date the prescription is written.
- D. Private Duty Nursing providers must maintain a copy of each relevant prescription in the Medicaid beneficiary's records and follow all prescriptions and care plans.
- E. The Private Duty Nursing provider must immediately make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary.
- F. At the time of an audit by the Division of Medical Services, Medicaid Field Audit Unit, all documentation must be **immediately made** available at the provider's place of business during normal business hours. In the case of recoupment, there will be no more than thirty days allowed after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the thirty-day period.

Failure to furnish records upon request may result in sanctions.

210.000**PROGRAM COVERAGE****10-13-03**

211.000

Introduction

7-1-06

The Arkansas Medicaid Program is designed to assist eligible Medicaid **beneficiaries** in obtaining medical care within the guidelines specified in this manual.

212.000**Scope**

7-1-06

Private duty nursing services are those medically necessary services that are provided by a registered nurse or licensed practical nurse under the direction of the **beneficiary's** physician, to a **beneficiary** in his or her place of residence, a Division of Developmental Disabilities Services (DDS) community provider facility or a public school. For purposes of the Medicaid program, private duty nursing services are those medically necessary services related to the coverage described in Section 213.000 and delivered by a registered nurse or licensed practical nurse, as required by the State Nurse Practice Act. The registered nurse or licensed practical nurse providing services may not be a family member or taking on the role of a family member of the Medicaid **beneficiary** as described in Section 212.100.

212.200**Private Duty Nursing Service Locations**

7-1-06

- A. Medicaid-eligible, ventilator-dependent **beneficiaries** age 21 and older may receive Private Duty Nursing Services (PDN). PDN services may be provided only in the **beneficiary's** own home and as necessary when the Medicaid **beneficiary's** normal life activities temporarily take the **beneficiary** away from the home. For purposes of this rule, normal life activity means routine work, school, church, office or clinic visits, shopping and social interactions with friends and family. The private duty nurse may accompany the **beneficiary** but may not drive. Normal life activities do not include non-routine or extended home absences.
- B. For Medicaid-eligible **beneficiaries** under the age of 21, PDN services are covered in the following locations:
 1. The **beneficiary's** home. PDN services may be provided only in the **beneficiary's** own home and as necessary when the Medicaid **beneficiary's** normal life activities temporarily take the **beneficiary** away from the home. For purposes of this rule, normal life activity means routine work, school, church, office or clinic visits, shopping and social interactions with friends and family. The nurse may accompany the **beneficiary** but may not drive. Normal life activities do not include non-routine or extended home absences.
 2. A public school. A school's location may be an area on or off-site based on accessibility for the student. When a student's education is the responsibility of the school district in which that student resides, "school" as a place of service for Medicaid-covered services is any location, on-site or away from the site of an actual school building or campus, at which the school district is discharging that responsibility.
 - a. When a child is attending school at a DDS community provider facility because the school district has contracted with the facility to provide educational services, the place of service is "school".
 - b. When the home is the educational setting for a child who is enrolled in the public school system, "school" is considered the place of service.
 - c. The student's home is not considered a "school" place of service when a parent elects to home school a child.
 3. A DDS community provider facility.
- C. PDN services are not covered at/or in a hospital, boarding home, nursing facility, residential care facility, or an assisted living facility.

213.000**Coverage of Private Duty Nursing Services**

7-1-06

Private Duty Nursing Services (PDN) may be covered for individuals who meet the following requirements:

- A. Medicaid-eligible ventilator-dependent **beneficiaries** when determined medically necessary and prescribed by a physician.
- B. Medicaid-eligible **beneficiaries** under age 21 who are:
 1. In the Child Health Services (EPSDT) Program, and
 2. High technology non-ventilator dependent **beneficiary** requiring at least two (2) of the following services, unless the **beneficiary** requires an extremely high level of one (1) service making a home care plan impossible without private duty nursing services:
 - a. Intravenous Drugs (e.g. chemotherapy, pain relief, or prolonged IV antibiotics)
 - b. Respiratory – Tracheostomy or Oxygen Supplementation
 - c. Total Care Support for ADLs and close patient monitoring
 - d. Hyperalimentation – parenteral or enteral

PDN services may be provided by a registered nurse and/or licensed practical nurse as directed by the **beneficiary's** physician.

All PDN services require prior authorization by the Medicaid Program. Refer to Section 220.000 of this manual for information on the prior authorization process.

213.200 Coverage of Private Duty Nursing Medical Supplies

7-1-06

The Arkansas Medicaid Program covers Private Duty Nursing Services (PDN) medical supplies. Supplies are limited to \$80.00 per month, per **beneficiary**.

Refer to Section 242.130 of this manual for PDN nursing supplies.

214.000 Medical Criteria and Guidelines for Coverage of Private Duty Nursing Services for Ventilator-Dependent **Beneficiaries**

7-1-06

The following medical criteria and guidelines are utilized in evaluating coverage of private duty nursing services for a ventilator-dependent **beneficiary**:

- A. Selection of Patient
 1. Medical: The patient must have a related diagnosis requiring ventilator support. These diagnoses are:
 - a. Neuromuscular disease involving the respiratory muscles
 - b. Brainstem respiratory center dysfunction
 - c. Severe thoracic cage abnormalities
 - d. Intrinsic lung disease
 - e. Lung disease associated with cardiovascular disordersEach patient must have cardiovascular stability.
 2. Social: The patient must depend upon family members to provide support at home for medical and non-medical care on an ongoing basis.
 3. Cost Effectiveness: The cost of private duty nursing care should not exceed the cost for acute inpatient hospital care.
- B. Specific factors to be **assessed**
 1. Medical
 - a. Mechanical ventilator support is necessary for at least six (6) hours per day and

- weaning has been tried but was unsuccessful.
- b. Frequent ventilator adjustments are unnecessary.
 - c. Oxygen supplementation at or below an inspired fraction of 40% (F_IO₂@0.40).
 - d. There are no anticipated needs for frequent re-hospitalizations.
 - e. There is a record of reasonable expectation of normal or near-normal growth while receiving ventilator support. (This criterion applies to children only.)
2. Social/Emotional/Environmental: Major commitments on the part of family and community are mandatory to meet the **beneficiary's** extraordinary needs. Specific components include:
- a. Stable parent or parent figures.
 - b. Caregivers understanding of **beneficiary's** condition.
 - c. Primary care physician.
 - d. Family must ID at least one (1) additional family member and/or community person beyond the immediate family.
 - e. Demonstrated interest and ability in the care of the patient related to trach care, ventilator management, drug administration, feeding needs and developmental stimulation.
 - f. An adequate physical environment within the home.
 - g. Support system.
 - h. Family composition.
 - i. Sufficient resources within the community including emergency medical services, educational and vocational programs and other support programs.
 - j. Identified stressors.
 - k. Financial status.
 - l. Transportation requirements.

215.000

Criteria For Coverage of High Technology, Non-Ventilator Dependent **Beneficiaries In the Child Health Services (EPSDT) Program**

7-1-06

Specific factors to be assessed:

A. Medical

1. Technology dependent children consist of those with medical technology including but not limited to the following. Each category requires a variety of services. The technology dependence is life threatening and requires attention around the clock with 2 or more of the below categories being present. The constancy of care exceeds the family's ability to care for the patient at home on a long-term basis without the assistance of home nursing care.
 - a. Intravenous Drugs (e.g., chemotherapy, pain relief or prolonged IV antibiotics)
 - b. Respiratory -- Tracheostomy or Oxygen Supplementation
 - c. Total Care Support for ADLs and close patient monitoring
 - d. Hyperalimentation – parenteral or enteral
2. The technology dependence may be related to any of the following diagnoses.
 - a. Severe neuromuscular, respiratory or cardiovascular disease not requiring mechanical ventilatory support.
 - b. Chronic liver or gastrointestinal disorders with associated nutritional compromise.
 - c. Multiple congenital anomalies or malignancies with severe involvement of vital

body functions.

- d. Serious infections that require prolonged treatment.

B. Social/Emotional/Environmental

Major commitments on the part of the child's family and community are mandatory to meet the child's extraordinary needs. Specific components include:

1. Stable parent or parent figures.
2. Caregivers understanding of **beneficiary's** condition.
3. Primary care physician.
4. Family must ID at least one (1) additional family member and/or community person beyond the immediate family.
5. Demonstrated interest and ability in the care of the patient related to trach care, drug administration, feeding needs and developmental stimulation.
6. An adequate physical environment within the home.
7. Support system.
8. Family composition.
9. Sufficient resources within the community including emergency medical services, educational and vocational programs and other support programs.
10. Identified stressors.
11. Financial status.
12. Transportation requirements.

216.000 Exclusions

7-1-06

Private duty nursing services will not be authorized for a **beneficiary** in a boarding home, hospital, nursing facility, residential care facility or any other institutional setting or health care facility.

222.000 Request for Prior Authorization

7-1-06

A request for prior authorization for private duty nursing services must originate with the provider. The provider is responsible for completion of the Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification (form DMS-2692) and obtaining the required medical information. Form DMS-2692 must be signed by the **beneficiary's** physician with documentation that a physical examination was performed within 12 months of the beginning of the initial request or the recertification. [View or print form DMS-2692 and instructions for completion.](#)

For PDN services in the **beneficiary's** home a social/environmental evaluation indicating a commitment on the part of the **beneficiary's** family to provide a stable and supportive home environment must accompany the request for prior authorization. Refer to Section 224.000 of this manual for additional information required for the initial request.

All PA requests for Medicaid-eligible **beneficiaries** will be evaluated by the Division of Medical Services, Utilization Review (UR) Section, to determine the level of care and amount of nursing services to be authorized. [View or print Utilization Review Section contact information.](#)

The UR Section will notify the provider of the approval or denial of the PDN services PA request within 15 working days following the receipt of the PA request. If the PA request for PDN services is approved, page 5 of form DMS-2692 will be returned to the provider with the number of hours approved indicated on the form. The PA number will be assigned after the provider sends in documentation of the actual hours worked.

NOTE: The prior authorization number **MUST** be entered on the claim form filed for payment of these services. The initial PA approval will only be authorized for a maximum of 90 days. A new request must be made for services needed for a longer period of time. Recertification may be authorized for a maximum of six (6) months. Refer to Section 224.000 of this manual for information regarding recertification of PDN services. The effective date of the PA will be the date the patient begins receiving PDN services or the day following the last day of the previous PA approval.

Providers are cautioned that a prior authorization approval does not guarantee payment. Reimbursement is contingent upon eligibility of both the **beneficiary** and provider at the time service is provided and upon completeness and timeliness of the claim filed for the service. The provider is responsible for verifying the **beneficiary's** eligibility.

225.000 Filing for Prior Authorization

7-1-06

To request prior authorization, the Private Duty Nursing Services (PDN) provider must complete and forward the original and one copy of Form DMS-2692 to the Division of Medical Services Utilization Review Section. [View or print the DMS Utilization Review Section contact information.](#)

A copy of the form should be retained in the provider's records.

Additional documentation is required for PDN services for eligible Medicaid **beneficiaries** under age 21. The following documentation must be provided:

- A. Current medical and surgical history
- B. Current psychosocial assessment
- C. Current PDN care plan (Home Health Certification and Plan of Care – form CMS-485)
[View or print form CMS-485.](#)

New requests for PDN services should be sent to the Division of Medical Services, Utilization Review Section (UR) as early as possible after the medical need for private duty nursing is identified.

Providers must submit requests for prior authorization of PDN services within 30 days of the beginning date of service. Providers assume the risk of services ultimately being found not medically necessary. When PDN services are approved by UR at the level requested, the effective date of the prior authorization will be retroactive to the beginning date of service.

226.000 Appealing An Adverse Action

7-1-06

Please see section 190.000 et al for information regarding administrative appeals.

232.000 Rate Appeal Process

7-1-06

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

240.000 BILLING PROCEDURES

10-13-03

241.000 Introduction to Billing

7-1-06

Private Duty Nursing providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

242.130 Medical Supplies Procedure Codes

7-1-06

The following HCPCS procedure codes must be used when billing the Arkansas Medicaid Program for medical supplies.

A4206	A4216	A4217	A4221	A4222	A4253
A4256	A4259	A4265	A4310	A4311	A4312
A4313	A4314	A4315	A4316	A4320	A4322
A4326	A4327	A4328	A4330	A4338	A4340
A4344	A4346	A4347	A4348	A4351	A4352
A4354	A4355	A4356	A4357	A4358	A4359
A4361	A4362	A4364	A4367	A4369	A4371
A4397	A4398	A4399	A4400	A4402	A4404
A4405	A4406	A4414	A4452	A4454	A4455
A4558	A4560	A4561	A4562	A4623	A4624
A4625	A4626	A4628	A4629	A4772	A4927
A5051	A5052	A5053	A5054	A5055	A5061
A5062	A5063	A5071	A5072	A5073	A5081
A5082	A5093	A5102	A5105	A5112	A5113
A5114	A5119	A5121	A5122	A5126	A5131
A6154	A6234	A6241	A6242	A6248	A6441
A6442	A6443	A6444	A6445	A6446	A6447
A6448	A6449	A6450	A6451	A6452	A6453
A6454	A6455	A7520	A7521	A7522	A7524

A7525	B4086	B4100	E0776
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National HCPCS Codes

Procedure Code	Required Modifier	Description
A6257		Transparent Film, each (16 square inches or less)
A6258		Transparent Film, each (more than 16, but less than 48 square inches)
A6259		Transparent Film, each (more than 48 square inches)
A6216 A6219 A6228		Gauze Pad, Medicated or Non-Medicated, each (16 square inches or less)
A6220 A6229 A6217		Gauze Pads, Medicated or Non-Medicated, each (more than 16, but less than 48 square inches)
A6221 A6230 A6218		Gauze Pads, Medicated or Non-Medicated, each (more than 48 square inches)
A4450		Gauze, Non-Elastic, Per Roll (1 linear yard)
A6245 A6242		Hydro gel Dressing, each (16 square inches or less)
A6246		Hydro gel Dressing, each (more than 16, but less than 48 square inches)
A6247 A6244		Hydro gel Dressing, each (more than 48 square inches)
A6248		Hydro gel Dressing, each (1 ounce)
A6237 A6234		Hydrocolloid Dressing, each (16 square inches or less)
A6238 A6235		Hydrocolloid Dressing, each (more than 16, but less than 48 square inches)
A6236 A6239		Hydrocolloid Dressing, each (more than 48 square inches)
A6196		Alginate Dressing, each (16 square inches or less)
A6197		Alginate Dressing, each (more than 16, but less than 48 square inches)
A6198		Alginate Dressing, each (more than 48 square inches)
A6197	UB	Alginate Dressing, each (1 linear yard)
A6209		Foam Dressing, each (16 square inches or less)
A6210		Foam Dressing, each (more than 16, but less than 48 square inches)
A6211		Foam Dressing, each (more than 48 square inches)
A6200		Composite Dressing, each (16 square inches or less)

National HCPCS Codes		
Procedure Code	Required Modifier	Description
A6201		Composite Dressing, each (more than 16, but less than 48 square inches)
A6202		Composite Dressing, each (more than 48 square inches)
A4253	UB	Blood Glucose test or reagent strip for home blood glucose monitor, per 25 strips
A4353		Urinary intermittent catheter with insertion tray
A4394		Ostomy deodorant, all types, per ounce
A4365		Adhesive remover wipes, 50 per box
A4368		Ostomy filters, any type, each
A4483		Tracheostomy vent-heat moisture device
L8239*		Stocking (Jobst)
A6549*		Gradient compression stocking, not otherwise specified

* Refer to section 242.430.

242.200 Place of Service and Type of Service Codes

7-1-06

Place of Service	Paper Claims	Electronic Claims
Patient's home	4	12
DDS Facility (for beneficiaries under age 21, not school age)	5	52
Public School (for beneficiaries under age 21)	S	03

Type of Service (paper only)

1-Private Duty Nursing Services

S-Public School (for beneficiaries under age 21) **NOTE:** Type of service code "S" requires the LEA number of the school district in Field 19 of the CMS-1500.

242.410 Private Duty Nursing Billing Procedures

7-1-06

Private duty nursing services (PDN) are billed on a per unit basis. One unit equals one hour. Arkansas Medicaid will reimburse for the actual amount of cumulative PDN time on a monthly basis. Service time of less than one hour may not be rounded up to a full hour.

Type of service code "1" must be used when filing paper claims. Public schools must use type of service code "S" when filing paper claims for beneficiaries under age 21.

Refer to Sections 242.110 and 242.120 for PDN procedure codes for single patient care and multiple patient care.

242.430 Private Duty Nursing Medical Supplies

7-1-06

Procedure code **L8239** must be prior authorized. Form DMS-679 may be used to request prior authorization. [View or print form DMS 679.](#)

Procedure code **A6549**, with types of service “**S**” and “**1**”, must be manually priced. Procedure code **A6549** with a type of service of “**1**” requires a prior authorization (PA).

Refer to Section 242.130 for procedure codes of covered medical supplies.
