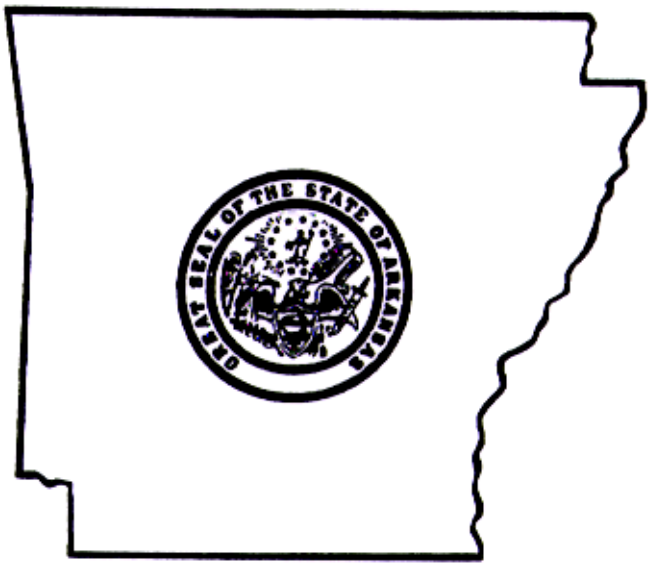
ARKANSAS
MEDICAID PROGRAM



CHILDREN'S MEDICAL SERVICES (CMS)
RESPITE CARE
PROVIDER MANUAL

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EDS

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200.000 CMS RESPITE CARE GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for CMS Respite Care Providers

Individual CMS respite caregivers, Division of Developmental Disabilities Services (DDS) licensed community-based providers and child care facilities that meet the participation requirements may be enrolled as CMS respite care providers.

The provider enrollment requirements listed below must be met to participate in the Arkansas Medicaid Program as a CMS respite care provider:

A. Individual CMS respite caregivers must meet the following requirements:

1. Complete a provider application (DMS-652) and a Medicaid contract (DMS-653) with the Arkansas Medicaid Program. (See Section I of this manual.)

2. Be certified by Children's Medical Services (CMS) of the Arkansas Department of Human Services, Division of Developmental Disabilities Services. (See sections 201.100 and 201.110.)

3. The provider application (DMS-652) and the Medicaid contract (DMS-653) must be approved by the Arkansas Medicaid Program.

B. DDS licensed community-based providers must meet the following requirements:

1. Complete a provider application (DMS-652) and a Medicaid contract (DMS-653) with the Arkansas Medicaid Program. (See Section I of this manual.)

2. Be licensed by the Division of Developmental Disabilities Services (DDS) of the Arkansas Department of Human Services. A copy of the current license must be submitted to CMS. Subsequent license renewals must be submitted to CMS when issued.

3. Be certified by CMS of the Arkansas Department of Human Services, Division of Developmental Disabilities Services. (See section 201.100.)

4. The provider application (DMS-652) and the Medicaid contract (DMS-653) must be approved by the Arkansas Medicaid Program.

201.000 Arkansas Medicaid Participation Requirements for CMS Respite Care Providers (Continued)

C. Child care facilities must meet the following requirements:

1. Complete a provider application (DMS-652) and Medicaid contract (DMS-653) with the Arkansas Medicaid Program. (See Section I of this manual.)

2. Be licensed by the Division of Child Care and Early Childhood Education (DCCECE) of the Arkansas Department of Human Services. A copy of the current license must be submitted to Children's Medical Services (CMS). Subsequent license renewals must be submitted to CMS when issued.

3. Be certified by CMS of the Arkansas Department of Human Services, Division of Developmental Disabilities Services. (See section 201.100.)

4. The provider application (DMS-652) and the Medicaid contract (DMS-653) must be approved by the Arkansas Medicaid Program.

201.100 CMS Certification Responsibilities

Children's Medical Services (CMS), Division of Developmental Disabilities Services (DDS) is responsible for certifying **all** providers of CMS respite care services.

The Service Agreement and Certification/Delegation of CMS Respite Caregiver (DMS-852) certifies that the provider has met the requirements and qualifications to be a CMS respite care provider. Form DMS-852 must be signed by the CMS respite care provider, parent or legal guardian, and a registered nurse (unless the CMS respite care provider is a registered nurse). CMS will review the DMS–852 and, if the certification criteria are met, will certify the provider by signing the DMS-852. CMS will retain a copy of the signed certification statement on all certified CMS respite care providers. The original, signed certification will be sent to the provider. (See section 214.700.)

CMS is responsible for furnishing the Division of Medical Services (DMS) Provider Enrollment Unit with written notification of the certification status of CMS respite care providers. CMS certifications must be renewed by the providers annually.

201.110 Additional Certification Requirements of the Individual CMS Respite Caregiver

In addition to the certification requirement in section 201.100, the individual CMS respite caregiver must also meet the following criteria:

A. Must be age 18 years or older.

B. Must be an U.S. citizen or legal alien authorized to work in the U.S.

C. Must be free from evidence of:

1. Abuse or fraud in any setting;
2. Violations in the care of a dependent population;
3. Conviction of a crime related to a dependent population; and
4. Conviction of a violent crime. (A criminal background check will be required and paid for by the Arkansas Medicaid Program.)

D. Must be able to read and write at a level sufficient to follow written instructions and maintain records.

E. Must be able to perform the essential job functions required (which will vary depending on the type and severity of the client's condition, but basically the CMS respite caregiver is to assist the client in the activities of daily living).

F. Must have a valid driver's license and a good driving record if transportation is to be provided for the client during CMS respite care services.

G. Must be a registered nurse (RN) or a healthcare paraprofessional as defined under the scope of the Arkansas State Board of Nursing *School Nurse Roles and Responsibilities Practice Guidelines*.

To meet the criterion for a healthcare paraprofessional, the DMS-852 must be signed and dated by an RN. The RN's signature certifies that the CMS respite caregiver meets the healthcare paraprofessional requirement specified in the *School Nurse Roles and Responsibilities Practice Guidelines*, is properly trained to perform the duties that are necessary to take care of the client and these duties (listed on the DMS-852) are appropriate to be delegated to the individual CMS respite caregiver.

H. A spouse, parent or legal guardian of the client who receives CMS respite care services **cannot** be the CMS respite caregiver.

201.110 Additional Certification Requirements of the Individual CMS Respite Caregiver (Continued)

I. A relative (excluding a spouse, parent or legal guardian) of the client may be the CMS respite caregiver if:

1. The relative does not reside in the same home as the client;
2. The relative meets the above certification and participation requirements; and
3. The family provides adequate justification as to why the relative is the provider of care (e.g., lack of other qualified providers in the area of residency).

202.000 Providers of CMS Respite Care Services in Arkansas and Bordering States

CMS respite care providers in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as **routine services providers** if they meet all Arkansas Medicaid participation requirements as outlined in section 201.000.

A. **Routine services providers** may furnish and claim reimbursement for CMS respite care services subject to the benefit limitations and coverage restrictions set forth in this manual.

B. Claims must be filed according to Section III of this manual.

203.000 Providers in Non-Bordering States

Providers in non-bordering states are not eligible to participate in the CMS Respite Care Program.

204.000 Records Requirement

CMS respite care providers must develop and maintain sufficient written records to corroborate that the services provided are of the type, frequency, duration and scope outlined in the CMS respite plan of care and confirm that the services were actually furnished.

CMS respite care providers must maintain a record of the following:

A. The Service Agreement and Certification/Delegation of CMS Respite Caregiver (DMS-852) signed and dated by an RN, CMS respite caregiver, parent or legal guardian and CMS representative;

B. A copy of the client's approved CMS respite plan of care; and

C. A copy of the completed billing forms (HCFA-1500) documenting the following information:

1. The date, actual time and duration for which the service(s) was provided;
2. The signature of the individual providing the services; and
3. The signature of the parent or legal guardian receiving the services.

204.100 Retention of Records

CMS respite care 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 period is longer. The records must be made available to authorized representatives of the Arkansas Department of Human Services, Division of Medical Services, Children's Medical Services, the State Medicaid Fraud Unit, and representatives of the Department of Health and Human Services and its authorized agents or officials. Failure to furnish records upon request will result in sanctions being imposed.

All documentation must be made available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business during normal business hours. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.

210.000 PROGRAM COVERAGE

210.100 Introduction

The CMS Respite Care Program is administered by Children's Medical Services of the Arkansas Department of Human Services, Division of Developmental Disabilities Services (hereafter referred to as CMS). The CMS Respite Care Program operates under the authority of a home and community-based waiver authorized under Section 1915(c) of the Social Security Act.

211.000 Scope

The Arkansas Medicaid Program offers certain home and community-based services to recipients to decrease the likelihood of institutionalization. The purpose of the CMS Respite Care Program is to provide temporary physical and emotional relief to families who are caring for clients with disabilities. This relief promotes continued care in the home, thereby reducing the likelihood of institutionalization of the client.

CMS respite care services are available only to Medicaid-eligible CMS clients who meet the CMS respite care eligibility criteria (see sections 214.000 through 214.700).

CMS is responsible for determining the client's eligibility for CMS respite care services. No primary care physician (PCP) referral is necessary to receive CMS respite care services.

212.000 Exclusions

The following individuals or services are **not covered** under the CMS Respite Care Program:

A. Inpatients of nursing facilities, hospitals or other inpatient institutions in accordance with 42 CFR 441.301(b)(1)(ii).

B. Foster care children.

C. Clients with solely a mental health diagnosis.

D. Room and board expenses.

E. DDS Waiver clients.

213.000 Benefit Limits

The following benefit limits apply to CMS respite care services:

A. CMS respite care services are limited to $1000 per client per twelve (12) calendar months, beginning with the month of approval. This amount may be extended in an emergency situation. See section 213.100, Extension of CMS Respite Care Benefits, for information about exceeding this limit.

B. The cost of CMS respite care services cannot exceed the following amounts:

1. $10.00 per hour or $2.50 per unit (one unit is equivalent to 15 minutes).

2. $160.00 daily maximum limit for 24 consecutive hours.

213.100 Extension of CMS Respite Care Benefits

In an emergency situation and subject to the availability of funds, additional CMS respite care services may be provided to families who have met the $1000 per client per twelve (12) months limit. A parent or legal guardian may request an extension of CMS respite care benefits by contacting the CMS respite care coordinator.

If the client is determined to be eligible for the extended CMS respite care benefits, the amount granted will be determined on a case-by-case basis.

214.000 CMS Respite Care Eligibility Criteria

CMS respite care services are limited to CMS clients who meet the CMS respite care eligibility criteria. The CMS respite care eligibility criteria consist of the following process:

A. The parent or legal guardian must complete a CMS respite care application through CMS;

B. The CMS client must be Medicaid eligible in certain aid categories (see section 214.200);

C. The CMS client must be under age 19;

D. The CMS client must meet the institutional level of care;

214.000 CMS Respite Care Eligibility Criteria (Continued)

E. The CMS client must have an approved CMS respite plan of care;

F. CMS must advise the family of the freedom of choice between home and community-based services and institutional services; and

G. There must be a completed and signed Service Agreement and Certification/Delegation of CMS Respite Caregiver (DMS-852).

The eligibility evaluation criteria for CMS respite care services is discussed in detail in sections 214.100 through 214.700.

214.100 Application for CMS Respite Care Services

The parent or legal guardian must complete the application packet for CMS respite care services. The application packet will include:

A. Application Form for Families (DMS-851)
B. Level of Functioning Survey for the Mentally Retarded/Developmentally Disabled (DMS-666)
C. Level of Functioning Survey for the Physically Disabled (DMS-667)
D. Family Friends CMS Respite Care Waiver Plan of Care (DMS-661)
E. Freedom of Choice and Fair Hearing (DMS-669)
F. Service Agreement and Certification/Delegation of CMS Respite Caregiver (DMS-852)

(A copy of the above forms can be found in this manual.)

The family may request the CMS respite care application by telephone or writing to the address below:

Arkansas Department of Human Services
Children's Medical Services
Family Friends CMS Respite Care
P.O. Box 1437, Slot S380
Little Rock, AR 72203-1437

Toll Free Telephone: 1-800-482-5850, ext. 22277.

A CMS respite care coordinator is available by telephone, at the number listed above, as a resource for families and CMS respite care providers to resolve any questions or problems they may encounter during the application process and after approval of CMS respite care services.

FAMILY FRIENDS RESPITE CARE
APPLICATION FORM FOR FAMILIES

Name of child (last name, first name, middle name) Date of birth

Child's Medicaid number Child's Social Security number

Parents/guardians names Home phone Business phone

Mailing Street address City Zip code County

What is your child's disability?

What are his/her strengths and needs in the following areas:

Communication

Feeding

Mobility

Toileting

Dressing

Sleeping

Other

If your child is receiving any type of medication, please specify below:

Name of medication	How often given	Route given (mouth, tube, rectal, injection)

Do you have friends or relatives who take care of your child with special needs? _____

Please explain why you need respite care (what kind of stress is your family under). _____
_____
_____
_____
_____
_____
_____
_____
_____

Is your child in school or day treatment center program? _____

If so, how many hours per day? _____

Does your child receive personal care? (paid for by Medicaid or DDS) _____

If so, how many hours per month? _____

Does your child receive private duty nursing care? _____

If so, how many hours per week? _____

Does your child receive any respite care from another agency? _____

If so, how many hours per week? _____

What is the number in your immediate family household under 18? _____

Are there any other persons with disabilities in your household?_____
Who?_____

I certify that they above information is correct.

_____
Parent/Legal Guardian Signature **Date**

Please return respite application to the address below.

Children's Medical Services
ATTN: Bruce Whitten
PO Box 1437, Slot S380
Little Rock, Arkansas 72203

214.200 Medicaid Aid Category

CMS clients must be Medicaid eligible in one of the following aid categories:

A. Supplemental Security Income (SSI); or

B. Tax Equity and Fiscal Responsibility Act (TEFRA).

Current Medicaid and categorical eligibility must be verified as part of the eligibility evaluation process. SSI eligibility is determined by the Social Security Administration. TEFRA eligibility is determined by the Department of Human Services, Division of County Operations.

214.300 Age Eligibility Determination

CMS respite care services are available to Medicaid-eligible CMS clients from birth up to age 19.

NOTE: After age 16, SSI and TEFRA clients who have a diagnosis of mental retardation and/or developmental delay will require an additional CMS-eligible diagnosis to remain eligible for CMS and CMS respite care services.

214.400 Level of Care Determination

The client must meet **one (1)** of the levels of care listed below:

A. Physically disabled requiring an nursing facility (NF) level of care; or

B. Mentally retarded and/or developmentally disabled requiring an intermediate care facility for mentally retarded (ICF/MR) or persons with related conditions level of care. Mentally retarded and/or developmentally disabled also include:

1. Autism,

2. Epilepsy,

3. Cerebral palsy, or

4. Any other condition of a person found to be closely related to mental retardation because it results in an impairment of general intellectual functioning or adaptive behavior similar to those of mentally retarded persons; or requires treatment and services to those similarly required for such persons; or is attributable to dyslexia resulting from a disability described above.

NOTE: After age 16, a diagnosis of mental retardation and/or developmental delay requires an additional CMS-eligible diagnosis in order to remain eligible for CMS and CMS respite care services.

214.410 CMS Eligibility Committee

The level of care determination is performed by the CMS Eligibility Committee. This committee consists of three (3) members:

A. Physician (M.D. or D.O.), licensed by the State of Arkansas;

B. Registered Nurse, licensed by the State of Arkansas; and

C. Registered Nurse, licensed by the State of Arkansas; **or**
Social Worker, licensed by the State of Arkansas with at least two years of experience as a social worker.

The CMS Eligibility Committee is responsible for the following:

1. Evaluating the client's need for a NF or ICF/MR level of care using the Level of Functioning Survey form (DMS-666 or DMS-667, depending on the specific medical condition of the client).

2. Notifying the parent(s) or legal guardian, in writing, if the client is determined to be eligible (or ineligible) for the appropriate level of care.

3. Approving or denying the CMS respite plan of care.

4. Re-evaluating the institutional level of care and CMS respite plan of care annually.

CMS RESPITE CARE WAIVER

LEVEL OF FUNCTIONING SURVEY
FOR THE MENTALLY RETARDED/DEVELOPMENTALLY DISABLED

SUMMARY SHEET

Client's Name:_____
Medicaid #_____

NOTE: *The individual must meet the indicated dependency level in 2 or more of the following categories to justify need for services in a Medicaid-certified Intermediate Care Facility for individuals with Mental Retardation or to meet level of care eligibility requirement for the MR/DD Respite Waiver.*

Date:		Date:		Date:		
MET	NOT MET	MET	NOT MET	MET	NOT MET	See qualifying option in each category below:
						Category 1: Health Status 2 or more questions answered with a 4
						Category 2: Communication Three or more questions answered with a 3 or 4
						Category 3: Task Learning Skills Three or more questions answered with a 3 or 4
						Category 4: Personal/Self Care Question "a" answered with a 4 or 5 Or Question "b" answered with a 4 or 5 Or Questions "c" and "d" answered with a 4 or 5
						Category 5: Mobility Any one question answered with a 4 or 5
						Category 6: Behavior: Any question answered with a 3 or 4
						Category 7: Community Living Skills Any two of questions "b", "e", or "g" answered With a 4 or 5; Or Three or more questions answered with a 4 or 5

Date:_____ Evaluators Signature:_____
Title/Affiliation: _____

Date:_____ Evaluators Signature:_____
Title/Affiliation:_____

CMS Respite Care Waiver

Level of Functioning Survey
For the Mentally Retarded/Developmentally Disabled

Instructions for Completing

For determining level of care eligibility for MR/DD Respite Waiver services, consider the individual's functioning in community environments. Complete the attached survey presuming the needed services and supports are not in place for the individual. Please note that, for items in the Health Status section, needed care or supervision may be provided by caregivers other than a licensed nurse.

DEFINITIONS:

"No Assistance" means no help is needed.

"Prompting/Structuring" means prior to the functioning, some verbal direction and/or some rearrangement of the environment is needed.

"Supervision" means that a helper must be present during the functioning and provide only verbal direction, gestural prompts, and/or guidance.

"Some Direct Assistance" means that a helper must be present and provide some physical guidance/support (with or without verbal direction).

"Total Care" means that a helper must perform all or nearly all of the functions.

"Rarely" means that the behavior occurs quarterly or less.

"Sometimes" means that a behavior occurs once a month or less.

"Often" means that a behavior occurs 2-3 times a month.

"Regularly" means that a behavior occurs weekly or more.

Client's Name:_____ Medicaid No._____

LEVEL OF FUNCTIONING SURVEY

1. HEALTH STATUS
   How often is nursing care or nursing supervision by a licensed nurse required for the following?

   Please put appropriate number in the box under year of assessment.
   (Key: 1= Rarely, 2=Sometimes, 3=Often, and 4=Regularly)

	Date:	Date:	Date:
a.) Medication administration and/or evaluation for effectiveness of a medication regimen			
b.) Direct services: i.e., care for lesions, dressings, treatments, (other than shampoos, foot powder, etc.)			
c.) Seizure Control			
d.) Teaching diagnosed disease control and care, including diabetes			
e.) Management of care of diagnosed circulatory or respiratory problems			
f.) Motor disabilities which interfere with all activities of Daily Living - Bathing, Dressing, Mobility, Toileting, etc.			
g.) Observation for choking/aspiration while eating, drinking			
h.) Supervision of use of adaptive equipment, i.e., special spoon, braces, etc.			
i.) Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity)			

Client's Name:_____ Medicaid No._____

2. COMMUNICATION
How often does this person:

Please put appropriate number in the box under the year of assessment.
(Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

	Date:	Date:	Date:
a.) Indicate wants by pointing, vocal noises, or signs?			
b.) Use simple words, phrases, short sentences?			
c.) Ask for at least 10 things using appropriate names?			
d.) Understand simple words, phrases or instructions containing prepositions: i.e., "on", "in", "behind" ?			
e.) Speak in an easily understood manner?			
f.) Identify self, place or residence, and significant others?			

3. TASK LEARNING SKILLS
How often does this person perform the following activities?

Please put the appropriate number in the box under the year of assessment.
(Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

	Date:	Date:	Date:
a.) Pay attention to purposeful activities for 5 minutes?			
b.) Stay with a 3-step task for more than 15 minutes?			
c.) Tell time to the hour and understand time intervals?			
d.) Count more than 10 objects?			
e.) Do simple addition, subtraction?			
f.) Write or print 10 words?			
g.) Discriminate shapes, sizes or colors?			
h.) Name people or objects when describing pictures?			
i.) Discriminate between "one", "many", "lot"?			

Client's Name:_____ Medicaid No._____

4. PERSONAL/SELF-CARE
With what type of assistance can this person currently:

Please put appropriate number in the box under year of assessment
(Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Perform toileting functions i.e., maintain bladder and bowel continence, clean self, etc.?			
b.) Perform eating/feeding functions: i.e., drink liquids and eat with spoon or fork, etc.?			
c.) Perform bathing function: i.e., bathe, run bath, dry self, etc.?			
d.) Dress self completely, i.e., including fastening and putting on clothes?			

5. MOBILITY
With what type of assistance can this person currently:

Please put appropriate number in the box under the year of assessment.
(Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Move (walking, wheeling) around environment?			
b.) Rise from lying down to sitting positions, sit without support?			
c.) Turn and position in bed, roll over?			

Client's Name:_____ Medicaid No._____

6. BEHAVIOR
   How often does this person:
   Please put appropriate number in the box under the year of assessment.
   (Key: 1=Rarely, 2=Sometimes, 3=Often, 4=Regularly)

	Date:	Date:	Date:
a.) Engage in self-destructive behavior?			
b.) Threaten or do physical violence to others?			
c.) Throw things or damage property, have temper outbursts?			
d.) Respond to others in a socially unacceptable manner (without undue anger, frustration or hostility)?			

7. COMMUNITY LIVING SKILLS
   With what type of assistance would this person currently be able to:

   Please put appropriate number in the box under the year of assessment.
   (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Prepare simple foods requiring no mixing or cooking?			
b.) Take care of personal belongings, room (excluding vacuuming, ironing, clothes washing/drying, wet mopping)?			
c.) Add coins of various denominations up to one dollar?			
d.) Use telephone to call home, doctor, fire, police?			
e.) Recognize survival signs/words: i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.?			
f.) Refrain from exhibiting unacceptable sexual behavior in public?			
g.) Go around cottage, ward, building, without running away, wandering off, or becoming lost?			
h.) Make minor purchases, i.e., candy, soft drinks, etc.?			

Addendum to LOF Survey

Client Name: _____ SSN: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____Birthdate: _____ Sex: _____

Primary Caregiver: _____

Address: _____

Relationship: _____Phone: _____

Presenting Problem/Diagnosis: _____

Medications: _____

_____

Is the Individual Oriented to:

Person: ____ Place: ____ Time: ____

Describe any problems with caregiving:

Assessment completed by:

Assessor's Name	Signature	Provider Name	Provider Number

RESERVED

CMS RESPITE CARE WAIVER

LEVEL OF FUNCTIONING SURVEY
FOR THE PHYSICALLY DISABLED

SUMMARY SHEET

Client's Name: _____
Medicaid # _____

NOTE: *The individual must meet the indicated dependency level in 2 or more of the following categories to justify need for services in a Medicaid-certified Nursing Facility for individuals with disabilities or to meet level of care eligibility requirement for the Physically Disabled Respite Waiver.*

Date:		Date:		Date:		
MET	NOT MET	MET	NOT MET	MET	NOT MET	See qualifying option in each category below:
						Category 1: Health Status 2 or more questions answered with a 4
						Category 2: Communication Three or more questions answered with a 3 or 4
						Category 3: Task Learning Skills Three or more questions answered with a 3 or 4
						Category 4: Personal/Self Care Question "a" answered with a 4 or 5 Or Question "b" answered with a 4 or 5 Or Questions "c" and "d" answered with a 4 or 5
						Category 5: Mobility Any one question answered with a 4 or 5
						Category 6: Behavior: Any question answered with a 3 or 4
						Category 7: Community Living Skills Any two of questions "b", "e", or "g" answered With a 4 or 5; Or Three or more questions answered with a 4 or 5
						Category 8: Current Support Situation Any two questions answered With a 4

Date:_____ Evaluators Signature:_____
Title/Affiliation:_____

CMS Respite Care Waiver

Level of Functioning Survey
For the Physically Disabled

Instructions for Completing

For determining level of care eligibility for Physically Disabled Respite Waiver services, consider the individual's functioning in community environments. Complete the attached survey presuming the needed services and supports are not in place for the individual. Please note that, for items in the Health Status section, needed care or supervision may be provided by caregivers other than a licensed nurse.

DEFINITIONS:

"No Assistance" means no help is needed.

"Prompting/Structuring" means prior to the functioning, some verbal direction and/or some rearrangement of the environment is needed.

"Supervision" means that a helper must be present during the functioning and provide only verbal direction, gestural prompts, and/or guidance.

"Some Direct Assistance" means that a helper must be present and provide some physical guidance/support (with or without verbal direction).

"Total Care" means that a helper must perform all or nearly all of the functions.

"Rarely" means that the behavior occurs quarterly or less.

"Sometimes" means that a behavior occurs once a month or less.

"Often" means that a behavior occurs 2-3 times a month.

"Regularly" means that a behavior occurs weekly or more.

Client's Name:_____ Medicaid No._____

LEVEL OF FUNCTIONING SURVEY

1. HEALTH STATUS
   How often is nursing care or nursing supervision by a licensed nurse required for the following?

   Please put appropriate number in the box under year of assessment.
   (Key: 1= Rarely, 2=Sometimes, 3=Often, and 4=Regularly)

	Date:	Date:	Date:
a.) Medication administration and/or evaluation for effectiveness of a medication regimen			
b.) Direct services: i.e., care for lesions, dressings, treatments, (other than shampoos, foot powder, etc.)			
c.) Seizure Control			
d.) Teaching diagnosed disease control and care, including diabetes			
e.) Management of care of diagnosed circulatory or respiratory problems			
f.) Motor disabilities which interfere with all activities of Daily Living - Bathing, Dressing, Mobility, Toileting, etc.			
g.) Observation for choking/aspiration while eating, drinking			
h.) Supervision of use of adaptive equipment, i.e., special spoon, braces, etc.			
i.) Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity)			
j.) Oxygen dependency, tracheostomy care, and/or ventilator-dependent			

Client's Name:_____ Medicaid No._____

2. COMMUNICATION
How often does this person:

Please put appropriate number in the box under the year of assessment.
(Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

	Date:	Date:	Date:
a.) Indicate wants by pointing, vocal noises, or signs?			
b.) Use simple words, phrases, short sentences?			
c.) Ask for at least 10 things using appropriate names?			
d.) Understand simple words, phrases or instructions containing prepositions: i.e., "on", "in", "behind" ?			
e.) Speak in an easily understood manner?			
f.) Identify self, place or residence, and significant others?			

3. TASK LEARNING SKILLS
How often does this person perform the following activities?

Please put the appropriate number in the box under the year of assessment.
(Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

	Date:	Date:	Date:
a.) Pay attention to purposeful activities for 5 minutes?			
b.) Stay with a 3-step task for more than 15 minutes?			
c.) Tell time to the hour and understand time intervals?			
d.) Count more than 10 objects?			
e.) Do simple addition, subtraction?			
f.) Write or print 10 words?			
g.) Discriminate shapes, sizes or colors?			
h.) Name people or objects when describing pictures?			
i.) Discriminate between "one", "many", "lot"?			

Client's Name:_____ Medicaid No._____

4. PERSONAL/SELF-CARE
With what type of assistance can this person currently:

Please put appropriate number in the box under year of assessment
(Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Perform toileting functions i.e., maintain bladder and bowel continence, clean self, etc.?			
b.) Perform eating/feeding functions: i.e., drink liquids and eat with spoon or fork, etc.?			
c.) Perform bathing function: i.e., bathe, run bath, dry self, etc.?			
d.) Dress self completely, i.e., including fastening and putting on clothes?			

5. MOBILITY
With what type of assistance can this person currently:

Please put appropriate number in the box under the year of assessment.
Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Move (walking, wheeling) around environment?			
b.) Rise from lying down to sitting positions, sit without support?			
c.) Turn and position in bed, roll over?			

Client's Name:_____ Medicaid No._____

6. BEHAVIOR
   How often does this person:
   Please put appropriate number in the box under the year of assessment.
   (Key: 1=Rarely, 2=Sometimes, 3=Often, 4=Regularly)

	Date:	Date:	Date:
a.) Engage in self-destructive behavior?			
b.) Threaten or do physical violence to others?			
c.) Throw things or damage property, have temper outbursts?			
d.) Respond to others in a socially unacceptable manner (without undue anger, frustration or hostility)?			

7. COMMUNITY LIVING SKILLS
   With what type of assistance would this person currently be able to:

   Please put appropriate number in the box under the year of assessment.
   (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Prepare simple foods requiring no mixing or cooking?			
b.) Take care of personal belongings, room (excluding vacuuming, ironing, clothes washing/drying, wet mopping)?			
c.) Add coins of various denominations up to one dollar?			
d.) Use telephone to call home, doctor, fire, police?			
e.) Recognize survival signs/words: i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.?			
f.) Refrain from exhibiting unacceptable sexual behavior in public?			
g.) Go around cottage, ward, building, without running away, wandering off, or becoming lost?			
h.) Make minor purchases, i.e., candy, soft drinks, etc.?			

Client's Name:_____ Medicaid No._____

8. CURRENT SUPPORT SITUATION

Please put appropriate number in the box under the year of assessment
(Key: 1=Over 12 hours daily, 2=4-8 hours daily (5 days or more a week), 3=Less than 20 hours a week, 4=None

	Date	Date	Date
a.) How many hours per day is the child out of home during a week – e.g. At school, in a day treatment center?			
b.) How many hours per day of in-home care from a personal care aide or nurse does the child receive during a week?			

Please put appropriate number in the box under the year of assessment
(Key: 2=More than two caregivers, 3=Two caregivers, 4=One caregiver)

	Date	Date	Date
c.) How many caregivers are available in the household to take care of the child – e.g., mother, father, grandparent, nurse, etc.?			

Please put appropriate number in the box under the year of assessment
(Key: 2=Less than one year, 3=Over one year, 4=From birth)

	Date	Date	Date
d.) How long has the child had this physically handicapping condition or chronic illness?			

Addendum to LOF Survey

Client Name: _____ SSN: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____Birthdate: _____ Sex: _____

Primary Caregiver: _____

Address: _____

Relationship: _____Phone: _____

Presenting Problem/Diagnosis: _____

Medications: _____

_____

Is the Individual Oriented to:

Person: ____ Place: ____ Time: ____

Describe any problems with caregiving:

Assessment completed by:

Assessor's Name	Signature	Provider Name	Provider Number

214.500 CMS Respite Plan of Care

Each eligible client must have an approved individualized CMS respite plan of care before CMS respite care services are approved. CMS will send the family a CMS Respite Care Waiver Plan of Care (DMS-661) for completion.

The CMS respite plan of care is the fundamental tool used to ensure that the services to be furnished are appropriate to and adequate for the nature and severity of the individual's disability. The parent(s) or legal guardian(s) of the client will complete, sign and submit the CMS respite plan of care form to CMS for approval.

The parent or legal guardian may contact the CMS respite care coordinator for assistance in completing the CMS respite plan of care.

The CMS respite plan of care must include the following information:

A. Why CMS respite care services are needed;

B. How and when the CMS respite care services will be used;

C. The frequency and duration of the CMS respite care services;

D. The rate of pay to the CMS respite care provider(s);

E. The name(s) and address(es) of the CMS respite care provider(s); and

F. The signature(s) of the parent(s) or legal guardian, including the date signed.

CMS must approve, recommend changes or deny the plan of care. If the plan is denied, the CMS respite care coordinator will work with the family to design an acceptable plan of care and to make revisions during the year, if necessary. Families may appeal any denied plan of care. See section 218.000 for the appeal process for Medicaid recipients.

CMS will furnish a copy of the approved CMS respite plan of care to the parent or legal guardian and to each CMS respite care provider. CMS will retain the original plan of care. CMS will review the CMS respite plan of care annually.

RESERVED

Name of Client_____
Medicaid #_____

FAMILY FRIENDS CMS RESPITE CARE WAIVER
PLAN OF CARE

Your family may be eligible for $1,000.00 worth of respite care services under the CMS Family Friends Respite Care Waiver from _____ until _____ pending approval of your respite application and plan of care and your acceptance of community-based respite services. Respite is the act of providing physical and emotional relief to families who are responsible for day-to-day care of children with disabilities. It is TEMPORARY respite care for families of children with disabilities and may not be used for day care while the parent goes to work.

Please indicate below your plan of care for using the total dollar amount of respite services listed above. If you have any questions regarding this form, please call toll-free the CMS Respite Coordinator at 1-800-482-5850, extension 22277.

How much will you pay per hour (or day for respite)? (Remember that the maximum hourly rate allowed is $10.00 per hour and the maximum daily [24 consecutive hours] rate is $160.00)._____(If you think the rate will vary (for example from $6 to $8), give an estimated average (for example $7).

At this rate, how many total hours or days of respite will you use during your approved respite period?_____(For example, if you paid the maximum of $10 an hour and no daily rates, you would have 100 hours of respite available during the year; on the other hand, if you paid the maximum of $160.00 per day and no hourly rates, you would have six days and six hours of respite available for the year.)

Describe below as best you can how and when you plan to use your respite dollar allocation and for what purpose throughout the respite period for which you are approved - for example, half-a-day once a month to go shopping, or six days in July to take a vacation, or 2-3 hours a week to do family business. To illustrate, you might use 3 days (@ $160.00 day maximum) for vacation at $480 and one hour a week (@ $10.00 an hour maximum) for family business at $520. We realize situations change but try to predict as accurately as possible how you plan to use your respite. Note that after the $1,000 is used up, all payment for respite waiver services will terminate (with the exception that in crisis/emergency situations, depending on the availability of funding, various funding sources may be utilized to provide emergency respite based on the urgency of the family's need for respite.

I plan to use my respite care as follows:

____ Vacation _____ # of hours/days (circle either hours or days) $_____

____ Shopping _____ # of hours/days $_____
____ Family business _____ # of hours/days $_____
____ Going Out for Dinner/Movie/etc. _____ # of hours/days $_____
____ Recreational Activities of Siblings _____ # of hours/days $_____
____ Obtaining Medical Care _____ # of hours/days $_____
____ Other (Explain)_____#hours/days

I plan to use my respite care according to the following approximate monthly schedule:

____ # of hours/days in October (circle either hours or days) $_____
____ # of hours/days in November $_____
____ # of hours/days in December $_____
____ # of hours/days in January $_____
____ # of hours/days in February $_____
____ # of hours/days in March $_____
____ # of hours/days in April $_____
____ # of hours/days in May $_____
____ # of hours/days in June $_____
____ # of hours/days in July $_____
____ # of hours/days in August $_____
____ # of hours/days in September $_____

The name(s) and address(es) of my respite provider(s) are:

(1)_____ (2)_____
_____ _____
_____ _____

(3)_____ (4)_____
_____ _____
_____ _____
_____ _____

I certify that the above information is correct to the best of my knowledge at this time.

Signature of CMS Parent/Legal Guardian Date

Approval of CMS Eligibility Committee Representative Date

214.600 Client's Notification of Freedom of Choice and Fair Hearing

The parent(s) or legal guardian will be given freedom of choice to receive services in an institution or in a home and community-based setting.

CMS will mail the Freedom of Choice and Fair Hearing (DMS-669) to the parent or legal guardian. The parent, legal guardian or CMS client (if 18 years old) must indicate, in writing, the choice selected by completing and signing the form. CMS respite care services cannot be authorized until CMS receives the completed form.

In addition, the Freedom of Choice and Fair Hearing form advises the parent or legal guardian of their right to a fair hearing if they are denied their choice of services or providers. Also, the instructions for filing a request for a fair hearing are provided.

CMS will retain the completed form for documentation of freedom of choice and fair hearing opportunity.

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ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
FAMILY FRIENDS CMS RESPITE CARE WAIVER
FREEDOM OF CHOICE AND FAIR HEARING

_____ _____
Name of Child Medicaid Number

Your family has been approved for $1,000.00 per year of respite care services under the Family Friends Respite Care Waiver from _____ until _____ pending approval of your plan of care and your acceptance of these community-based respite services below.

It has been determined that the child named above is eligible for services in an institution. If you wish for your child to be institutionalized, please indicate below that you want your child to receive services in an institution. If you wish your child to stay within your community and receive services there, please indicate below that you want your child to receive services in the community. Specifically, in order to qualify for respite services outside an institution, the parent or legal guardian of the child (or the child him/herself if 18 years of age or older) must certify below that he/she desires services "in a community setting." Please read the statement below and **answer the following question and sign with the signature of the parent or legal guardian (or by the child him/herself if 18 years of age or older)**.

"I understand I may choose (for my child) to be provided services in an institution or a community setting. If denied my choice, I understand I am entitled to a fair hearing under 42 CFR Part 431, Subpart E. See reverse side for instructions on how to request a fair hearing.

I CHOOSE (FOR MY CHILD) TO RECEIVE SERVICES: IN AN INSTITUTION_____ IN A COMMUNITY SETTING_____.

Additionally, I understand I am entitled to a fair hearing if I am denied my choice of services or I am denied my choice of providers."

Signature of Parent or Legal Guardian Date

Signature of Child if 18 years of age or older Date
(If unable to sign, make an "X" with two witnesses' signatures)

HOW TO FILE FOR A FAIR HEARING

If you are not satisfied with the decision on your case, you may request a Hearing by writing the Appeals and Hearings Section, P.O. Box 1437, Little Rock, AR 72203-1437. Any request for a Hearing must be received within thirty (30) days from the date on the notice of the decision.

YOUR RIGHT TO REPRESENTATION

If you request a Hearing, you have the right to appear in person and to be represented by a lawyer or other person you select. If you wish to have a lawyer, you may ask the local County Human Services Office to help you arrange for one. If free legal services are available where you live, you may ask your County Office for their address and phone number.

214.700 Service Agreement and Certification/Delegation of CMS Respite Caregiver

The Service Agreement and Certification/Delegation of CMS Respite Caregiver form (DMS-852) initially must be completed by the parent or legal guardian and approved by an RN. The parent or legal guardian will list on the DMS-852 the duties and/or tasks to be performed by the CMS respite caregiver while caring for the client. *Only* those duties listed on the DMS-852 will be performed by the CMS respite caregiver.

In accordance with the Arkansas State Board of Nursing *School Nurse Roles and Responsibilities Practice Guidelines*, a registered nurse (RN) may delegate certain tasks to the CMS respite caregiver by approving and signing the DMS-852. The RN must assess and train, if necessary, the CMS respite caregiver in performing the duties that may be delegated. If the RN determines that the CMS respite caregiver is capable of performing the duties, he or she must complete and sign DMS-852 certifying that the duties are appropriate to delegate to the CMS respite caregiver and the CMS respite caregiver is qualified to perform the duties.

In order for the CMS respite care provider to meet the certification requirement (see sections 201.100 and 201.110), the DMS-852 must be signed and dated by the individuals listed below:

A. The CMS respite care provider (also referred to as CMS respite caregiver) certifying that:

   1. He or she is qualified and properly trained to perform the duties listed on DMS-852; and
   2. He or she meets all certification requirements as specified in section 201.100 and section 201.110 of the CMS Respite Care Provider Manual.

B. The parent or legal guardian certifying that:

   1. He or she agrees that the CMS respite caregiver is qualified and properly trained to perform the duties listed on DMS-852; and
   2. He or she accepts full responsibility for placing the client in the care of said CMS respite caregiver.

C. An RN certifying that:

   1. The CMS respite caregiver is qualified and properly trained to perform the duties listed for the client; and
   2. Delegation of the duties to the CMS respite caregiver is appropriate for this client.

   NOTE: If the CMS respite caregiver is an RN, the signature of a registered nurse is not required on DMS-852.

D. The CMS respite care coordinator certifying that the CMS respite caregiver meets the CMS respite care requirements.

214.700 Service Agreement and Certification/Delegation of CMS Respite Caregiver (Continued)

CMS will mail the DMS-852 to each family. The parent or legal guardian is responsible for returning the completed form to CMS with all required signatures. The signed DMS-852 must be on file with CMS before services may begin. CMS will retain a copy of the signed DMS-852 and mail the original form to the CMS respite caregiver.

A DMS-852 must be completed and signed annually. If the family changes providers or obtains additional providers, an additional DMS-852 must be completed for each new CMS respite care provider, signed by the required individuals and forwarded to CMS before payment can begin to the new providers.

Also, if changes in the client's condition result in additional or different duties and/or tasks, the family must obtain a new DMS-852, signed by all required individuals, to ensure that delegation of the new duties is appropriate and the CMS respite caregiver is trained and qualified to perform the duties.

The CMS respite caregiver must retain a copy of the DMS-852 for his or her records. (See section 204.000 for records requirement.)

214.800 Approval of CMS Respite Care Services

After the client's CMS respite care services application is approved, CMS will furnish billing forms (HCFA-1500) to the family for completion by the CMS respite caregiver as services are provided. (See Section III of this manual for special billing procedures.)

SERVICE AGREEMENT AND CERTIFICATION/DELEGATION OF CMS RESPITE CAREGIVER

Client's Name_____ Medicaid #_____

Client's Address_____

CMS Respite Caregiver's Name_____ Relationship to Client_____

(Items 1-8 are to be completed by the parent(s) or legal guardian.)

Please list duties of CMS Respite Caregiver in the following areas:

1. Communication

2. Feeding

3. Mobility

4. Toileting

5. Dressing

6. Sleeping

7. Medication

NAME OF MEDICATION	DOSAGE	HOW OFTEN GIVEN	ROUTE (GIVEN BY MOUTH OR GASTRIC TUBE, ETC)*

(*Note – Only a registered nurse may administer rectal or injectible medications)

8. Other

By signing below, the CMS RESPITE CAREGIVER certifies that he or she is in fact qualified and properly trained to perform the tasks listed on page 1 and meets all requirements as specified in Section 201.110 of the Medicaid Provider Manual for providing CMS respite care under the CMS Respite Care Waiver program. The respite caregiver also agrees to CMS conducting a criminal background check on him or her. Please circle if you are an R.N., L.P.N. or L.P.T.N. and give your license number _____.

Signature of CMS Respite Caregiver Date

By signing below, the PARENT or LEGAL GUARDIAN certifies that he or she agrees that the CMS respite caregiver is qualified and properly trained to perform the tasks listed on page 1 and accepts full responsibility for placing his or her child in the care of said CMS respite caregiver.

Signature of Parent or Legal Guardian Date

By signing below, the REGISTERED NURSE licensed in the State of Arkansas certifies that he or she has assessed the client listed on page 1 and agrees that the CMS respite caregiver is qualified and properly trained to perform the tasks listed on page 1 for the client and that delegation of these tasks is appropriate for this client and this CMS respite caregiver. License #_____.

(Note This signature is NOT required if the CMS respite caregiver is a registered nurse).

Signature of Registered Nurse Date

By signing below, the CMS RESPITE CARE COORDINATOR certifies that the CMS Respite Caregiver meets the CMS respite care requirements.

Signature of CMS Respite Care Coordinator Date

215.000 Reporting Changes

It is the parent or legal guardian's responsibility to notify the CMS respite care provider at least twenty-four hours prior to an appointment for CMS respite care services if the appointment must be cancelled.

If the client is expected to be out of the home for 30 days or longer, the parent or legal guardian must notify CMS.

216.000 Description of CMS Respite Care

CMS respite care services allow temporary physical and emotional relief to a family that is caring for a client with disabilities.

DMS-852 will list specific duties the CMS respite caregiver must provide while the client is in his or her care. The duty areas are communication, feeding, mobility assistance, toileting, dressing, administering certain medications and other duties that will be defined by the parent or legal guardian and RN, depending on the client's needs.

It is the parent or legal guardian's responsibility to provide clear and precise written instructions to the CMS respite caregiver regarding the client's needs. It is the CMS respite caregiver's responsibility to ensure that all instructions are performed as stated.

216.100 Allowed Units of Service

One (1) unit of CMS respite care service equals 15 minutes, e.g., if the duration of the service is one hour and 30 minutes, Medicaid will cover 6 units.

Services of less than one hour duration per date of service are not covered, e.g., 50 minutes of service on a given date are not covered.

Services of less than fifteen minutes in duration are not covered, e.g., if the service lasts one hour and 20 minutes, Medicaid will cover only one hour and 15 minutes (5 units).

Odd minutes may not be saved to add to minutes from a previous date of service.

(See section 213.000 for benefit limits and Section III of this manual for the procedure code.)

217.000 Quality Assurance

To ensure that the CMS Respite Care Program requirements are being met, the Medicaid agency will perform annual reviews of a random sampling of client records. Also, an annual client satisfaction and program evaluation survey of the total CMS respite care client population will be conducted to determine whether quality standards are met. Appropriate action(s) (e.g. recommendation for training, disqualification of provider, etc.) will be taken if an investigation of negative allegations reveals that quality standards are not met.

218.000 Appeal Process for Medicaid Recipients

When an adverse decision (e.g., application denied, case closed, choice of providers denied, plan of care denied, etc.) is received from CMS, the Medicaid recipient may request a fair hearing from the Department of Human Services for reconsideration of the denied services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Arkansas Department of Human Services within thirty (30) days of the date of the denial or adverse action notice. Submit the appeal request to:

Arkansas Department of Human Services
Appeals and Hearings Section
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437

240.000 PRIOR AUTHORIZATION

CMS respite care services do not require prior authorization, but must be provided in accordance with the approved CMS respite plan of care.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement

Reimbursement in the CMS Respite Care Program is by fee schedule. Payment is the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable amount for each service.

252.000 Rate Appeal Process

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/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 Human Services (DHS) 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.

300.000 GENERAL INFORMATION

301.000 Introduction

The purpose of Section III of the Arkansas Medicaid Manual is to explain the procedures for billing in the Arkansas Medicaid Program.

Three major areas are covered in this section:

A. General Information: This section contains information about timely filing of claims, claim inquiries and supply procedures.

B. Billing Procedures: This section contains information on completing paper claims. This section also contains information on procedure codes and other program-specific data elements.

C. Financial Information: This section contains information on the Remittance and Status Report or Remittance Advice (RA), adjustments, refunds, and additional payment sources.

CMS respite care providers must complete and forward HCFA-1500 billing claims to Children's Medical Services (CMS). CMS will electronically bill Arkansas Medicaid on behalf of the CMS respite care providers. (See Billing Instructions – Paper Claims Only, section 311.200.)

302.000 Timely Filing

The *Code of Federal Regulations* (42 CFR), at 447.45 (d) (1), states "The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service." The 12-month filing deadline applies to all claims, including:

A. Claims for services provided to recipients with joint Medicare/Medicaid eligibility.

B. Adjustment requests and resubmissions of claims previously considered.

C. Claims for services provided to individuals who acquire Medicaid eligibility retroactively.

There are no exceptions to the 12-month filing deadline policy. However, the definitions and additional federal regulations below will permit some flexibility for those who adhere closely to them.

302.100 Medicare/Medicaid Crossover Claims

Federal regulations dictate that providers must file the Medicaid portion of claims for dually eligible beneficiaries within 12 months of the beginning date of service. The Medicare claim will establish timely filing for Medicaid, if the provider files with Medicare during the 12-month Medicaid filing deadline. Medicaid may then consider payment of Medicare deductible and/or coinsurance, even if the Medicare intermediary or carrier crosses the claim to Medicaid after more than a year has passed since the date of service. Medicaid may also consider such a claim for payment if Medicare notifies only the provider and does not electronically forward the claim to Medicaid. Federal regulations permit Medicaid to pay its portion of the claim within 6 months after the Medicaid "agency or the provider receives notice of the disposition of the Medicare claim."

Claims for dates of service over 12 months in the past may not be electronically transmitted to EDS. To submit a Medicare/Medicaid crossover claim meeting the timely filing conditions in the first paragraph above, please refer to *Patients With Joint Medicare/Medicaid Coverage*, section 342.000, of this manual. In addition to following the billing procedures explained in section 342.000, enclose a signed cover memo or Claim Inquiry Form requesting payment for the Medicaid portion of a Medicare claim which was filed to Medicare within 12 months of the date of service, and which Medicare adjudicated more than 12 months after the date of service.

302.200 Clean Claims and New Claims

The definitions of the terms, *clean claim* and *new claim*, help to determine which claims and adjustments Medicaid may consider for payment, when more than 12 months have passed since the beginning date of service.

42 CFR, at 447.45 (b), defines a clean claim as a claim that Medicaid can process "...without obtaining additional information from the provider of the service or from a third party." The definition "...includes a claim with errors originating in a State's claims system."

A claim that denies for omitted or incorrect data, or for missing attachments, is not a clean claim. A claim filed more than 12 months after the beginning date of service is not a clean claim, except under the special circumstances described below.

A new claim is a claim that is unique, differing from all other claims in at least one material fact. It is very important to note that identical claims, received by Medicaid on different days, differ in the material fact of their receipt date, and are both new claims, unless defined otherwise in the next paragraph.

302.300 Claims Paid or Denied Incorrectly

Sometimes a clean claim pays incorrectly or denies incorrectly. When a provider files an adjustment request for such a claim, or refiles the claim after 12 months have passed from the beginning date of service, the submission is not necessarily a new claim. The adjustment or claim may be within the filing deadline. For Medicaid to consider that the submission is not a new claim and, therefore, is within the filing deadline, the adjustment or claim must meet two requirements:

A. The only material fact that differs between the two filings is the claim receipt date, because the Medicaid agency or its fiscal agent processed the initial claim incorrectly; *and*

B. The provider includes documentation that the Medicaid agency or fiscal agent error prevented resubmittal within the 12-month filing deadline.

302.400 Claims With Retroactive Eligibility

Retroactive eligibility does not constitute an exception to the filing deadline policy. If an appeal or other administrative action delays an eligibility determination, the provider must submit the claim within the 12-month filing deadline. If the claim denies for recipient ineligibility, the provider may resubmit the claim when the patient becomes eligible for the retroactive date(s) of service. Medicaid may then consider the claim for payment because the provider submitted the initial claim within the 12-month filing deadline, and the denial was not the result of an error by the provider.

302.400 Claims With Retroactive Eligibility (Continued)

To submit a claim for services rendered to a patient who is not yet eligible for Medicaid, enter, on the claim form or on the electronic format, a pseudo Medicaid recipient identification number, 9999999999. Medicaid will deny the claim. Retain the denial or rejection for proof of timely filing if eligibility determination occurs more than 12 months after the date of service.

Occasionally, the state Medicaid agency or a federal agency, such as the Social Security Administration, is unable to complete a Medicaid eligibility determination in time for service providers to file timely claims. Arkansas Medicaid's claims processing system is unable to accept a claim for services rendered to an ineligible individual and to suspend that claim until the individual is retroactively eligible for the claim dates of service. To resolve this dilemma, Arkansas Medicaid considers the pseudo recipient identification number 9999999999 to represent, an "...error originating within (the) State's claims system." Therefore, a claim containing that number is a clean claim if it contains all other information necessary for correct processing. By defining the initial claim as a clean claim, denied by processing error, we may allow the provider to refile the claim when the government agency completes the eligibility determination. The provider must submit with the claim, proof of the initial filing and a letter or other documentation sufficient to explain that administrative processes (such as determination of SSI eligibility) prevented the resubmittal before the filing deadline.

302.500 Submitting Adjustments and Resubmitting Claims

When it is necessary to submit an adjustment or resubmit a claim to Medicaid after 12 months have passed since the beginning date of service, the procedures below must be followed.

302.510 Adjustments

If the fiscal agent has incorrectly paid a clean claim, and the error has made it impossible to adjust the payment before 12 months have passed since the beginning date of service, CMS will send a completed Adjustment Request Form (Form EDS-AR-004, following section 331.000 of this manual) to the address specified on the form. Attach the documentation necessary to explain why the error has prevented refiling the claim until more than 12 months have passed after the beginning date of service.

302.520 Claims Denied Incorrectly

CMS will submit a paper claim to the address below, attaching:

A. A copy of the Remittance and Status Report, or Remittance Advice (RA) page that documents a denial within 12 months after the beginning date of service, *or*

B. A copy of the error response to an AEVCS transmission, **computer-dated** within twelve (12) months after the beginning date of service; and

302.520 Claims Denied Incorrectly (Continued)

C. Attach additional documentation to prove that the denial or rejection was due to the error of the Division of Medical Services or the fiscal agent. Explain why the error has prevented refiling the claim until more than 12 months have passed after the beginning date of service.

CMS will send these materials to:

EDS
Provider Assistance Center
P.O. Box 8036
Little Rock, AR 72203-8036

302.530 Claims Involving Retroactive Eligibility

CMS will submit a paper claim to the address below, attaching:

A. A copy of the Remittance and Status Report or Remittance Advice (RA) page documenting a denial of the claim with 9999999999 as the Medicaid recipient identification number, dated within 12 months after the beginning date of service, *or*

B. A copy of the error response to an AEVCS transmission of the claim with 9999999999 as the Medicaid recipient identification number; the error response **computer-dated** within 12 months after the beginning date of service, *and*

C. Any additional documentation necessary to explain why the error has prevented refiling the claim until more than a year has passed after the beginning date of service.

CMS will send these materials to:

EDS
Provider Assistance Center
P.O. Box 8036
Little Rock, AR 72203-8036

302.600 ClaimCheck® Enhancement

To solve some of the billing problems associated with differing interpretations of procedure code descriptions, EDS implemented the ClaimCheck® enhancement to the Arkansas Medicaid Management Information System (MMIS). This software analyzes procedure codes and compares them to nationally accepted published standards to recommend more accurate billing. If you think your claim was paid incorrectly, see section 330.000 for information about how to use the Adjustment Request Form. If you think your claim was denied incorrectly, contact the Provider Assistance Center (PAC) at the numbers listed below.

ClaimCheck® developers based the software's edits on the guidelines contained in the *Physicians' Current Procedural Terminology* (CPT) book, and Arkansas Medicaid customized the software for local policy and procedure codes. Please note that ClaimCheck® implementation does not affect Medicaid policy.

If there are other questions regarding the function of ClaimCheck® edits, call the Provider Assistance Center (PAC) at (501) 376-2211 (local and out-of-state) or 1-800-457-4454 (in-state WATS).

303.000 Claim Inquiries

The Arkansas Medicaid Program distributes a weekly Remittance and Status Report or Remittance Advice (RA) to each provider with claims paid, denied or pending, as of the previous weekend processing cycle. (Sections 320.000 through 324.800 of this manual contain information for a complete explanation of the RA). Use the RA to verify claim receipt and to track claims through the system. Claims transmitted through the Automated Eligibility Verification and Claims Submission (AEVCS) system will appear on the RA within 2 weeks of transmission. Paper claims and adjustments may take as long as six weeks to appear on the RA.

If a claim does not appear on the RA within the amount of time appropriate for its method of submission, CMS will contact the EDS Provider Assistance Center. A Provider Assistance Center Representative can explain what system activity, if any, regarding the submission, has occurred since EDS printed and mailed the last RA. If the transaction on the RA cannot be understood, or is in error, the representative can explain its current status and suggest remedies when appropriate. If there is no record of the transaction, the representative will suggest that the claim be resubmitted.

303.100 Claim Inquiry Form

When a written response to a claim inquiry is preferred, use the Medicaid Claim Inquiry Form, EDS-CI-003, provided by EDS. The form in this manual may be copied or a supply may be requested from EDS. A separate form for each claim in question must be used. EDS is required to respond in writing only if they can determine the nature of the questions. The Medicaid Claim Inquiry Form is for use in locating a claim transaction and understanding its disposition. If help is needed with an incorrect claim payment, refer to section 330.000 of this manual for the Adjustment Request Form and information regarding adjustments.

303.200 Completion of the Claim Inquiry Form

To inquire about a claim, the CMS respite care coordinator will complete and submit the Medicaid Claim Inquiry Form to EDS. A copy of this form follows these instructions. In order to answer the inquiry as quickly and accurately as possible, please follow these instructions:

A. Submit one Claim Inquiry Form (EDS-CI-003) for each claim inquiry.

B. Include supporting documents for the inquiry. (Use claim copies, AEVCS transaction printouts, RA copies and/or medical documents as appropriate).

C. Provide as much information as possible in Field 9. This information makes it possible to identify the specific problem in question and to answer the inquiry.

	Field Name and Number	**Instructions for Completion**
1.	Provider Number	Enter the 9-digit Arkansas Medicaid provider number assigned. If requesting information regarding a clinic billing, indicate the clinic provider number.
2.	Provider Name and Address	Enter the name and address of the provider as shown on the claim in question.
3.	Recipient Name (First, Last)	Enter the patient's name as shown on the claim in question.
4.	Recipient ID	Enter the 10-digit Medicaid identification number assigned to the patient.
5.	Billed Amount	Enter the amount the Medicaid Program was billed for the service.
6.	Remittance Advice Date	Enter the date of the Medicaid RA on which the claim most recently appeared.
7.	Date(s) of Service	Enter the month, day and year of the date of service, or the date range.

303.200 Completion of the Claim Inquiry Form (Continued)

	Field Name and Number	Instructions for Completion
8.	ICN (Claim Number)	Enter the 13-digit claim control number assigned to the claim by Medicaid. If the claim being questioned is shown on a Medicaid RA, this number will appear under the heading "Claim Number."
9.	Provider Message/Reason for Inquiry	State the specific description of the problem and any remarks that may be helpful to the person answering the inquiry.
10.	Signature, Phone and Date	The provider of service or designated authorized individual inquiring must sign and date the form.

NOTE: The lower section of the form is reserved for the response to the inquiry.

RESERVED

MEDICAID CLAIM INQUIRY FORM

ONE INQUIRY FORM PER CLAIM FORM,
SUBMIT ADJUSTMENT REQUEST ON ADJUSTMENT REQUEST FORM.

EDS
P.O. Box 8036
Little Rock, Arkansas 72203

1. Provider Number _____

2. Provider Name and Address:

_____

_____

_____

3. Recipient Name (first, last) _____

4. Recipient ID _____

5. Billed Amount _____ 6. RA Date _____

7. Date(s) of Service _____

8. ICN (Claim Number) _____

THE ABOVE INFORMATION IS USED FOR MAILING PURPOSES, PLEASE COMPLETE

9. Provider Message/Reason for Inquiry: _____

_____

_____

_____

_____

_____

10. Provider Signature _____ Phone _____ Date _____

RESERVED FOR EDS RESPONSE

Dear Provider:

- O This claim has been resubmitted for possible payment.
- O EDS can find no record of receipt of this claim as indicated above. Please resubmit.
- O This claim paid on _____ in the amount of $ _____.
- O This claim was denied on _____ with EOB code _____.
- O This claim denied on _____ with EOB code 952, "Service requires primary care physician referral."
- O This claim denied on _____ with EOB code 900, "Pricing of this procedure includes related services."
- O This claim denied on _____ with EOB code 280, "Recipient has other medical coverage, bill other insurance first."
- O This claim was received for payment after the 12 month filing deadline.

OTHER: _____

_____

_____

_____

EDS REPRESENTATIVE SIGNATURE _____ DATE _____

304.000 Supply Procedures

304.100 Ordering Forms from EDS

To order EDS-supplied forms, please use the Medicaid Form Request, Form EDS-MFR-001. An example of the form appears on page III-14. EDS supplies the following forms:

Acknowledgement of Hysterectomy Information	(DMS-2606)
Adjustment Request Form - Medicaid XIX	(EDS-AR-004)
Certification Statement for Abortion	(DMS-2698)
Consent for Release of Information	(DMS-619)
DDTCS Transportation Survey	(DMS-632)
DDTCS Transportation Log	(DMS-638)
EPSDT	(DMS-694)
Explanation of Check Refund	(EDS-CR-002)
Hospice/INH Claim Form	(DHS-754)
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	(DCO-645)
Inpatient Services Medicare-Medicaid Crossover Invoice	(EDS-MC-001)
Long Term Care Services Medicare-Medicaid Crossover Invoice	(EDS-MC-002)
Medicaid Claim Inquiry Form	(EDS-CI-003)
Medicaid Form Request	(EDS-MFR-001)
Medicaid Prior Authorization and Extension of Benefits Request	(DMS-2694)
Medical Equipment Request for Prior Authorization & Prescription	(DMS-679)
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	(DMS-633)
Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral	(DMS-640)
Outpatient Services Medicare-Medicaid Crossover Invoice	(EDS-MC-003)
Personal Care Assessment and Service Plan	(DMS-618)
Primary Care Physician Selection and Change Form	(DMS-2609)
Professional Services Medicare-Medicaid Crossover Invoice	(EDS-MC-004)
Referral for Medical Assistance	(DMS-630)
Request for Extension of Benefits	(DMS-699)
Request for Extension of Benefits for Medical Supplies for Medicaid Recipients Under Age 21	(DMS-602)
Request for Prior Authorization and Prescription for Hyperalimentation	(DMS-2615)
Request for Private Duty Nursing Services Prior Authorization and Prescription - Initial Request or Recertification	(DMS-2692)
Request for Targeted Case Management Prior Authorization for Recipients Under Age 21	(DMS-601)
Sterilization Consent Form	(DMS-615)
Sterilization Consent Form - Information for Men	(PUB-020)
Sterilization Consent Form - Information for Women	(PUB-019)
Visual Care	(DMS-26-V)

304.100 Ordering Forms from EDS (Continued)

Complete the Medicaid Form Request and indicate the quantity needed of each form.

Mail your request to:
EDS
Provider Assistance Center
P. O. Box 8036
Little Rock, AR 72203-8036

The provider may request the HCFA-1500 claim form by contacting the CMS respite care coordinator at (501) 682-8207.

MEDICAID FORM REQUEST

Provider #: _____ Name: _____

Address: _____

City: _____ State/ZIP: _____

Please indicate the quantity of forms below:

_____ DCO-645 (Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage)

_____ DHS-754 (Hospice/INH Claim Form)

_____ DMS-26-V (Visual Care)

_____ DMS-601 (Request for Targeted Case Management Prior Authorization for Recipients Under Age 21)

_____ DMS-602 (Request for Extension of Benefits for Medical Supplies for Medicaid Recipients Under Age 21)

_____ DMS-615 (Sterilization Consent Form)

_____ DMS-618 (Personal Care Assessment and Service Plan)

_____ DMS-619 (Consent for Release of Information)

_____ DMS-630 (Referral for Medical Assistance)

_____ DMS-632 (DDTCS Transportation Survey)

_____ DMS-633 (Mental Health Services Provider Qualification form for LCSW, LMFT and LPC)

_____ DMS-638 (DDTCS Transportation Log)

_____ DMS-640 (Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral)

_____ DMS-679 (Medical Equipment Request for Prior Authorization & Prescription)

_____ DMS-694 (EPSDT)

_____ DMS-699 (Request for Extension of Benefits)

_____ DMS-2606 (Acknowledgement of Hysterectomy Information)

_____ DMS-2609 (Primary Care Physician Selection and Change Form)

_____ DMS-2615 (Request for Prior Authorization and Prescription for Hyperalimentation)

_____ DMS-2692 (Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification)

_____ DMS-2694 (Medicaid Prior Authorization & Extension of Benefits Request)

_____ DMS-2698 (Certification Statement for Abortion)

_____ EDS-AR-004 (Adjustment Request Form - Medicaid XIX)

_____ EDS-CI-003 (Medicaid Claim Inquiry Form)

_____ EDS-CR-002 (Explanation of Check Refund)

_____ EDS-MFR-001 (Medicaid Form Request)

_____ EDS-MC-001 (Inpatient Services Medicare-Medicaid Crossover Invoice)

_____ EDS-MC-002 (Long Term Care Services Medicare-Medicaid Crossover Invoice)

_____ EDS-MC-003 (Outpatient Services Medicare-Medicaid Crossover Invoice)

_____ EDS-MC-004 (Professional Services Medicare-Medicaid Crossover Invoice)

_____ PUB-019 (Sterilization Consent Form Information for Women)

_____ PUB-020 (Sterilization Consent Form Information for Men)

Received	Mailed
Date _____	Date _____
By _____	Qty _____

310.000 BILLING PROCEDURES

311.000 Introduction

CMS respite care providers use the HCFA-1500 format to bill the Arkansas Medicaid Program for services provided to eligible Medicaid recipients. CMS respite care providers must submit a paper HCFA-1500 claim form. See section 311.200 for detailed billing instructions.

311.100 Billing Instructions - AEVCS

The CMS respite care coordinator's staff will electronically bill the Arkansas Medicaid Program on behalf of the CMS respite care provider using the AEVCS system. Payment will be sent directly to the provider who performed the services.

The Automated Eligibility Verification and Claims Submission (AEVCS) system is the electronic method for verifying a recipient's eligibility and filing claims for payment. AEVCS will edit the claim for billing errors and advise of the claim's acceptance into the processing system for adjudication. If AEVCS rejects the claim, it will list up to 9 reasons for the rejection and permit the claim to be corrected and resubmitted by CMS.

EDS processes each week's accumulation of claims during the weekend cycle. The deadline for each weekend cycle is 12:00 midnight Friday.

The following table lists the values/comments for each of the fields associated with an electronically filed HCFA-1500 claim transaction. The last column provides a cross-reference to section 311.300 of this manual for specific field requirements and instructions.

311.110 PES Professional Claim Field Descriptions

Field Name	Values/Comments	Refer to section 311.300
Header 1 Information		
Provider ID	Required field for all claim types. The 9-digit identification number of the provider who is to receive payment for the service. If the number you enter on the claim is not on file or not eligible on the dates of service you enter, the claim will not be accepted.	Field 33
Recipient – ID	The 10–digit, assigned identification number of the individual receiving services.	Field 1A
Recipient First Name	At least the first character of the recipient's first name.	Field 2
Recipient Last Name	At least the first two letters of the recipient's last name.	Field 2
Patient Account #	Unique number assigned by the provider's facility for the recipient. Optional field.	Field 26
Prior Authorization #	Not applicable to CMS respite care services.	Field 23
Referring Phys ID	Not applicable to CMS respite care services.	Field 17A
Header 2 Information		
Diagnosis Code	The identity of a condition or disease for which the service is being billed. Diagnosis codes are listed in the ICD-9-CM code book and are 3 to 5 characters.	Field 21

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to section 311.300
Header 2 Information (Continued)		
Employment Related?	If the service being billed was necessary because of a job-related incident, type Y. If not, type N.	Field 10A
Incident Date	Date of incident that required the patient to be hospitalized.	Field 14
Accident Related?	If the condition is the result of an accident, type Y. If not, type N.	Field 10B or 10C
Hospital Admit Date	Not applicable to CMS respite care services.	Field 18
Facility Name	If the services were rendered somewhere other than an office or home, type the name of the facility.	Field 32
Facility Address	If the services were rendered somewhere other than an office or home, type the address of the facility.	Field 32
Outside Lab Work?	Not applicable to CMS respite care services.	Field 20
Therapy Services Code	Not applicable to CMS respite care services.	Field 19
School District Code	Not applicable to CMS respite care services.	Field 19
Other Insurance?	If recipient has other insurance coverage, type Y. If not, type N.	N/A
TPL Paid Amount	The amount paid by the other insurance company. If *Other Insurance?* is Y and *TPL Denial Date* is blank, this field is required.	Field 29
TPL Denial Date	The date on which the other insurance company denied payment for services billed.	N/A

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to section 311.300
TPL Information		
Carrier Code	Code assigned by the state to identify Third Party Liability (TPL) or other insurance carrier name and address. When you verify eligibility, the response includes the TPL Carrier Code along with other TPL information for the recipient. If you enter this code on a claim, you do not have to type the TPL company's name and address.	N/A
Policy Number	The recipient's third party insurance company policy number.	Field 11
Company Name	The name of the third party insurance company.	Field 11C
Address	Type the address of the third party insurance company.	N/A
Second TPL	Indicates whether the recipient has a second insurance. Response required if primary insurance is entered. "Y" = Yes "N" = No.	Field 11D
Carrier Code	Code assigned by the state to identify the second Third Party Liability (TPL) or other insurance carrier name and address.	N/A
Policy Number	The recipient's additional third party insurance company policy number.	Field 9A
Company Name	The name of the second third party insurance company.	Field 9D
Address	The address of the second third party insurance company.	N/A
Insured/Other Than Recipient – First Name	If the recipient is not the insured person, type the first name of the insured person.	Field 4
Insured/Other Than Recipient – Last Name	If the recipient is not the insured person, type the last name of the insured person.	Field 4

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to section 311.300
TPL Information (Continued)		
Insured/Other Than Recipient – Address	If the recipient is not the insured person, type the address of the insured person.	Field 7
Employer or School Name	Name of recipient's employer or school.	Field 9C
Detail Information		
From DOS	Beginning date of service. For spanning dates of service, do not include any date on which no service was rendered. Units of service must be the same for each of the dates included in the span.	Field 24A
To DOS	Ending date of service. For spanning dates of service, do not include any date on which no service was rendered.	Field 24A
POS	Place of service code. (See section 311.400 for a list of codes.)	Field 24B
TOS	Type of service code. (See section 311.400 for a list of codes.)	Field 24C
Procedure	The procedure code for the service provided.	Field 24D
Modifier	Not applicable to CMS respite care services.	Field 24D
Hours	Not applicable to CMS respite care services.	Field 24D
Minutes	Not applicable to CMS respite care services.	Field 24D
Extreme Age	Not applicable to CMS respite care services.	N/A
Surgical Avoid	Not applicable to CMS respite care services.	N/A

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to section 311.300
Detail Information (Continued)		
Hypothermia	Not applicable to CMS respite care services.	N/A
Hypertension	Not applicable to CMS respite care services.	N/A
Pressure	Not applicable to CMS respite care services.	N/A
Circulation	Not applicable to CMS respite care services.	N/A
Units	Required field for all claim types. Number of units of a service that were supplied for the claim detail.	Field 24G
Diagnosis	Not applicable to CMS respite care services.	Field 24E
Charges	Required for all claim types. Provide the amount billed for a service performed for this detail. If you bill more than one unit of service on a detail, provide the total charge for all units billed for that detail.	Field 24F
Fund Code	Not applicable to Medicaid claims.	N/A
EPSDT/Family Planning	If the service was rendered as the result of an EPSDT screening, type E. If the service was rendered under the Family Planning Program, type F. If neither condition applies, leave this field blank.	Field 24H
Performing Provider ID	Required field for all claim types. The 9-digit identification number of the provider who performed the service. If the number you enter on the claim is not on file or not eligible on the dates of service you enter, the claim will not be accepted.	Field 24K

311.120 PES Professional Claim Response

Field Name	Values/Comments
Recipient ID	Displays the 10 digit assigned identification number of the individual receiving services.
Recipient Name	Displays the recipient's first and last name.
Patient Acct	Patient Account – Displays the unique number assigned by the provider's facility for the recipient.
Transaction Type	Displays the transaction type. This response will read "HCFA-1500".
Date	Displays the date the claim was submitted.
Time	Displays the time the claim was submitted.
Pay to Provider Number	Displays the provider number of the provider that is to receive payment.
Primary TPL - TPL Indicator	Displays "Y" for yes or "N" for no, depending on the information that was submitted.
Secondary TPL – TPL Indicator	Displays "Y" for yes or "N" for no, depending on the information that was submitted.
Employment Related	Displays "Y" for yes or "N" for no, depending on the information that was submitted.
Accident Related	Displays "Y" for yes or "N" for no, depending on the information that was submitted.
Outside Lab Work	Displays "Y" for yes or "N" for no, depending on the information that was submitted.
Diagnosis	Not applicable to CMS respite care services.
Detail Number	Displays the number of the detail that was submitted, up to six. Each detail and detail criteria will be listed separately.

311.120 PES Professional Claim Response (Continued)

Field Name	Values/Comments
From Date of Service	Displays the beginning date of service for the detail submitted.
To Date of Service	Displays the ending date of service for the detail submitted.
Place of Service	Displays the place of service for the detail submitted.
Type of Service	Displays the type of service for the detail submitted.
Procedure Code	Displays the procedure code for the detail submitted.
Diagnosis	Not applicable to CMS respite care services.
Charge	Displays the dollar amount billed for the detail submitted.
Number of Units	Displays the number of units for the detail submitted.
Modifier	Not applicable to CMS respite care services.
Performing Provider	Medicaid ID number of the provider who performed the procedure.
Total Amount Billed	Displays the total amount billed for the submitted claim.
TPL Amount	Displays the total amount from other insurances on the claim submitted.
Net Amount Billed	Displays the amount billed minus the TPL amount on the submitted claim.
Claim Submission Accepted - Net Amount Billed	Displays the net billed amount for the claim submitted.
ICN	Displays the unique 13-digit internal control number assigned by EDS to the submitted claim.

311.130 PES Claim Reversal

Field Name	Values/Comments
Provider ID	Enter the 9-digit identification number of the provider who filed the claim being reversed.
Patient ID	Enter the 10 digit assigned identification number of the individual receiving services.
ICN	Enter the unique 13-digit internal control number assigned by EDS to an accepted or adjudicated claim.

311.140 PES Claim Reversal Response

Field Name	Values/Comments
Transaction Type	Displays the transaction type. This response will read "Claim Reversal".
Date	The date of the claim reversal.
Time	The time of the claim reversal.
Provider ID	Displays the 9-digit identification number of the provider who filed the reversed claim.
Patient ID	Displays the 10 digit assigned identification number of the individual that received the services.
ICN	Displays the unique 13-digit internal control number assigned by EDS to an accepted or adjudicated claim.

311.150 PES Claim Rejected and Claim Reversal Rejected

If a claim or claim reversal is rejected, PES will display error codes and the meaning of the codes.

311.200 Billing Instructions - Paper Claims Only

The CMS respite care provider must complete the HCFA-1500 claim form for each recipient of CMS respite care services. The numbered items correspond to numbered fields on the claim form. (A sample HCFA-1500 claim form follows these billing instructions.) The provider's signature is required in field 31 of the HCFA-1500 claim form.

It is the provider's responsibility to obtain the parent's or legal guardian's signature on the HCFA-1500 claim form. The parent or legal guardian must sign in field 13 to certify that the information reported on the form (i.e., dates of service, units of service) is correct.

The provider **must** retain a copy of the completed form (with both signatures) for his or her records. (See section 204.000 of this manual for documentation requirements.)

To complete the billing process, the parent or provider must send the completed HCFA-1500 claim form to the CMS respite care coordinator at:

Arkansas Department of Human Services
Children's Medical Services
P.O. Box 1437, Slot S380
Little Rock, AR 72203

The CMS respite care coordinator will review the HCFA-1500 claim form to check for:

A. Signatures of both the person legally responsible for the child and the provider;

B. Compliance with the respite plan of care;

C. Medicaid eligibility of the child during the dates of service; and

D. Accuracy.

All discrepancies must be resolved prior to authorizing Medicaid payment.

The CMS respite care coordinator's staff will bill Medicaid on behalf of the provider using the AEVCS system. Payment will be sent directly to the provider who rendered the services.

311.300 Completion of HCFA-1500 Claim Form

	Field Name and Number	Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
1a.	Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number as it appears on the AEVCS eligibility verification transaction response.
2.	Patient's Name	Enter the client's last name and first name as they appear on the AEVCS eligibility verification transaction response.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name, (post office box or RFD), city name, state name and zip code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if the insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.

311.300 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number	Instructions for Completion
9. Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
b. Other Insured's Date of Birth	This field is not required for Medicaid.
Sex	This field is not required for Medicaid.
c. Employer's Name or School Name	Enter the employer's name or school name.
d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10. Is Patient's Condition Related to	
a. Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."
b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter State postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
10d. Reserved for Local Use	This field is not required for Medicaid.

311.300 Completion of HCFA-1500 Claim Form (Continued)

	Field Name and Number	Instructions for Completion
11.	Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
	a. Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer's Name or School Name	Enter the insured's employer's name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13.	Insured's or Authorized Person's Signature	This field must be signed by the parent or legal guardian of the patient.
14.	Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15.	If Patient Has Had Same or Similar Illness, Give First Date.	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17.	Name of Referring Physician or Other Source	Not applicable to CMS respite care services.
17.a	I.D. Number of Referring Physician	Not applicable to CMS respite care services.
18.	Hospitalization Dates Related to Current Services	Not applicable to CMS respite care services.

311.300 Completion of HCFA-1500 Claim Form (Continued)

	Field Name and Number	Instructions for Completion
19.	Reserved for Local Use	Not applicable to CMS respite care services.
20.	Outside Lab Work?	Not applicable to CMS respite care services.
21.	Diagnosis or Nature of Illness or Injury	Not applicable to CMS respite care services.
22.	Medicaid Resubmission Code	Reserved for future use.
	Original Ref No.	Reserved for future use.
23.	Prior Authorization Number	Not applicable to CMS respite care services.
24.	A. Dates of Service	Enter the "from" and "to" dates of service for each service provided in MM/DD/YY format. A single date of service need not be entered twice on the same line. Each claim detail line may include dates from only one calendar month. For example, dates of service 06-15-01 through 07-14-01 must be billed on two lines: 06-15-01 to 06-30-01 and 07-01-01 to 07-14-01. For spanning dates of service, do not include any date on which no service was rendered.
	B. Place of Service	Enter the appropriate place of service code. See section 311.400 for a list of codes.
	C. Type of Service	Enter the appropriate type of service code. See section 311.400 for a list of codes.

311.300 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number	Instructions for Completion
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct HCPCS procedure code from section 311.410.
Modifier	Not applicable to CMS respite care claims.
E. Diagnosis Code	Not applicable to CMS respite care claims.
F. $ Charges	Enter the charge for the service. This charge should be the provider's customary fee to private-pay clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral and "F" if services rendered are Family Planning related.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.
K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter this number in Field 33 after "GRP#."

311.300 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number		Instructions for Completion
25.	Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28.	Total Charge	Enter the total of Column 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE in Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the recipient, unless the recipient has an insurer that requires copay. In such a case, enter the sum of the insurer's payment and the recipient's copay. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE:** For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.

311.300 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number		Instructions for Completion
31.	Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and zip code of the facility where services were performed.
33.	Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
	PIN #	This field is not required for Medicaid.
	GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."

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PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE(State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes, return to and complete item 9 a-d.*
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATES OF SERVICE FROM MM DD YY TO MM DD YY	B Place Of Service	C Type Of Service	D PROCEDURES. SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27.ACCEPT ASSIGNMENT (For govt. claims, see back) ☐ YES ☐ NO
28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I Certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS. SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS, and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 US 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as other necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed. Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988" permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this

311.400 Place of Service and Type of Service Codes

Place of Service	Type of Service
4 - Patient's Home 5 - Day Care Facility I - Day Treatment Centers J - Respite Care Facility	9 - Other Medical Service

311.410 CMS Respite Care Procedure Code

Use the following procedure code for CMS respite care services:

Procedure Code	Description
Z2631	CMS Respite Care Services 1 unit = 15 minutes minimum of 4 units per day maximum of 96 units per day

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320.000 REMITTANCE AND STATUS REPORT

321.000 Introduction of Remittance and Status Report

The Remittance and Status Report, or Remittance Advice (RA), is a computer generated document that reports the status and payment breakdown of all claims submitted to Medicaid for processing. It is designed to simplify provider accounting by facilitating reconciliation of claim and payment records.

An RA is generated and mailed each week a provider has claims paid, denied or in process. Once a week, all claims completed in a daily cycle are processed through the financial cycle. The RA is produced at the time checks are issued. The RA explains the provider's payment on a claim by claim basis. Only providers who have finalized claims or claims in process (claims that have been through at least one financial cycle) will receive an RA.

Since the RA is a provider's only record of paid and denied claims, it is necessary for the provider to retain all copies of the RAs.

321.100 Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT) allows providers to have their Medicaid payments automatically deposited instead of receiving a check. See Section I of the provider manual for an enrollment form and additional information.

322.000 Purpose of the RA

The RA is the first source of reference if there are questions regarding a particular claim. If the The RA is a status report of active claims. It is the first source of reference to resolve questions regarding a claim. If the RA does not resolve the question, it may be necessary to contact the EDS Provider Assistance Center (PAC). PAC will need the claim number from the RA to research the question. The Provider Assistance Center (PAC) may be contacted at (501) 376-2211 (local and out-of-state) or 1-800-457-4454 (in-state WATS).

If a claim does not appear on the RA within six weeks after submission, contact PAC. If PAC can find no record of the claim, they will suggest resubmitting it.

323.000 Segments of the RA

There are eight main segments of an RA:

Report Heading
Paid Claims
Denied Claims
Adjusted Claims
Claims In Process
Financial Items
AEVCS Transactions
Claims Payment Summary

Refer to the explanation and example of the RA on the following pages. The printed column headings at the top of each page and the numbered field headings are described to help in reading the RA.

324.000 Explanation of the Remittance and Status Report

324.100 Report Headings

	Report Heading	Description
1.	PROVIDER NAME AND ADDRESS	The name and address of the Medicaid provider to whom the Medicaid payment will be made.
2.	RA NUMBER	A unique identification number assigned to each RA.
3.	PROVIDER NUMBER	The unique 9-digit number to which this RA pertains. The payment associated with each RA is reported to the IRS on the federal tax ID linked to each provider number.
4.	CONTROL NUMBER	Internal page number for all RAs produced on each cycle date.
5.	REPORT SEQUENCE	Assigned sequentially for the provider's convenience in identifying the RA. The first RA received from EDS for the calendar year is numbered "1," the second "2," etc. Filing your RAs in chronological order by this number ensures that none are missing.
6.	DATE	The date the RA was produced. This is also the "checkwrite" date, or the date on the check associated with this RA.
7.	PAGE	The number assigned to each page comprising the RA. Numbering begins with "1" and

increases sequentially.

324.100 Report Heading (Continued)

	Report Heading	Description
8.	NAME AND RECIPIENT ID	The recipient's last name, first name, middle initial and 10-digit Medicaid identification number. Claims are sorted alphabetically, by patient last name.
9.	SERVICE DATES	Format MM/DD/YY (Month, Day, Year) in "From" and "To" dates of service. For each detail, "From" indicates the beginning date of service and "To" indicates the ending date of service.
10.	DAYS OR UNITS	The number of times a particular service is billed within the given service dates.
11.	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	Procedure code - CPT or HCPCS code corresponding to the service on the claim. The type of service code directly precedes the 5-digit procedure code.
12.	TOTAL BILLED	The amount the provider bills per detail.
13.	NON-ALLOWED	The amount of the billed charge that is non-allowed per detail.
14.	TOTAL ALLOWED	The total amount Medicaid allows for that detail. (Total Allowed = Total Billed - Non-Allowed)
15.	SPEND DOWN	The amount of money a patient must pay toward his medical expenses when his income exceeds the Medicaid financial guidelines.
16.	PATIENT LIABILITY	Not applicable.
17.	OTHER DEDUCTED CHARGES	The total amount paid by other resources (other insurance or co-pay if either exist).
18.	PAID AMOUNT	The amount Medicaid pays (Paid Amount = Total Allowed - Other Deducted Charges).
19.	EXPLANATION OF BENEFIT CODE(S)	A number corresponding to a message which explains the action taken on claims. The messages for each explanation code are listed on the final page of the RA.
20.	COVER PAGE MESSAGES	Messages written for provider information.

324.200 Paid Claims

This section shows all claims that have been paid or partially paid, since the previous checkwrite.

	Field Name	Description
1.	CO	County Code - A unique 2-digit number assigned to each recipient's county of residence.
2.	RCC	Reimbursement Cost Containment - The reimbursement rate on file for a hospital. This item doesn't apply to claims filed on HCFA-1500.
3.	COST SHARE, PA/LEA, TPL	"COST SHARE=" displays Medicaid and ARKids First-B copay amounts. "PA/LEA=" displays applicable prior authorization or LEA numbers. Third Party Liability (TPL) will show the amount paid from insurance or other sources.
4.	CLAIM NUMBER	A unique 13-digit control number assigned to each claim by EDS for internal control purposes. Please use this internal control number (ICN) when corresponding with EDS about a claim. Example: 0599033067530 (ICN) Format: RRYYDDDBBBSSS a. RR-05 - The first and second digits indicate the media the claim was submitted on to EDS (e.g., "05" - AEVCS, "10" - magnetic tape, "98" - paper, "50" - adjusted claims). b. YY-99 - The third and fourth digits indicate the year the claim was received. c. DDD-033 - The fifth, sixth and seventh digits indicate the day of the year, or Julian date, the claim was received (e.g., 033 = February 2). d. The remaining digits are used for internal record-keeping purposes.

324.200 Paid Claims (Continued)

	Field Name	Description
5.	MRN	Medical Record Number - The "patient control number" entered in electronic claim format or "patient account number" (field 26) entered on the HCFA-1500 paper claim.
6.	DIAG	Diagnosis - The primary diagnosis code used on the claim.
7.	SERV PHYS	Servicing Physician – The servicing physician's (performing provider) provider number appears only on RAs for groups or clinics.
8.	ADMIT	Date of admission to a facility.
9.	COINS, DED, MCR PD, TPL	Coinsurance, deductible, the Medicare paid amount and will be listed for crossover claims. Third Party Liability (TPL) will show the amount paid from insurance or other sources.

324.300 Denied Claims

This section identifies denied claims and denied adjustments. Denial reasons may include: ineligible status, non-covered services and claims billed beyond the filing time limits. Claims in this section will be referenced alphabetically by the recipient's last name, thereby facilitating reconciliation with provider records. Up to three code numbers will appear in the column entitled EOB (Explanation of Benefit) codes. Definitions of EOB codes are on the last page of the RA. The EOB messages regarding denied claims specify the reason EDS is unable to process the claims further.

Denied claims are final. No additional action will be taken on denied claims.

Denied claims are listed on the RA in the same format as paid claims.

324.400 Adjusted Claims

Payment errors - underpayments and overpayments as well as payments for the wrong procedure code, wrong dates of service, wrong place of service, etc., - can be adjusted by canceling ("voiding") the incorrectly adjudicated claim and processing the claim as if it were a new claim. Most adjustment transactions appear in the *Adjusted Claims* section of the RA. Denied adjustments appear at the end of the *Denied Claims* section of the RA.

The simplest explanation of an adjustment transaction is:

A. EDS subtracts from today's check total the full amount paid on a claim that contained at least one payment error.

B. EDS reprocesses the claim - or processes the corrected claim - and pays the correct amount.

C. EDS adds the difference to the remittance (or subtracts the difference if it is a negative amount).

Adjustments sometimes appear complicated because the necessary accounting and documentation procedures add a number of elements to an otherwise routine transaction. Also, there are variations in the accounting and documentation procedures, because there is more than one way to submit an adjustment and there is more than one way to adjudicate and record adjustments. There are positive (additional payment is paid to the provider) and negative (the provider owes EDS additional funds) adjustments, adjustments involving withholding of previously paid amounts, adjustments submitted with check payments and denied adjustments. The following sections thoroughly explain adjustments, how they appear on the RA and the meaning, from a bookkeeping perspective, of each significant element.

324.410 The Adjustment Transaction

The *Adjusted Claims* section has two parts. Each part is divided into two segments. The first part is the adjustment transaction. The adjustment transaction is divided into a "Credit To" segment and a "Debit To" segment.

324.411 The "Credit To" Segment

The first segment of the adjustment transaction is the "Credit To" segment. In this section, EDS identifies the adjustment transaction, the adjusted claim, and the previously paid amount EDS will withhold from today's check as a result of this adjustment. The adjustment transaction is identified by an internal control number (ICN) that follows the field heading, "Claim Number." Adjustment ICNs are formatted in the same way as claim numbers; the first two digits of an adjustment ICN are "50." Immediately to the right of the adjustment ICN are the words "Credit To," followed by the claim number and paid date of the original claim that paid in error.

324.411 The "Credit To" Segment (Continued)

Underneath the "Credit To" line are displayed the recipient's Medicaid ID number, the claim beginning and ending dates of service and the provider's medical record number (or the patient account number) from the original claim, followed by the original billed amount. Keep in mind that EDS adjusts the entire claim, even if only one detail paid in error, so the total billed amount shown here is the total billed amount of the entire claim being adjusted. At the right end of this line, in the "Paid Amount" column, is the amount originally paid on the claim, which is the amount EDS will withhold from today's remittance.

The actual withholding of the original paid amount does not occur in the *Adjusted Claims* section; it occurs in the *Financial Items* section of the RA. Adjustments are listed in *Financial Items*, with the appropriate amounts displayed under the field headings "Original Amount," "Beginning Balance," "Applied Amount" and "New Balance." (Please see the discussion of *Financial Items* in section 324.600.) Finally, the total of all amounts withheld from the remittance is displayed under "Withheld Amount," in the *Claims Payment Summary* section of the RA.

324.412 The "Debit To" Segment

A. The second segment of the adjustment transaction is the "Debit To" segment. In this segment, EDS displays the adjudication of the reprocessed claim and, for informational purposes, the net adjustment amount. The net adjustment amount is the additional amount to be paid in this remittance as a result of the adjustment **or** it is the amount by which the remittance will be less than the total of all paid claims minus AEVCS fees and other withheld amounts.

B. The "Net Adjustment" amount - the amount due to EDS when adjusting an overpayment or the amount due to the provider when adjusting an underpayment - is on the second line of the "Debit To" segment.

1. In the case of an adjustment of an underpayment, the "Net Adjustment" amount will be added to the total paid claims amount on today's remittance.

2. If EDS is due the amount shown as the net adjustment, the letters "CR" will immediately follow the amount. "CR" means that the claim's original paid amount is greater than the new paid amount (as when the original payment is an overpayment) and the amount denoted by "CR" must be deducted from the total paid claims amount on today's remittance.

C. Adjudication:

Immediately following the "Net Adjustment" line is the complete adjudication of the reprocessed claim, cross-referenced to the original claim number. The last line displays the new paid amount. The difference between the paid amount in the "Credit To" segment and the paid amount in the "Debit To" segment is the amount shown in "Net Adjustment." (See part B, above.)

324.420 Adjusted Claims Totals

At the end of the adjustment transactions is the total number of adjusted claims in today's RA, the total of all billed amounts, the total non-allowed amounts and the total of all paid amounts, the last being the total "Debit To" amount, as well.

For information purposes, the last segment is the total of all "Net Adjustment" amounts in today's RA. Net adjustment amounts displayed with "CR" are treated as negative numbers in the calculation of the net adjustment total.

324.430 Adjustment Submitted with Check Payment

Some providers prefer to send a check for the overpayment amount with their adjustment request. In such a case, the original paid amount displayed in the "Credit To" segment is listed in the *Financial Items* section of the RA with an EOB code indicating that EDS has received a check for that amount. Also, since EDS does not withhold that amount from the remittance, it appears in the *Claims Payment Summary* section under "Credit Amount" (instead of appearing under "Withheld Amount"). If EDS acknowledges more than one payment by check in *Financial Items*, the total of those check payments appears under "Credit Amount" in the *Claims Payment Summary* section. Amounts shown under "Credit Amount" are never deducted from the remittance because they are already paid.

324.440 Denied Adjustments

Occasionally an adjusted claim is denied. Adjustments can be denied for any of the reasons for which any other claim can be denied. Denied adjustments do not appear in the *Adjusted Claims* section. Denied adjustments do not have "Credit To" segments. Denied adjustments do not reflect a cross-reference to the original claim. Denied adjustments appear at the end of the *Denied Claims* section. Their adjudication is displayed by detail, in the same manner as an adjustment "Debit To" segment. The original paid amount of the claim intended to be adjusted is withheld from the remittance and it is so indicated in the *Financial Items* section, listed under the adjustment ICN.

324.500 Claims In Process

This section lists those claims that have been entered into the system, but have not reached final disposition. Please do not rebill a claim shown in this section, as it is already in our system and will result in a rejection as a duplicate claim. These claims will appear on subsequent RAs in this section until they are paid, denied or returned.

Summary totals follow this section.

	Field Name	Description
1.	RECIPIENT ID	The recipient's 10-digit Medicaid identification number.
2.	PATIENT NAME	The recipient's last name, first name and middle initial.
3.	SERVICE DATES: FROM	The beginning date of service for this claim.
4.	SERVICE DATES: TO	The ending date of service for this claim.
5.	ICN	Claim Number – The unique 13-digit number assigned to each claim for control purposes.
6.	TOTAL BILLED	The total amount billed by the provider. (The sum of the detail lines.)
7.	MEDICAL RECORD	The "patient control number" entered in electronic claim format or "patient account number" (field 26) entered on the HCFA-1500 paper claim.
8.	EOB CODE(S)	Explanation of Benefit Codes – Numeric representation of messages which explain what research is being done to the claim before payment can occur. Detailed descriptions of these messages will be listed on the last page of the RA.

324.600 Financial Items

This section contains a listing of the payments refunded by the provider, amounts recouped since the previous checkwrite, payouts and other transactions. It also includes any other recoupment activities being applied that will reflect negatively to the provider's total earnings for the year. The Explanation of Benefit codes beside each item indicate the action taken.

The "Credit To" entries from the *Adjusted Claims* section that are being recouped are listed in the *Financial Items* section. The "Credit To" portion of adjusted claims appears in the *Adjusted Claims* section as information only and is actually applied in the *Financial Items* section.

	Field Name	Description
1.	RECIP ID	Recipient ID – The recipient's 10-digit Medicaid identification number.
2.	FROM DOS	The from date of service.
3.	TXN DATES	Transaction Dates – The date on which this transaction was entered into the system.
4.	CONTROL NUMBER	The unique number assigned to this transaction by EDS.
5.	REFERENCE	Information that may be of help in identifying the transaction (For example, claim number or AEVCS transaction fees).
6.	ORIGINAL AMOUNT	The original amount of the transaction. This amount will be the same on each RA for a particular transaction until it has been completed.
7.	BEGINNING BALANCE	The amount remaining for this transaction before this RA. (For example, if a recoupment had been initiated for $1,000.00, but only $200.90 was deducted, then the next RA would show a beginning balance of $799.10 to be recouped.)

324.600 Financial Items (Continued)

	Field Name	Description
8.	APPLIED AMOUNT	The amount applied on this RA to the beginning balance. (If the provider sent a refund check for two different recipients or if the monies were recouped from two different recipients, then the amounts applicable to each recipient would be displayed in the applied amount column individually.)
9.	NEW BALANCE	The amount left for this transaction after this RA.
10.	EOB	Explanation of Benefit Code(s) - The last page of the RA will give detailed descriptions.

324.700 AEVCS Transactions

This section contains a listing of all AEVCS transactions by the transaction category and transaction type submitted by the CMS respite care coordinator on behalf of the provider. It also contains separate totals for claim transactions, reversal transactions and total transactions for this provider.

	Field Name	Description
1.	TRANSACTION CATEGORY	This field indicates the type of transaction submitted by the provider.
2.	TRANSACTION TYPES	The type of claim transmitted by the provider.
3.	TRANSACTION COUNT	The total number of transactions for the transaction type.
4.	TRANSACTION AMOUNT	The total charges for transactions transmitted for the transaction type.
5.	TOTAL CLAIM TRANSACTION	The total number of claims transmitted and the total charges for the transaction category.
6.	TOTAL REVERSAL TRANSACTION	The total number of reversals submitted by the provider. This is informational only as there are no transaction fees for reversals.
7.	TOTAL TRANSACTIONS FOR THIS PROVIDER	The total number of AEVCS transactions, including claims transmitted, reversals, eligibility verifications and total charges.

324.800 Claims Payment Summary

This section summarizes all Medicaid payments and credits made to each provider for the specific RA pay period entitled "Current Processed" as well as for the year entitled "Year to Date Total."

	Field Name	Description
1.	DAYS OR UNITS	The total units paid, denied and adjusted. Includes details added to indicate ARKids First-B copays. Does not include crossovers.
2.	CLAIMS PAID	Total number of claims paid, denied and adjusted by the Medicaid Program, including crossovers.
3.	CLAIMS AMOUNT	Total paid amount from *Paid Claims* section plus any supplemental payouts (e.g., resulting from a positive adjustment listed in the *Adjusted Claims* section).
4.	WITHHELD AMOUNT	Total amount withheld from RA (e.g., resulting from negative adjustments). This amount is the sum of the "Applied Amount" fields of the *Financial Items* section. This does not include the withheld AEVCS transaction amount.
5.	NET PAY AMOUNT	Claims amount less withheld amount(s), including AEVCS transaction fees. This is the amount of the provider's payment.
6.	CREDIT AMOUNT	Total amount refunded to the Medicaid Program by the provider. EDS posts refunds here. See section 330.000.
7.	NET 1099 AMOUNT	The provider's income reported to federal and state governments for tax purposes. This amount is the "Net Pay Amount" plus the "AEVCS Transaction Recoupment Amount". AEVCS transaction fees are paid with taxable revenue, so they are added back to the "Net Pay Amount" for tax reporting purposes.
8.	TAX AMOUNT	The amount of tax withheld on this RA. Not currently used.
9.	QTR TAX AMOUNT	Quarterly Tax Amount – The cumulative amount of tax withheld for this financial quarter. Not currently used.

324.800 Claims Payment Summary (Continued)

	Field Name	Description
10.	AEVCS TXN FEES	AEVCS Transaction Fees – Total amount of AEVCS transaction fees charged to the provider.
11.	AEVCS TXN RECOUP AMT	AEVCS Transaction Recoupment Amount – Total amount of AEVCS transaction fees withheld from the payment. This amount is obtained from the "Total Transactions For This Provider" field under the "Transaction Amount" column of the AEVCS transactions section.
12.	DEF COMP RECOUP AMT	Deferred Compensation Recoup Amount – Amount withheld from the payment and deposited in the provider's designated account for deferred compensation.
13.	ARKIDS 1ST/CHIP/MEDICAID SUMMARY	A summary count and total amount paid for ARKids First, CHIP and Medicaid claims.
14.	DESCRIPTION OF EOB CODES	The descriptions of all explanation of benefit codes used in the RA.
15.	FEDERAL TAX ID	The provider's social security number or federal Employer Identification Number (EIN). All monies paid to the provider will be reported to the IRS under this number. If the number listed is incorrect, contact the provider enrollment unit to update the file.

CMS Respite Care sample RA

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

1 PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

2 R/A NUMBER 12345

3 **STATE OF ARKANSAS**

PROVIDER NUMBER 123456190

4 CNTRL NUM 1

5 REPORT SEQ NUMBER 3

6 DATE 01/01/03 PAGE 1 7

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
8		9					10	11	12	13	14	15	16	17	18	19

20 TO ALL PROVIDERS

THE PURPOSE OF THE “RA MESSAGE”
IS TO KEEP YOU INFORMED.
PLEASE READ EACH ONE AND CONTACT EDS IF YOU HAVE ANY QUESTIONS CONCERNING THE RA MESSAGE.

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

REMITTANCE ADVICES CANNOT BE FORWARDED. THEREFORE, THE ARKANSAS MEDICAID PROGRAM MUST BE NOTIFIED OF AN ADDRESS CHANGE WITH THE PROVIDER’S ORIGINAL SIGNATURE (NO FACSIMILE). PLEASE INDICATE ALL PROVIDER NUMBERS AFFECTED BY THE CHANGE.

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456190 CNTRL NUM 2 REPORT SEQ NUMBER 3 DATE 01/01/03 PAGE 2

NAME / RECIPIENT ID	SERVICE DATES FROM MM DD YY	SERVICE DATES TO MM DD YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
PAID CLAIMS MEDICAL	[1]	[2]		[4]	[5]	[6]		[7]		[8]		
DUNN, JOHN	CO = 60	RCC =		CLAIM NUMBER = 0502354051456	MRN =	DIAG =		SERV PHYS = 123456190		ADMIT =		
0123456789	12 11 02	12 11 02	8 9	Z2631 CMS RESPITE CARE SERVICES	16 00	00	16 00	00		00	16 00	61
[3]	COST SHARE = 00		PA/LEA =	TPL = 00	16 00	00	16 00	00		00	16 00	TAX = 00
SMITH, BOB	CO = 26	RCC =		CLAIM NUMBER = 0502352061456	MRN =	DIAG =		SERV PHYS = 123456190		ADMIT =		
0123654789	12 07 02	12 07 02	8 9	Z2631 CMS RESPITE CARE SERVICES	16 00	00	16 00	00		00	16 00	61
[9]	COINS = 0.00		DED = 00	MCR PD = 0.00 TPL = 00	16 00	00	16 00	00		00	16 00	TAX = 00
2 CLAIMS			2 MEDICAL	**********	32 00	00	32 00	00		00	32 00 TAX=00	
********* TOTAL PAID CLAIMS			2 CLAIMS		32 00	00	32 00	00		00	32 00 TAX=00	

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456190 CNTRL NUM 3 REPORT SEQ NUMBER 3 DATE 01/01/03 PAGE 3

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
DENIED CLAIMS MEDICAL																
SMITH, MARY 0112233456	CO = 37 12	19	02	RCC = 12	19	02	10	9 CLAIM NUMBER = 0502359051456 Z2631 CMS RESPITE CARE SERVICES	MRN = 25 00	DIAG = 25 00	00	SERV PHYS = 123456190 00	ADMIT = 00	00	00	470
	COST SHARE = 00						PA/LEA =	TPL = 00	25 00	25 00	00	00	00	00	00	TAX = 00
1 CLAIMS						1	MEDICAL	**********	25 00	25 00	00	00	00	00	00 TAX=00	
******* TOTAL DENIED CLAIMS							1 CLAIMS		25 00	25 00	00	00	00	00	00 TAX=00	

CMS Respite Care sample RA (Continued)

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456190 CNTRL NUM 4 REPORT SEQ NUMBER 3 DATE 01/01/03 PAGE 4

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
ADJUSTED CLAIMS PROFESSIONAL ADJUSTMENT																
SMITH, MARY 0112233456	CO = 37 11	16	02	CLAIM NUMBER = 5003001927456 11	16	02		** ADJUSTMENT MED REC =	50 00		** CREDIT TO 0502333051456	PAID DATE 120202			50 00	336
SMITH, MARY 0112233456	CO = 37 11	16	02	CLAIM NUMBER = 5003001927456 11	16	02	16	** ADJUSTMENT Z2631 CMS RESPITE CARE SERVICES	50 00	18 00	** DEBIT TO 0502333051456 NET ADJUSTMENT 32 00	PAID DATE 120202 00	00	SERV PHYS = 123456178 TAX= 00 00	18 00CR 32 00 TAX=00	365
	COST SHARE = 00						PA/LEA =	TPL = 00								
1 CLAIMS							1	PROFESSIONAL ADJUSTMENT *****								
*** TOTAL ADJUSTED CLAIMS							1	CLAIMS								
TOTAL NET ADJUSTMENT									50 00	18 00 TOTAL NET TAX = 00	32 00	00	00	00	32 00 18 00CR	TAX=00

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456190 CNTRL NUM 5 REPORT SEQ NUMBER 3 DATE 01/01/03 PAGE 5

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
CLAIMS IN PROCESS PROFESSIONAL				THESE CLAIMS ARE BEING PROCESSED AS LISTED												
1 SMITH, FRANKLIN 5544332211	12	12 3	02	12	12 4	02		ICN 0502350051456 5	18 00 6		MEDICAL RECORD=430001001 7					14 8
1 CLAIMS								PROFESSIONAL	********	18 00						
** TOTAL PENDING CLAIMS								1 CLAIMS		18 00						

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456190 CNTRL NUM 6 REPORT SEQ NUMBER 3 DATE 01/01/03 PAGE 6

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
FINANCIAL ITEMS																
	2			3			4	5			6	7	8		9	10
RECIP ID	FROM DOS			TXN DATES			CONTROL NUMBER	REFERENCE			ORIGINAL AMOUNT	BEGINNING BALANCE	APPLIED AMOUNT		NEW BALANCE	EOB
5544332211	12	03	02	12	03	02	7584756102	0502340051564			50 00	50 00	50 00		0 00	
				12	27	02	9364758673	AEVCS TRANSACTION FEES			1 51	1 51	1 51		0 00	
								TOTAL FINANCIAL ITEMS 2								

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456190 CNTRL NUM 7 REPORT SEQ NUMBER 3 DATE 01/01/03 PAGE 7

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
AEVCS TRANSACTIONS																
1 TRANSACTION CATEGORY							2	3 TRANSACTION COUNT			4 TRANSACTION AMOUNT					
CLAIM								MEDICAL		3			51			
							5	TOTAL CLAIM TRANSACTIONS		3			51			
REVERSAL								MEDICAL		1						
							6	TOTAL REVERSAL TRANSACTIONS		1						
ELIGIBILITY VERIFICATION										10			1 00			
							7	TOTAL TRANSACTIONS FOR THIS PROVIDER		14			1 51			

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456190 CNTRL NUM 8 REPORT SEQ NUMBER 3 DATE 01/01/03 PAGE 8

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	FROM DD	TO MM	TO DD	TO YY	DAYS OR UNITS [1]	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION [2]	[3]	TOTAL BILLED [4]	NON ALLOWED [5]	TOTAL ALLOWED [6]	SPENDDOWN [7]	PATIENT LIABILITY [8]	OTHER DEDUCTED CHARGES [9]	PAID AMOUNT	EOB CODES
CLAIMS PAYMENT SUMMARY							DAYS OR UNITS	CLAIMS PAID	CLAIMS AMOUNT	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT	TAX AMOUNT	QTR TAX AMOUNT		
CURRENT PROCESSED							42	4	64.00	50 00	12 49	00	14 00	00	00		
YEAR-TO-DATE TOTAL							42	4	64.00	50 00	12 49	00	14 00	00	00		
							[10] AEVCS TXN FEES	[11] AEVCS TXN RECOUP AMT	DEF COMP RECOUP AMT								
CURRENT PROCESSED							1.51	1.51	.00								
YEAR-TO-DATE TOTAL							1.51	1.51	.00								

[13] ARKIDS 1ST/CHIP/MEDICAID SUMMARY

	ARKIDS 1ST CLAIMS	ARKIDS 1ST TOTAL PAID	CHIP CLAIMS	CHIP TOTAL PAID	MEDICAID CLAIMS	MEDICAID TOTAL PAID
DRUG	0	0.00	0	0.00	0	0.00
DRUG ADJUSTMENT	0	0.00	0	0.00	0	0.00
MEDICAL	0	0.00	0	0.00	2	32.00
DENTAL	0	0.00	0	0.00	0	0.00
SCREEN	0	0.00	0	0.00	0	0.00
PROFESSIONAL CROSSOVER	0	0.00	0	0.00	0	0.00
VISION	0	0.00	0	0.00	0	0.00
PROFESSIONAL ADJUSTMENT	0	0.00	0	0.00	0	0.00
INPATIENT HOSPITAL	0	0.00	0	0.00	0	0.00
INPATIENT NURSING HOME	0	0.00	0	0.00	0	0.00
INPATIENT CROSSOVER	0	0.00	0	0.00	0	0.00
NURSING HOME CROSSOVER	0	0.00	0	0.00	0	0.00
NURSING HOME ADJUSTMENT	0	0.00	0	0.00	0	0.00
INPATIENT ADJUSTMENT	0	0.00	0	0.00	0	0.00
OUTPATIENT	0	0.00	0	0.00	0	0.00
OUTPATIENT CROSSOVER	0	0.00	0	0.00	0	0.00
OUTPATIENT ADJUSTMENT	0	0.00	0	0.00	0	0.00

[14] IF AN * APPEARS TO THE LEFT OF A DETAIL, PAID DETAIL HAS BEEN ADDED SYSTEMATICALLY.
IF ** APPEARS TO THE LEFT OF A DETAIL, A DENIED DETAIL WAS ADDED SYSTEMATICALLY. RECOMMENDED BILLING INDICATED ON DETAIL.

THE FOLLOWING IS A DESCRIPTION OF THE EOB CODES UTILIZED THROUGHOUT THE REPORT.

14 CLAIM IN PROCESS. PLEASE DO NOT REBILL.
61 PAID IN FULL BY MEDICAID.
336 ADJUSTMENT TO SERVICES PREVIOUSLY PAID OR DENIED.
365 FEE ADJUSTED TO MAXIMUM AMOUNT.
470 DUPLICATE OF CLAIM PAID.

[15] **** FEDERAL TAX ID EIN 222334455

330.000 ADJUSTMENT REQUEST FORM

The Adjustment Request Form is to be submitted for the reconsideration of a previously **paid** claim (even if the paid amount is $0.00) due to incomplete or inaccurate claim information, processing errors or pricing file errors. CMS will submit an Adjustment Request Form on behalf of the CMS respite care providers. All of the necessary information for processing the adjustment must be included on the request form. A copy of the corrected claim or transaction and a copy of the page of the RA it was paid on may be attached to offer further clarification. However, on joint Medicare/Medicaid claims, the Explanation of Medicare Benefits (EOMB) must be attached. If CMS submits an Adjustment Request Form that is not valid, the EDS Adjustment Unit will notify the provider.

Adjustment Request Forms should be filed as soon as the incorrect payment has been identified. Requests for correction or review must be submitted by CMS to EDS within the 12-month timely filing deadline. Adjustment requests cannot be processed if more than 12 months have passed since the "from date of service".

The following instructions explain how to complete the form. A copy of the form is included following these instructions.

331.000 Instructions for Completing the Adjustment Request Form

	Field Name and Number	Instructions for Completion
1.	Provider Number	Enter the 9-digit Arkansas Medicaid provider number under which payment is to be made.
2.	Provider Name and Address	Complete this field with the same information with which you bill Medicaid.
3.	Overpayment (Credit)	If duplicate payments, incorrect payments or overpayments are made, submit an adjustment request and check the box labeled overpayment. EDS will withhold (recoup) the overpayment amount from future claims payments.
4.	Underpayment (Debit)	If a claim is underpaid, check the box labeled underpayment to have the correct amount added to future claims payments.

331.000 Instructions for Completing the Adjustment Request Form (Continued)

	Field Name and Number	Instructions for Completion
5.	Informational Corrections	Check this box if the claim paid the correct amount using incorrect information such as wrong dates of service. This box should be checked only if it will not affect the amount paid.
6.	Claim Number (ICN - Internal Control Number)	Enter the 13-digit claim number exactly as it is printed on your RA.
7.	Patient Name	Enter the patient's last name, first name and middle initial.
8.	Recipient ID Number	Enter the entire 10-digit Medicaid identification number assigned to the recipient as it appears on the RA.
9.	Remittance Advice Date	Enter the date of the RA, which is found at the top right corner of the RA.
10.	Date(s) of Service	Enter the beginning and ending month, day and year of services rendered.
11.	Billed Amount	Enter the amount the Medicaid Program was actually billed for the service(s).
12.	Paid Amount	Enter the amount actually paid by Medicaid for the service(s) in question.
13.	Description of the Problem	Indicate a specific reason for the adjustment request and the nature of the incorrect payment.
14.	Signature and Date	Enter the signature of the requester and the date the adjustment request was prepared.

ADJUSTMENT REQUEST FORM - MEDICAID XIX

MAIL TO: EDS; Adjustments; P.O. Box 8036; Little Rock, Arkansas 72203
IMPORTANT: If all required information is not complete, the form will be returned to provider.

Provider Number: _____

Provider Name: _____

Address: _____

_____

☐ Overpayment: Please process to correct the overpayment.

☐ Underpayment: Please process to correct the underpayment.

☐ Informational Corrections: Please process to reflect the correct information.

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

Claim Number: _____ Patient Name: _____

Recipient I.D. Number: _____ Remittance Advice Date: _____

Date(s) of Service: _____

Billed Amount: _____ Paid Amount: _____

Description of the Problem:

_____

_____

_____

_____

Signature: _____ Date: _____

EDS USE ONLY

_____ Date of Adjustment Reviewer: _____

Adjustment Action:

_____ Pay

_____ Deny

_____ Recoup

EDS-AR-004 Revised 6/02

332.000 Explanation of Check Refund Form

The Arkansas Medicaid Program provides RAs each week to providers who have claims paid, denied or in process. If an overpayment occurs, the provider is responsible for refunding the Medicaid Program.

Refunds to the Medicaid Program may be accomplished by sending a check in the amount of the overpayment made payable to the Arkansas Medicaid Program or by returning the original check issued by EDS. The Arkansas Medicaid Explanation of Check Refund Form must be completed and submitted with the refund.

In instances of underpayment, some providers prefer returning the original check or forwarding a check in the amount of the underpayment instead of requesting an adjustment. When EDS posts the refund, the amount of the refund appears in the *Claims Payment Summary* section of the RA. The provider may then resubmit the original or corrected claim for correct adjudication and payment.

Provide the following information in the appropriate fields on an Arkansas Medicaid Explanation of Check Refund Form for each refund you send to EDS:

1. Provider Name and Medicaid Provider Number
2. Refund Check Number, Check Date and Check Amount
3. 13-digit Claim Number (from RA)
4. Recipient ID Number and Name
5. Dates of Service
6. Date of Medicaid Payment
7. Date of Service Being Refunded
8. Services Being Refunded
9. Amount of Refund
10. Amount of Insurance Received
11. Insurance Name, Address and Policy Number
12. Reason for Return (from codes listed on form)
13. Signature, Date and Telephone

This information will allow the refund to be processed accurately and efficiently.

Explanation of Check Refund

Mail To: Arkansas Medicaid
Refunds
PO Box 8104
Little Rock, AR 72203

Provider Name _____ Medicaid Provider Number _____

Refund Check Number _____ Refund Check Date _____ Refund Check Amount _____

Information needed on each claim being refunded		**Claim 2**	
13 digit Claim Number (from RA)			
Recipient's ID Number (from RA)			
Recipient's Name (Last, First)			
Date(s) of service on claim			
Date of Medicaid payment			
Date(s) of service being refunded			
Services being refunded			
Amount of refund			
Amount of insurance received, if applicable			
Insurance Co. name, address, and policy number, if applicable			
Reason for return (see codes listed below)			

1. BILL: An incorrect billing or keying error was made.
2. DUP: A payment was made by Arkansas Medicaid more than once for the same service(s).
3. INS: A payment was received by a third party source other than Medicare.
4. MC ADJ: An over application of deductible or coinsurance by Medicare has occurred.
5. PNO: A payment was made on a recipient who is not a client in your office.
6. OTHER: (Please explain)

_____

_____

Signature _____ Date _____ Telephone _____

340.000 ADDITIONAL PAYMENT SOURCES

341.000 Introduction

The Medicaid Program is required by federal regulations to utilize all third party sources and to seek reimbursement for services that have also been paid by Medicaid. "Third party" means an individual, institution, corporation or public or private agency that is liable to pay all or part of the medical cost of injury, disease or disability of a Medicaid recipient. Examples of third party resources are:

1. Medicare (Title XVIII)

2. Railroad Retirement Act

3. Insurance Policies
   a. private health
   b. group health
   c. liability
   d. automobile/medical insurance
   e. family health insurance carried by an absent parent

4. Worker's Compensation

5. Veteran's Administration

6. CHAMPUS

The Medicaid policies concerning the handling of cases involving Medicare/Medicaid coverage differ from the policies concerning other third party coverage.

Arkansas Rehabilitation Services (ARS) is not a third party source. If ARS and Medicaid pay for the same service, refund ARS.

342.000 Patients With Joint Medicare/Medicaid Coverage

342.100 Claim Filing Procedures

If medical services are provided in Arkansas to a patient who is entitled to Medicare under the Social Security Act and also to Medicaid benefits, it is necessary to file a claim only with Medicare. If the Medicare fiscal intermediary is Arkansas Blue Cross/Blue Shield or Mississippi Blue Cross/Blue Shield (Medicare intermediary for Louisiana, Missouri and Mississippi), the claim should be filed according to Medicare's instructions and sent to the Medicare intermediary. The claim will automatically cross to Medicaid. Mississippi Blue Cross/Blue Shield will cross over only Medicare Part A claims.

342.100 Claim Filing Procedures (Continued)

According to the terms of the Medicaid provider contract, a provider must "accept Medicare assignment under Title XVIII in order to receive payment under Title XIX for any appropriate deductible or coinsurance which may be due and payable under Title XIX."

When the Medicare intermediary or carrier completes the processing of the claim, they will forward it to EDS on computer tape. EDS will process it in the next weekend cycle for payment of coinsurance and deductible. The transaction will usually appear on the Medicaid RA within 3 weeks of payment by Medicare. If it does not appear within that time, you should request payment according to the instructions below.

When a provider learns of a patient's Medicaid eligibility only after filing a claim to Medicare, the instructions below should be followed after Medicare pays the claim.

Some Medicare carriers and intermediaries do not cross claims to Arkansas Medicaid. Claims for Medicare beneficiaries entitled under the Railroad Retirement Act never cross to Medicaid.

EDS provides software with which to electronically bill Medicaid for Professional Crossover claims that do not cross to Medicaid. Institutional providers and those without electronic billing capability must mail a red-lined copy of the appropriate crossover invoice to the address on the top of the form.

To order copies of the appropriate Medicare-Medicaid crossover invoice, please use the Medicaid Form Request, Form EDS-MFR-001. Instructions for filling out the invoice are included with the ordered forms. Indicate the quantity of each form needed and mail your request to:

EDS
Provider Assistance Center
P. O. Box 8036
Little Rock, AR 72203-8036

A sample copy of the Professional Services Medicare-Medicaid Crossover Invoice is provided below. When you complete the appropriate red lined Medicare-Medicaid crossover form, sign and date the form, and mail it to the address printed at the top of the Crossover Invoice.

Mail to: EDS
P.O. Box 8034
Little Rock, AR 72203

PROFESSIONAL SERVICES

MEDICARE/MEDICAID CROSSOVER INVOICE

Reserved for office use

Use a separate form for each Medicare claim.

Header 1

Medicaid Provider ID

Recipient ID | First Name | Last Name

Patient Account #

Medicare ICN

From DOS (MM DD YY) | To DOS (MM DD YY)

Procedure | Primary Modifier | Secondary Modifier | Units

Header 2

Other Insurance | Coinsurance Amount

Deductible | Medicare Non-Covered

Medicare Paid Amount | Medicare Paid Date (MM DD YY)

Total Billed Amount | Total Allowed

Net Billed

By signing below, I certify that the foregoing information is true, accurate and complete, and understand that falsifying essential information to receive payment from federal and state funds requested by this form may, upon conviction, be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payment claimed for providing such services as the state agency may request. I further agree to accept as payment in full the amount paid by the Medicaid program for claims submitted, with the exception of authorized amount.

Mail claims for payment to:
EDS
P.O. Box 8033
Little Rock, AR 72201

Provider Name and Address

Provider Signature

Date

342.200 Denial of Claim by Medicare

Any charges denied by Medicare will not be automatically forwarded to Medicaid for reimbursement. In cases where the patient does not have Medicare coverage, but is eligible for Medicaid, it will be necessary for the provider to file a claim with Medicaid.

342.300 Adjustments by Medicare

Any adjustment made by Medicare will not be automatically forwarded to Medicaid. If Medicare makes an adjustment that results in an overpayment or underpayment by Medicaid, providers may submit an adjustment using the PES software provided by EDS. Providers may also submit an Adjustment Request Form with a copy of the proper red lined crossover form reflecting Medicare's adjustment. Enter the Medicaid provider number and the patient's Medicaid identification number from the Medicare EOMB.

350.000 OTHER PAYMENT SOURCES

351.000 General Information

Many persons eligible for Arkansas Medicaid are covered by private insurance or may sustain injuries for which a third party could be liable. The following is an explanation of the patient's and the provider's role in the detection of third party sources and in the reimbursement of the third party payment to the Medicaid Program for services that have been paid by Medicaid.

EDS has a full time staff of trained professionals to assist with any questions or problems regarding third party liability, including, payment of claims involving third party liability and requests for insurance information. Providers should contact the EDS Provider Assistance Center (PAC) for any questions regarding third party liability. PAC may be contacted at (501) 376-2211 (local and out-of-state) or 1-800-457-4454 (in-state WATS).

352.000 Patient's Responsibility

It is the responsibility of the recipient to report the name and policy number of any other payment source to the provider of medical services at the time services are provided. The recipient must also authorize the insurance payment to be made directly to the provider.

353.000 Provider's Responsibility

It is the provider's responsibility to be alert to the possibility of third party sources and to make every effort to obtain third party insurance information. The provider should also inquire about liability coverage in accident cases and pursue this or notify Medicaid. It is the responsibility of the provider to file a claim with the third party source and to report the third party payment to the Medicaid Program. If a provider is aware that a Medicaid recipient has other insurance that is not reflected by AEVCS, the insurance information should be faxed to the DMS Third-Party Liability Unit at (501) 682-1644.

All Medicaid claims, including claims that involve third party liability, are filed on an assignment basis. In no case may the recipient be billed for charges above the Medicaid allowable on paid claims. A claim is considered paid, even though the actual Medicaid payment has been reduced to zero by the amount of third party liability. This applies whether the third party payment was reported on the original claim or whether it was refunded by way of an adjustment or by personal check. All paid services that are limited by the Medicaid Program count toward the patient's benefit limits even when the amount of Medicaid payment is reduced to zero by the amount of third party liability, except for Medicare crossover claims with no secondary payer other than Medicaid.

The AEVCS system provides fields to capture any Third Party Liability (TPL) information the provider may obtain. The provider is required to record TPL for each claim submitted.

When an AEVCS user enters a claim for services to a recipient who has other insurance coverage for the service and enters a TPL paid amount of $0.00, the software prompts the user to enter the date of the denial Explanation of Benefits (EOB) or the date of the EOB showing that the allowed amount was applied to the insurance deductible.

360.000 REFERENCE BOOKS

361.000 Diagnosis Code Reference

The Arkansas Medicaid Program uses the *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM) as a reference for coding primary and secondary diagnoses for all providers that are required to file claims with diagnosis codes completed.

You can order the ICD-9-CM, online at http://www.ingenixonline.com/, or contact Ingenix using the information provided below.

Ingenix
P.O. Box 27116
Salt Lake City, UT 84127-0116

Fax: 1-800-982-4033
Telephone: 1-877-464-3649

362.000 HCPCS Procedure Code Reference

The State of Arkansas uses the HCFA Common Procedure Coding System (HCPCS). HCPCS is composed of unique state assigned codes and CPT codes. If applicable, the state-assigned codes are listed in the Billing Procedures section of this manual. *The Physician's Current Procedural Terminology* (CPT) is the basic component of the HCFA Common Procedure Coding System (HCPCS).

You can order the CPT, online at http://www.ingenixonline.com/, or contact Ingenix using the information provided below.

Ingenix
P.O. Box 27116
Salt Lake City, UT 84127-0116

Fax: 1-800-982-4033
Telephone: 1-877-464-3649

CPT is a systematic listing of medical terms and identifying codes for reporting medical services provided by physicians. Each procedure or service is identified with a 5-digit code. The use of CPT codes simplifies the reporting of services.

Arkansas Medicaid Manual: CMS RESPITE CARE	Page: APPENDIX A
	Effective Date: 11-1-02
Subject: UPDATE CONTROL LOG	Revised Date:

Update No.	Release Date	Update No.	Release Date	Update No.	Release Date	Update No.	Release Date
1.		21.		41.		61.	
2.		22.		42.		62.	
3.		23.		43.		63.	
4.		24.		44.		64.	
5.		25.		45.		65.	
6.		26.		46.		66.	
7.		27.		47.		67.	
8.		28.		48.		68.	
9.		29.		49.		69.	
10.		30.		50.		70.	
11.		31.		51.		71.	
12.		32.		52.		72.	
13.		33.		53.		73.	
14.		34.		54.		74.	
15.		35.		55.		75.	
16.		36.		56.		76.	
17.		37.		57.		77.	
18.		38.		58.		78.	
19.		39.		59.		79.	
20.		40.		60.		80.	