Arkansas Department of Human Services
Division of Medical Services
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TO: **Health Care Provider – DDS Alternative Community Services (ACS) Waiver**

DATE: **February 1, 2003**

SUBJECT: **Update Transmittal No. 39**

REMOVE		INSERT	
Page	**Date**	**Page**	**Date**
Table of Contents	1-1-01	Table of Contents	2-1-03
II-1 through II-18	Dates Vary	II-1 through II-35	2-1-03
III-1 through III-67	7-1-00	III-1 through III-66	2-1-03

Explanation of Updates

PLEASE NOTE: A new numbering system is being initiated in Section II. Throughout this update, references to EDS Corporation are changed to EDS, information is incorporated from past Official Notices and RA Messages and many pages are renumbered. We are including all pages for Sections II and III, so please replace the entire sections.

Section II has been completely revised in order to comply with mandatory changes in the waiver as required by the Centers for Medicare and Medicaid Services (CMS).

Integrated support services are being "unbundled" as required by federal authority. Services are now identified as supportive living services, community experiences services, respite care, transportation (non-medical) and waiver coordination. Self-directed options have been added for these new services, other than for waiver coordination. Waiver coordination will be the financial intermediary for self-directed options shown above.

Physical adaptations are "unbundled" as required by federal authority. The two unbundled services are now identified as adaptive equipment and environmental modifications.

A new service, supplemental supports, has been added. This service can be used in lieu of ACS Specialized Medical Supplies or in combination with that service.

Case Management, Level IV was never utilized and is being deleted.

Case Management minimum visit/contact rules are being revised to reflect the level of care the person is receiving.

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Explanation of Updates (Continued)

Case Management is an option for Level III, Limited Categories. When this option is chosen a willing, responsible adult must perform this function.

Policy has been revised to identify by category the minimum information to be submitted for prior authorization consideration.

Crisis abatement services have been deleted, because the services were not utilized.

This update provides clarification usage of Supported Employment Services.

Approval for Interim Plan of Care Services to Case Management and Waiver Coordination only has been reduced.

Provides clarification that in the absence of prior authorization by the Division of Developmental Disabilities Services, any services delivered without prior authorization will not be reimbursed. A provision for emergencies has been included.

Prohibits a single provider delivering both case management and direct care services to the same waiver person.

Provides supported employment services clarifications.

Pages III-1 through III-10, sections 300.000 through 303.200, are revised to clarify electronic and personal computer (PC) billing options, to clarify the ClaimCheck® enhancement for electronic billing and to correct minor grammatical and formatting errors.

Page III-11 includes the latest version of the Medicaid Claim Inquiry Form.

Pages III-12 through III-14, section 304.100, are revised to update the list of forms available from EDS, provide an address for ordering HCFA-1500 claim forms and provide an updated copy of the Medicaid Form Request form.

Pages III-15 through III-24, sections 310.000 through 311.150, are revised to include Professional Electronic Solutions (PES) software field descriptions, add new headings to the pages and furnish provider-specific instructions.

Pages III-25 through III-31, sections 311.200 through 311.400, are included to give the HCFA-1500 instructions for DDS Alternative Community Services (ACS) Waiver providers and to correct minor grammatical and formatting errors.

Pages III-33 and III-34 are included to provide a blank copy of the HCFA-1500 form.

Pages III-35, section 311.500, is included to update the procedure codes payable for DDS Alternative Community Services Waiver (ACS) providers.

Page III-36 is reserved for future use.

Pages III-37 through III-49, sections 320.000 through 324.800, are included to correct information about the Remittance and Status Report, or Remittance Advice (RA), and update field descriptions for the RA.

Pages III-50 through III-55 are included to update the sample DDS Alternative Community Services (ACS) Waiver RA.

Explanation of Updates (Continued)

Pages III-56 and III-57, sections 330.000 and 331.000, are included to update the Adjustment Request form field descriptions and correct minor formatting and grammatical errors.

Page III-58 includes the latest version of the Adjustment Request Form.

Pages III-59 and III-60, section 332.000, are included to revise the instructions for completing the Explanation of Check Refund Form and provide an updated copy of the form.

Pages III-61 through III-64, sections 340.000 through 342.300, are included to give instructions for ordering Medicare-Medicaid crossover forms, to provide a sample copy of the Professional Services Medicare-Medicaid Crossover Invoice and to clarify how adjustments by Medicare are handled.

Page III-65, sections 350.000 through 353.000, is included to correct minor grammatical errors and to include the telephone numbers for contacting the EDS Provider Assistance Center.

Page III-66, sections 360.000 through 362.000, is included to update the contact information for ordering reference books from Ingenix.

The following **Official Notices** should be deleted. The content, where appropriate, has been incorporated into this update:

DMS-1996-GG-1	DMS-1998-GG-2	DMS-2000-W-3
DMS-1998-GG-1	DMS-1998-W-1	DMS-2000-W-5

The following **Remittance Advices** should be deleted. The content, where appropriate, has been incorporated into this update:

8/27/98	Service restrictions for categories 61, 62 and 69
3/11/99	Revisions to RA November 5 and 12, 1998, regarding documentation requirements
7/1/99	Arkansas Medicaid recipient identification cards
9/9/99	Another reminder
11/4/99	Arkansas Medicaid provider manual price increase
2/3/00	Provider Electronic Solutions software upgrade
3/16/00	AEVCS hardware upgrade
6/1/00	Billing instructions from Arkansas Behavioral Care (ABC)
8/10/00	PES software upgrade
10/26/00	Medicare Crossover Claims
12/7/00	HCFA-1500 claims adjustment
12/7/00	ICD-9 revisions for 2001
7/4/02	Erroneous future eligibility end dates on AEVCS
10/24/02	2003 ICD-9-CM coding
10/24/02	HIPPA: Focus on Privacy

A change bar in the left margin denotes a revision.

Attached are updated pages to file in your provider manual.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 and 1-877-708-8191. Both telephone numbers are voice and TDD.

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

Thank you for your participation in the Arkansas Medicaid Program.

Kurt Knickrehm, Director
Department of Human Services

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

200.000 DDS ALTERNATIVE COMMUNITY SERVICES (ACS) WAIVER GENERAL INFORMATION

201.000 Arkansas Medicaid Program Participation Requirements for DDS ACS Waiver Program

All DDS ACS Waiver providers must meet the following requirements in order to participate in the Arkansas Medicaid Program:

A. DDS Alternative Community Services (ACS) Waiver providers must be licensed and/or certified by the Arkansas Division of Developmental Disabilities Services (DDS) as an ACS Waiver provider. A copy of the current license and/or certification must accompany the provider application. Any subsequent licensure and/or certification renewals must be forwarded to the Provider Enrollment Unit at the time of renewal.

B. Providers must complete and submit a provider application (DMS-652) and Medicaid contract (DMS-653) with the Arkansas Medicaid Program. (See Section I of this manual.)

C. The provider application and the Medicaid contract must be approved by the Division of Medical Services.

201.100 Providers of DDS ACS Waiver Services in Arkansas and Bordering States Trade Area Cities

DDS ACS Waiver services are limited to Arkansas and bordering state trade area cities. Providers located in a bordering state trade area city must be certified by the Division of Developmental Disabilities Services as ACS Waiver providers before services may be provided for Arkansas Medicaid recipients. Bordering state trade area cities are Monroe and Shreveport Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff, Missouri; Poteau and Salisaw, Oklahoma; Memphis, Tennessee and Texarkana, Texas.

201.200 Organized Health Care Delivery System Provider

The DDS Alternative Community Services (ACS) Waiver allows a provider who is licensed and certified as a DDS ACS case manager or a DDS ACS supportive living services provider to make application to the Arkansas Medicaid Program as a DDS ACS Organized Health Care Delivery System (OHCDS) provider.

An organized health care delivery system (OHCDS) provider, as long as the OHCDS provides at least one waiver service, can provide any DDS ACS Waiver service via a sub-contract with an entity qualified to provide the waiver service for individuals who are eligible to receive DDS ACS Waiver services. The organized health care delivery system provider renders the services as the individual's provider of choice as described in the person's multi-agency plan of services (MAPS). The organized health care delivery system provider will adhere to policy regulating the DDS ACS Waiver as outlined in this provider manual. The OHCDS assumes all liability for services provided and/or performed by sub-contracted entity.

210.000 PROGRAM COVERAGE

211.000 Scope

The Arkansas Medical Assistance Program (Medicaid) offers certain home and community based services as an alternative to institutionalization. These services are available for eligible individuals, with a developmental disability, who would otherwise require an ICF/MR level of care. The home and community based services to be provided through this waiver are described herein as the DDS Alternative Community Services Waiver Renewal, hereafter referred to as DDS ACS Waiver.

42 CFR §441.301(b)(1)(ii) states home and community based waiver services are available **only** to individuals who are **not inpatients** (residents) of a hospital, nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR).

Services provided under this program are as follows:

A. Supportive Living

B. Community Experiences

C. Respite Care

D. Non-Medical Transportation

E. Waiver Coordination

F. Supported Employment Services

G. Adaptive Equipment

H. Environmental Modifications

I. Specialized Medical Supplies

J. Supplemental Support Services

K. Case Management Services

L. Consultation Services

M. Crisis Intervention Services

N. Crisis Center

212.000 Description of Services

DDS ACS services provide the support necessary for an individual to live in the community. Without these services, the individual would require institutionalization.

213.000 Supportive Living Services

Supportive living services are an array of individually tailored services and activities provided to enable eligible individuals to reside successfully in their own homes, with their families, or in an alternative living residence or setting. The services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in the home and community based setting.

213.100 Supportive Living Services Exclusions

Only hired caregivers may be reimbursed for supportive living services provided.

Payments for supportive living services will not be made to the parent, step parent or legal guardian of a person less than 18 years old.

Payments will not be made to a spouse or to the guardian or guardian's spouse when the spouse is named as co-guardian and has the authority to act in such manner for an individual over age 18.

The payments for these services exclude the costs of room and board, including general maintenance, upkeep or improvement to the individual's own home or that of his or her family.

Routine care and supervision for which payment will not be made are defined as those activities that are necessary to assure a person's well being but are not activities that directly relate to active treatment goals and objectives.

See section 311.500 for billing information.

213.200 Supportive Living Services Array

There are three broadly defined service models that are covered through supportive living services. They include residential habilitation supports, residential habilitation reinforcement supports and companion and activities therapy services.

A. Residential Habilitation Supports

Residential habilitation supports are aimed at assisting the person to acquire, retain or improve his or her skill in a wide variety of areas that directly affect his or her ability to reside as independently as possible in the community. These services provide the supervision and support necessary for a person to live in the community. The supports that may be provided to an eligible individual include the following habilitation areas of need:

1. Self direction, which includes the identification of and response to dangerous or threatening situations, making decisions and choices affecting the person's life and initiating changes in living arrangement or life activities.

2. Money management that consists of training, assistance or both in handling personal finances, making purchases and meeting personal financial obligations.

3. Daily living skills that include habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications (to the extent permitted under state law) and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid and emergency procedures.

4. Socialization that includes training, assistance or both in participation in general community activities and establishing relationships with peers. Training associated with participation in community activities includes assisting the person to continue to participate in such activities on an ongoing basis.

5. Community integration, which includes activities intended to instruct the person in daily living and community living skills in integrated settings. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. The habilitation objectives to be served by such training must be documented in the person's service plan.

6. Mobility, including training, assistance or both, aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel or movement within the community.

213.200 Supportive Living Services Array (continued)

7. Communication, which includes training in vocabulary building, use of augmentative communication devices and receptive and expressive language.

8. Behavior shaping and management that includes training, assistance or both in appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors.

B. Residential Habilitation Reinforcement Supports

Residential habilitation reinforcement supports may be provided to eligible individuals. The services include the following:

1. Reinforcement of therapeutic services which consist of conducting exercises or reinforcing physical, occupational, speech and other therapeutic programs.

2. Performance of tasks to assist or supervise the person in such activities as meal preparation, laundry, shopping and light housekeeping that are incidental to the care and supervision of the participant, but cannot be performed separately from other waiver services.

   a. Assistance is defined as hands-on care of both a supportive and health-related nature, supports that substitute for the absence, loss or diminution or impairment of a physical or cognitive function, homemaker/chore services, fellowship and protection that includes medication oversight permitted under state law.

   b. Services are furnished to individuals who receive these services in conjunction with residing in the home.

   c. The total number of individuals (including participants served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed 4.

   d. General household work on behalf of the participant is incidental and cannot exceed 20% of the total weekly hours worked.

   NOTE: This does not include nursing services available through Medicaid State Plan.

213.200 Supportive Living Services Array (continued)

C. Companion and Activities Therapy Services and Activities

Companion and activities therapy services and activities provide reinforcement of habilitative training being received by participants. This reinforcement is accomplished by using animals as modalities to motivate and to meet functional goals established for the individual's habilitative training.

Through the utilization of an animal's presence, enhancement and incentives are provided to persons to practice and accomplish such functional goals as:

1. Language skills,

2. Increased range of motion,

3. Socialization by developing the interpersonal relationships skills of interaction, cooperation, trust and the development of self-respect, self-esteem, responsibility, confidence and assertiveness. Purchase of animals, animal feed or items used to care for or routinely equip an animal are not covered services.

214.000 Community Experiences Services

Community experiences services are a flexible array of supports designed to allow individuals to gain experience and abilities that will prevent institutionalization. Through this broad base of learning opportunities, participants will identify, pursue and gain skills and abilities in activities that reflect their interests.

This model helps to improve community acceptance, employment opportunities and general well being. The services are preventive, therapeutic, diagnostic and habilitative and will create an environment that will promote a person's optimal functioning.

The model also teaches developmental and living skills in the natural environment or clinic setting to ensure maximum learning and generalization. The services focus on enabling the person to attain or maintain his or her potential functional level and must be coordinated with any physical, occupational or speech therapies listed in the plan of care. These services reinforce skills or lessons taught in school, therapy or other settings.

When supports are provided in a clinic setting and the individual receives four or more hours of support, a noon meal is included in the service.

214.000 Community Experiences Services (continued)

Services include activities and supports to accomplish individual goals or learning areas, including recreation, and/or for specific training or leisure activities. To participate in community experiences activities, an individualized plan of treatment is required. Each activity is then adapted according to the participant's needs. Activities include:

A. Community Based Time Management

B. Home Safety (sanitation, food handling, laundry, chemical storage)

C. Etiquette/Manners

D. Physical Exercise

E. Literacy

F. Job Interviewing Skills

G. Inter-Personal Skills

H. Sex Education

I. Self Care/Proper Attire

J. Budgeting

K. Diet/Nutrition

L. Verbal Communication Skills

M. Self Improvement

N. Mental Health Support Groups

O. Adapted Curriculum AA Groups

P. Understanding Medications (what medication is for, side effects, how to contact the physician or emergency services, how to communicate with physician, understanding various lab and x-ray procedures, fear abatement, etc.)

Q. Disability Support Groups

See section 311.500 for billing information.

215.000 Respite Care

Respite care is defined as services provided to or for waiver participants, regardless of their age, who are unable to care for themselves. It is furnished on a short-term basis because of the absence or need for relief of non-paid individuals, including parents of minors, primary caregivers and spouses of participants, who normally provide the care.

Respite care may be provided in the individual's home or place of residence, a foster home, Medicaid certified ICF/MR, group home, licensed respite care facility or licensed/accredited residential mental health facility for participants who have a dual diagnosis.

Room and board is not a covered service except when provided as part of respite care furnished in a facility that is not a private residence but is approved by the state as a respite care facility.

215.100 Respite Care Child Support Services

Respite care service includes child care support services which are services that promote access to and participation in child care through a combination of basic child care and support services required to meet the needs of a mentally retarded, developmentally disabled child aged birth to 18 years.

These services are not intended to supplant the responsibility of the parent or guardian. Parents or guardians will be responsible for the cost of basic child care which is defined as fees charged for services provided in a specific childcare setting the same as for a child who does not have a developmental disability, mental retardation or both.

The services will be provided only in the absence of the primary caregiver during those hours when the caregiver is at work, in job training or at school.

Child care support services may be provided in a variety of settings including a licensed daycare facility, licensed daycare home, the child's home or other lawful childcare setting.

Medicaid pays only for support staff required due to the individual's developmental disability, not for daycare fees.

Services are separate and distinct from educational services provided at a school where attendance is mandated and the primary focus of the institution is the accomplishment of specified educational goals.

The services are separate and distinct from respite care services that are provided on a short-term basis because of the need for relief of those unpaid individuals normally providing the care.

Parents of minors, primary caregivers or a spouse of a participant may not be covered as respite care providers.

See section 311.500 for billing information.

216.000 Non-Medical Transportation

Non-medical transportation services are provided to enable individuals served to gain access to DDS ACS and other community services, activities and resources. Activities and resources MUST be identified and specified in the plan of care. This service is offered in addition to medical transportation as required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and must not replace them.

DDS ACS transportation services must be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized. In no case will a parental or legal representative be reimbursed for the provision of transportation for a minor.

See section 311.500 for billing instructions.

217.000 Waiver Coordination

Waiver coordination services include the responsibility for ensuring the delivery of all direct care services. This responsibility includes:

A. The coordination of all direct service workers who provide care through the direct service provider.

B. Serving as liaison among the individual, parents or legal representatives, case management entity and DDS officials.

C. Coordinating schedules for both DDS ACS waiver and other Medicaid service categories.

D. Providing direct planning input and preparing all direct service provider segments of any initial plan of care and annual continued stay review.

E. Providing assistance relative to the obtaining of waiver Medicaid eligibility and ICF/MR level of care eligibility determination.

F. Assuring the integrity of all direct service Medicaid wavier billing in that the service delivered must have DDS prior authorization and meet required waiver service definition and must be delivered before billing can occur.

G. Arranging for all alternative living settings.

H. Assuring transportation as identified in individual's plan of care.

I. Assuring submission of timely (advance) and comprehensive behavior/ assessment reports, continued plans of care, revisions as needs change and information and documents required for ICF/MR level of care and waiver Medicaid eligibility determination.

217.000 Waiver Coordination (continued)

J. Reviewing the participant's records and environment(s) in which services are provided by accessing appropriate professional sources to determine whether the individual is receiving appropriate support in management of medication.

Minimum components of medication management include:

1. Staff is aware of the medications being used by the person,

2. Staff is knowledgeable of potential side effects of the medications being used by the person,

3. All medications consumed are prescribed or approved by the person's physician or other health care practitioner,

4. The person and/or the person's guardian(s) are informed about the nature and effect of medications being consumed, and consent to the consumption of those medications,

5. Staff is implementing the service provider's policies and procedures as to medication management, appropriate to the person's needs,

6. If psychotrophic medications are used, appropriate restrictive measures and positive behavior programming are present and in use,

7. The consumption of medications are monitored to ensure that they are accurately consumed as prescribed,

8. Any administration of medications or other nursing tasks or activities are performed only by staff to whom a nurse has delegated the duty and under the nurse's supervision,

9. Medications are regularly reviewed to monitor their effectiveness to address the reason for which they are prescribed and for possible side effects and

10. An appropriate response is made to medication errors.

K. Serves as fiscal intermediary when the person or guardian elects to act as the employer for the hire and retention of caregivers when accessing supportive living services.

Fiscal intermediary responsibilities include technical assistance and training in interview and hiring techniques. They also include supervision, taking corrective action, dismissal, record keeping, tax withholding and reporting and assistance for compliance with all state, federal and Department of Human Services and Division of Developmental Disabilities Services laws, regulations, policies and rules that apply to employment.

See section 311.500 for billing information.

218.000 ACS Supported Employment Services

Supported employment services are designed for individuals for whom competitive employment at or above the minimum wage is unlikely, or who, because of their disabilities, need intensive ongoing support to perform in a competitive work setting.

The services consist of paid employment conducted in a variety of settings, particularly work sites in which individuals without disabilities are employed. In accordance with the federal definition, DDS supports integrated work settings where the employment situation provides frequent, daily social interaction among people with and without disabilities.

The federal standard for integration requires that an individual work in a place where no more than eight people with disabilities work together and where co-workers without disabilities are present in the work setting or immediate vicinity.

When supported employment services are provided at a work site where individuals without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities. Coverage will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment includes:

A. Activities needed to sustain paid work by waiver individuals, including supervision and training

B. Re-training for job retention or job retention or job enhancement

C. Job site assessments

D. Job maintenance visits with the employer for purposes of obtaining, maintaining and/or retaining current or new employment opportunities.

The employer is responsible for making reasonable accommodations in accordance with the Americans with Disabilities Act.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites when the person receives habilitation services in more than one place, as a component part of the habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation service (non-medical transportation service).

218.000 ACS Supported Employment Services (continued)

Supported employment provided as a long-term support must be monitored, at a minimum, to consist of two meetings with the individual participating in supported employment and one employer contact a month. The job coach, after consultation with each person in supported employment can determine, on a case-by-case basis, how to best acquire current information relevant to assessing job stability and the individual's needs. If on-site monitoring is not necessary to assess stability, alternative methods of gathering information for the twice-monthly assessment may be permitted. This may take a variety of forms, including telephone calls with supervisors and off-site meetings with the individual participating in supported employment as well as visits to the work site.

218.100 ACS Supported Employment Services Exclusions

Supported employment requires related activities to be identified and included in outcomes with an accompanying work plan submitted as documentation of need for service.

Payment for employment services excludes:

A. Incentive payments made to an employer of waiver individuals to encourage or subsidize an employer's participation in the program;

B. Payments that are passed through to waiver individuals or

C. Payments for vocational training that is not directly related to the waiver individual's employment. In addition, reimbursement cannot be claimed if the individual is not able to perform the essential functions of the job. The functions of a job coach are to "coach" not to do the work for the person.

D. Eligible individuals may not receive ACS Waiver supported employment services when the same services are otherwise funded under the Rehabilitation Act of 1973 or Public Law 94-142. This means that such services must be exhausted before waiver supported employment services can be approved or reimbursement can be claimed.

218.200 Documentation Requirements for Supported Employment Services

Supported employment providers must maintain documentation in each waiver participant's personnel file to support that the individual is not receiving and has exhausted, either by reaching authorized limits, by denial or unavailability, services otherwise funded by P.L. 94-142.

Documentation must include proof from the funded provider where services were exhausted.

218.300 Benefit Limits for Supported Employment Services

Individuals are limited to a maximum of thirty-two (32) units (8 hours) of supported employment services per date of service.

See section 311.500 for billing information.

219.000 Adaptive Equipment (Environmental Accessibility Adaptations)

Adaptive equipment service provides for the purchase, leasing and, as necessary, repair of adaptive, therapeutic and augmentative equipment required to enable individuals to increase, maintain or to improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Adaptive equipment needs for supportive employment for a person are also included. This service may include specialized medical equipment such as devices, controls or appliances that will enable the person to perceive control or communicate with the environment in which they live.

Equipment may only be covered if not available to the individual from any other source. Professional consultation must be accessed to ensure that the equipment will meet the needs of the individual. All items must meet applicable standards of manufacture, design and installation.

Computer equipment may be approved when it allows the participant control of his or her environment, assists in gaining independence or when it can be demonstrated that it is necessary to protect the health and safety of the person. Computers will not be purchased to improve socialization or educational skills.

Printers may be approved for non-verbal persons.

Computer desks or other furniture items will not be covered.

Communication boards are allowable devices. Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the person more appropriately than a communication board.

Software will be approved only when required to operate the accessories included for environmental control or to provide text-to-speech capability.

Personal emergency response systems (PERS) may be approved when they can be demonstrated to be necessary to protect the health and safety of the participant. PERS is an electronic device that enables individuals to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the individual’s telephone and programmed to signal a response center once a “help” button is activated. The response center must be staffed by trained professionals.

PERS services are limited to individuals who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.

219.100 Benefit Limits for Adaptive Equipment

The annual expenditure for adaptive equipment is $7500.00 per person. If the person is also receiving environmental modification services, the COMBINED annual expenditure cannot exceed $7500.00.

220.000 Environmental Modifications (Environmental Accessibility Adaptations)

Environmental modifications are adaptations to the waiver participant's place of residence (structure) that are necessary to ensure the health, welfare and safety of the individual or which enable the individual to function with greater independence and without which the individual would require institutionalization.

Adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities or installation of specialized electric and plumbing systems to accommodate medical equipment and supplies.

All services must be provided as directed by the individual's multi-agency plan of service (MAPS) and in accordance with all applicable state or local building codes.

Environmental modifications must be made within the existing square footage of the residence and cannot add to the square footage of the building.

Modifications are considered and approved as single, all-encompassing projects and, as such, cannot be split whereby a part of the project is submitted in one plan of care year and another part submitted in the next plan of care year. Any such activity is prohibited.

220.100 Environmental Modifications Exclusions

Modifications or improvements to the individual's place of residence that are not of direct medical or remedial benefit to the individual (e.g.: carpeting, roof repair, central air conditioning, etc.) are excluded as covered services. Also excluded are modifications or improvements that are of aesthetic value such as designer wallpaper, marble counter tops, ceramic tile, etc.

220.200 Benefit Limits for Environmental Modifications

A person's annual expenditure cannot exceed $7500.00. If the person is also receiving adaptive equipment services, the COMBINED total cannot exceed $7500.00.

221.000 ACS Specialized Medical Supplies

Specialized medical supplies include items necessary for life support, and the ancillary supplies and equipment necessary for the proper functioning of such items. Non-durable medical equipment not available under the Medicaid State Plan may also be provided as an ACS specialized medical supply. All items provided must be specified in the individual's multi-agency plan of service (MAPS) and must be in addition to any medical equipment and supplies covered as a Medicaid State Plan service. Items that are not of direct medical or remedial benefit to the individual are excluded from this service.

Additional supply items are covered as a waiver service when they are considered essential for home and community-care. Covered items include:

A. Disposable incontinence undergarments such as adult diapers and reusable briefs with disposable liners

B. Ostomy and colostomy supplies

C. Nutritional supplements

D. Non-Prescription medications

E. Drug/alcohol screening

Incontinence undergarments, ostomy and colostomy supplies, nutritional supplement and non-prescription medications must be ordered by a physician for recipients. A physician, psychologist or court of law must order drug/alcohol screening. The item(s) must be included in the plan of care. When the items are included in Medicaid State Plan services, this service will be an extension of such services.

221.100 Benefit Limits for ACS Specialized Medical Supplies

The maximum annual allowance for ACS specialized medical supplies service is $3600.00. This service is a companion service to supplemental support services that has a maximum annual allowance of $1200.00. When both services are accessed in the same plan of care review year, the combined maximum allowance is $3600.00.

See section 311.500 for billing information.

222.000 Supplemental Support Services

Supplemental support services help improve or enable the continuance of community living, to allow the opportunity to participate in integrated leisure, recreational, social and educational activities and make a positive difference in the life of the waiver participant. Supplemental support services include:

A. Emergency medical costs, including prescription drug co-pay;

B. Transitional expenses for initial integration into the community when transitioning from an ICF/MR or nursing facility to the waiver, or prevention of a need for or return to a more restrictive environment;

C. Ancillary supports to assure continued health and safety in crisis situations caused by acts of nature or events beyond the person's control;

D. Fees for activities that compliment and reinforce community living or specific habilitation needs. The activities must be therapeutic in nature and support needs as identified through multi-agency planning. Fees may only be paid for the waiver participant. Family membership fees are not included in the service. Renewal of this component must require documentation of prior use.

Up to two meals each day is an allowable service. As an example, food obtained in restaurants, catering services and fast food outlets, may be consumed on or off the site where a purchase is made is allowable.

Supplemental support services will be based upon demonstrated needs as identified in a person's treatment plan to be included in the plan of care as emergencies arise.

222.100 Supplemental Support Services Exclusions

Supplemental support services are not allowed to be used for rent, lease or house payments or for the purchase of food (groceries, such as purchased at a grocery store, market, farm, etc.) or any other room and board type of services.

222.200 Supplemental Support Services Benefit Limits

This service can be accessed only as a last resort. Lack of other available resources must be proven. The maximum annual allowance is $1200.00 and this reimbursement must reduce the maximum allowable for the service, specialized medical needs, by the same amount of dollars that are used for this service. The total dollars used for the two services combined CANNOT exceed $3600.00 annually.

223.000 ACS Case Management Services

ACS case management services refer to a system of ongoing monitoring of the provision of services included in the waiver participant's multi-agency plan of service (MAPS). ACS case managers initiate and oversee the process of assessment of the individual's level of care and the review of MAPS at specified reassessment intervals.

Case management services include responsibility for locating, coordinating and monitoring:

A. All proposed waiver services;

B. Other Medicaid State Plan services;

C. Needed medical, social, educational and other publicly funded services regardless of the funding source and

D. Informal community supports needed by individuals and their families.

The intent of ACS case management services is to enable waiver participants to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner.

ACS case management services consist of the following activities:

A. Arranging for the provision of services and additional supports;

B. Monitoring and reviewing participant services;

C. Facilitating crisis intervention;

D. Guidance and support;

E. Case planning;

F. Needs assessment and referral for resources;

G. Follow-along to ensure quality of care and

H. Case reviews that focus on the individual's progress in meeting goals and objectives established through the case plan;

I. Assuring the integrity of all case management Medicaid waiver billing in that the service delivered must have prior authorization and meet required waiver service definitions and must be delivered before billing can occur and

J. Assuring submission of timely (advance) and comprehensive behavior and/or assessment reports, continued plans of care, revisions as needs change and information and documents required for ICF/MR level of care and waiver Medicaid eligibility determination.

223.000 ACS Case Management Services (continued)

Case management services are optional for some level categories and are available at three levels of service. They are:

A. Pervasive – Minimum of one personal visit **AND** one other contact monthly.

B. Extensive – Minimum of one personal visit **OR** one other contact monthly.

C. Limited – Minimum of one personal visit each quarter.

The level is determined by the needs or options of the person receiving waiver services as defined in sections 230.000 through 230.300.

See section 311.500 for billing information.

224.000 ACS Consultation Services

Consultation services assist waiver participants, parents/guardians/responsible individuals, community living services providers and alternative living setting providers in carrying out the participant's service plan.

Consultation activities may be provided by professionals who are licensed as psychologists, psychological examiners, mastered social workers, professional counselors, speech pathologists, occupational therapists, physical therapists, registered nurses, certified parent educators and certified communication and environmental control adaptive equipment/aids providers. These services are indirect in nature.

Activities include:

A. Provision of updated psychological/adaptive behavior testing;

B. Screening, assessing and developing therapeutic treatment plans;

C. Assisting in the design and integration of individual objectives as part of the overall individualized service planning process;

D. Training of direct services staff or family members in carrying out special community living services strategies identified in the person's service plan;

E. Providing information and assistance to the individuals responsible for developing the participant's overall service plan;

F. Participating on the interdisciplinary/multi-agency plan of service (MAPS) team, when appropriate;

G. Consulting with, and providing information and technical assistance with other service providers or with direct service staff and/or family members in carrying out a participant's service plan;

224.000 ACS Consultation Services (continued)

H. Assisting direct services staff or family members to make necessary program adjustments in accordance with the person's service plan;

I. Determining the appropriateness and selection of adaptive equipment to include communication devices and computers;

J. Training and/or assisting persons, direct services staff or family members in the set up and use of communication devices, computers and software;

K. Assisting in dealing with person's behavioral challenges and in the development of a behavioral management plan for the person;

L. Training of direct services staff and/or family members by a professional consultant in:

1. Activities to maintain specific behavioral management programs applicable to the person,

2. Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the person,

3. The provision of newly identified medical procedures necessary to sustain the person in the community.

224.100 ACS Consultation Services Benefit Limits

Eligible individuals may receive twenty-five (25) hours of ACS consultation services per waiver eligible year.

See section 311.500 for billing information.

225.000 Crisis Intervention Services

Crisis intervention services are defined as services delivered in the participant's place of residence or other local community site by a mobile intervention team or professional.

Intervention services must be available 24 hours a day, 365 days a year and must be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to Developmental Disabilities Services waiver settings for current or targeted waiver service participants.

225.000 Crisis Intervention Services (continued)

Admission guidelines must be as approved by the Division of Developmental Disabilities Services and apply when:

A. The individual is receiving waiver services in a community placement.

B. The individual needs non-physical intervention to maintain or re-establish behavior management plan and prevent admission into a crisis center or ICF/MR.

C. Intervention is on-site in the community.

An individual may require one hour or a maximum of twenty-four hours of service during any one day.

See section 311.500 for billing information.

226.000 Crisis Center Services

Crisis center services are services provided in a crisis center equipped to provide short-term intervention.

Services include 24-hour emergency care services for individuals eligible for waiver services with priority given to individuals with a dual diagnosis or based upon clinical judgment that a high probability exists that further evaluation and assessment will identify a dual diagnosis.

Individuals who are court ordered for alternate placement or who are involved with the court system in the State of Arkansas, according to Act 609 of 1995, may be considered eligible.

Individuals served by the waiver who have significant behavioral disorders and are in need of temporary intensive management or transition may also receive services.

This service will accommodate individuals who, by the nature of the emergency or court order time frames, have not been incorporated into the typical level of care categorical eligibility process or who are in need of transition.

Admission is limited to individuals in a crisis situation where their current placement is no longer viable and an immediate alternate placement cannot be identified. Individuals, depending on the crisis situation or intensity, may receive services in one of three levels.

Placement in the crisis center may only be approved in no greater than 3-month increments. This does not imply that a person must remain for a minimum of 3 months. This period of time must be used for stabilization, identification of alternate placements with emphasis on family reunification (when appropriate) and identification of support mechanisms to facilitate transition. A person may be transitioned to the least restrictive environment available at the earliest possible time that will assure the highest probability of success.

226.100 Admission Guidelines

A. General Admission Guidelines for All Levels of Crisis Center Services as approved by the Division of Developmental Disabilities Services are:

1. All admissions will be made by an admissions committee capable of a 24-hour turn around. Admissions will be based upon age, sex and behavior compatibility with health and safety considerations.

2. The individual must not be actively suicidal or homicidal or actively psychotic.

3. The individual must have a developmental disability as his or her primary presenting problem.

4. An individual's behaviors limit his or her ability to function in his or her current placement and may be detrimental to the person's health and safety or the health and safety of others.

5. Physical examination by a qualified medical professional is required as soon as possible upon admission, but no later than 24 hours after admission.

6. Levels I and II cannot be mixed.

B. Crisis Center Level I Admission Guidelines:

1. The individual may be overtly assaultive/combative with ongoing risk of repeat assault to self and/or others or property.

2. The person's behaviors may indicate need for intensive physical behavior management interventions to reduce the risk of harm to self, others or property.

3. The individual's needs must be able to be met using local community services (e.g., those needing psychiatric or conventional hospitalization, shock treatment, etc.) are not appropriate for admissions.

4. The individual initially requires a self-contained program with little or no initial community integration.

5. The person must be able to function with staff/client ratio of 1:2 (an exception may be granted for persons requiring 1:1 staff ratios with prior approval).

226.100 Admission Guidelines (continued)

C. Crisis Center Level II Admission Guidelines:

1. The individual may have been assaultive/combative in past, but is not currently at a high-risk level.

2. The individual may require behavior intervention at a physical level.

3. The person is homeless due to unforeseen, uncontrollable and contemporaneous circumstances.

4. The individual needs, with appropriate supervision, to be able to function in the community for part of the day.

5. He or she needs to be able to function with staff/client ratio of 1:3 (a waiver may be granted for persons requiring 1:2 staff ratios with prior approval).

D. Crisis Center Level III Admission Guidelines:

1. The individual displays behavior placing self, other persons or property in imminent danger or exhibits some signs of behavioral difficulties, but his or her behaviors can be controlled with non-physical interventions.

2. The person must be able to function in community settings with very minimal supervision.

3. The individual is usually transitioning from Level II placement, but may be admitted at this level.

226.200 Crisis Center Services Plan of Care

All persons must have a pre-approved interim plan of care that permits options based upon the level of need. Each plan is specific to pre-identified treatment needs with the amount or intensity of each service option adjustable within a maximum daily reimbursement rate. Appropriate psychiatric supports will be available. Medical needs will be met through private, Medicaid State Plan or other funding sources.

A. Crisis Center Level I - Interim Plan of Care Menu:

1. Assessments
   a. Behavioral
   b. Needs
   c. Psychological

2. Consultation

3. Therapeutic Programming
   a. Psychotherapy
   b. Behavioral Management
   c. Day Habilitation
   d. Medication Management

4. Transportation

5. Waiver Coordination

6. Case Management

B. Crisis Center Level II - Interim Plan of Care Menu:

1. Assessment
   a. Behavioral
   b. Needs
   c. Psychological

2. Consultation

3. Therapeutic Programming
   a. Psychotherapy
   b. Behavioral Management
   c. Medication Management
   d. Day Habilitation
   e. Supportive Living
   f. Community Integration

4. Transportation

5. Waiver Coordination

6. Case Management

226.200 Crisis Center Services Plan of Care (continued)

C. Crisis Center Level III - Interim Plan of Care Menu:

1. Assessment
   a. Behavioral
   b. Needs
   c. Psychological

2. Therapeutic Programming
   a. Psychotherapy
   b. Behavioral Management
   c. Medication Management
   d. Day Habilitation
   e. Supportive Living
   f. Alternate Living
   g. Community Integration

3. Transportation

4. Waiver Coordination

5. Case Management

See section 311.500 for billing information.

227.000 Eligibility Assessment

The intake and assessment process for the DDS ACS Waiver Program includes a determination of categorical eligibility, a level of care determination, a comprehensive diagnosis and evaluation, the development of a plan of care, a cost comparison to determine cost-effectiveness and notification of a choice between home and community-based services and institutional services.

228.000 Categorical Eligibility Determination

Current eligibility for the Arkansas State Medicaid Program must be verified as part of the in-take and assessment process for admission into the ACS Waiver Program. Medicaid eligibility is determined by the Division of Developmental Disabilities Services or by the Social Security Administration for SSI Medicaid eligibles. Failure to obtain any required eligibility determination, whether initial or subsequent (time bound) re-assessments, will result in the individual's case being closed. Once closure has occurred, the affected person will have to make a new request for services through the waiver program intake process.

229.000 Level of Care Determination

The ICF/MR level of care determination is performed by the Division of Developmental Disabilities. The ICF/MR level of care criteria provides an objective and consistent method for evaluating the need for institutional placement in the absence of community alternatives. The level of care determination must be completed and the individual deemed eligible for ICF/MR level of care prior to receiving ACS waiver services.

Recertification will be performed by the Division of Developmental Disabilities to determine the individual's continuing need for an ICF/MR level of care.

230.000 Levels of Care

Coverage is provided within three levels of care. Levels of care are defined as pervasive, extensive and limited levels of care.

230.100 Pervasive Level of Care

The pervasive level of care is defined as needs that require constant supports provided across environments that are potentially life sustaining in nature. Supports are intrusive, long term and include a combination of any available waiver supports provided 24 hours a day, 7 days a week for 365 days a year with case management at the highest level (minimum of one personal visit and one other contact monthly). Sub-Levels are:

A. People who are adjudicated under Act 609; are receiving Department of Human Services (DHS) Integrated Supports; are civil commitments; are children in custody of the Division of Children and Family Services (DCFS) and who are receiving services through the Children's Adolescents Special Services Programs.

B. Human Development Center (HDC) residents transitioning to community living.

C. Nursing facility residents transitioning to community living.

D. Individuals who have compulsive behavior disorder that is life threatening and appropriate care in a group setting would be a violation of the rights of others.

E. People who otherwise meet the pervasive definition.

230.200 Extensive Level of Care

The extensive level of care is defined as needs that require daily supports in one or more of a work, home or community environment. Supports are less intrusive than supports that may be needed daily but less than 24 hours per day or 7 days a week. Supports are long-term and may require intermittent, short-term crisis intervention as characterized by episodic behavior needs. Supports include habilitation, residential habilitation reinforcement and other assisted living waiver services based upon individual needs. Case management is available at a reduced level of minimally one visit or contact per month.

230.300 Limited Level of Care

The limited level of care is defined as supports that are anticipated to be consistent for the foreseeable future. They are individually time-limited and may be intermittent in nature and are subject to re-evaluation every 12 months. This level of support requires parental support, group settings and community assistance available to the individual.

Intermittent and time limited supports are supports for primary caregiver relief, employment training, transitional supports, crisis behavior management and assisted living supports.

Case management for this Level I is a minimum of one visit per quarter. When case management is not chosen as a service component there must be a willing, responsible adult to assume all case management functions. Sub-levels are:

A. Supported living arrangements – are provided only for adults who are recipients of DDS funded supported living arrangements. General revenue must be available and in use for the existing service level with supporting general revenue to be used for the payment of Medicaid match in order for waiver conversion to occur. There are two categories of supported living arrangements:

1. Moderate supported living services level – 15 days service per month inclusive of case management and

2. Minimal supported living services level – 10 days service per month inclusive of case management.

B. Supplemental supports – are available to all ages in need of only supplemental supports and who elect this option of receiving up to $1500.00 general revenue per year in lieu of waiver services. In this event, the person or guardian is solely responsible for service procurement and record keeping to be submitted to DDS monthly.

In the event any non-allowable service is purchased, DDS must require full restitution and the service will be discontinued. Under this option, a waiver placement is held in abeyance for up to 2 years from the date of the decision to use this option. At any time during this 2-year period, the person or guardian may exercise their option for waiver and purchase equivalent waiver services with any remaining unexpended allotment. Re-determination of waiver eligibility will be required.

231.000 Service Models

There are three distinct service models available, traditional, self-directed and supportive living arrangement.

231.100 Traditional Service Model

In the traditional service model, services are delivered through a DDS and Medicaid licensed service provider network with all services coordinated and obtained through a case management provider.

Individuals or guardians determine provider choice from this network and may change providers upon written notice to DDS. In the traditional service model, the direct care service provider is responsible to advertise for, interview, hire, supervise, train and otherwise manage an employment workforce who provides supported living care.

Services are provided on a fee for service or cost reimbursement methodology. In this model, providers may provide both case management and direct care services but **CANNOT** provide both case management and direct care services to a person.

231.200 Self-Directed Model

Through the self-directed model individuals needing supported living services have the option of hiring and otherwise managing their direct caregivers. When this option is chosen, the person, their parent or legal guardian is responsible for advertisement, interviewing, supervising and otherwise directing the caregiver(s). They are responsible for compliance with all state and federal laws, rules and regulations pertaining to employment and compensation inclusive of drug screens and criminal background checks, withholdings and reporting to the government.

The individual's chosen direct service provider will be responsible to assist in all aspects as fiscal intermediary. Responsibilities include serving as payee for the authorization and dispensation of payment to the caregivers, providing required caregiver training, maintaining payroll records with completion and submission of all required government (federal, state or local) reports and remuneration.

The self-directed model option applies to non-medical transportation and respite care. Waiver coordination is included as a function of the direct service provider.

A self-directed option is also available for supplemental supports but this option will not have the assistance of a fiscal intermediary. A competent adult must assume all responsibilities related to this service. The arrangement will provide for an option of receiving up to $1500.00 state general revenue per year in lieu of waiver services.

231.300 Supportive Living Arrangement Model

In the supported living arrangement model, care is provided in DDS supported living arrangements, in supported living apartments, follow along in home and in group homes up to (but not inclusive of) 15 beds.

Supported living, community experiences, respite, waiver coordination and non-medical transportation are available for one monthly rate of reimbursement with at least one service component being provided on at least 15 days each month for the moderate level or at least 10 days each month for the minimum level.

Under this model, the provider must deliver the level of care needed regardless of minimum service provision requirements. Case management, crisis center and crisis intervention is available and payable in addition to the monthly rates.

232.000 Living Arrangements

Living arrangements include:

A. Existing group homes may serve groups of no more than 14 unrelated adults (age 18 and above) with developmental disabilities in the residential setting.

B. Existing DDS licensed supportive living apartments serving up to 4 unrelated adults (age 18 and above) with developmental disabilities in each self contained apartment unit up to the total number of licensed units in the complex.

C. Adults served in their family home, in their own home or in an integrated apartment complex or in a alternative living setting with no more than 4 unrelated adults with developmental disabilities in the home.

D. Children served in their family home or in the home of an alternative family with no more than 4 unrelated children with developmental disabilities in the home.

Exception: Only those supportive living apartments and group homes licensed by the DDS prior to July 1, 1995, are approved to serve more than 4 adults. No expansions will be approved beyond the July 1, 1995, total capacity (waiver and non-waiver).

233.000 Comprehensive Diagnosis and Evaluation

A comprehensive diagnosis and evaluation (D&E) must be administered in order to determine that applicants are persons with a developmental disability prior to receiving ACS Waiver services from the Division of Developmental Disabilities Services.

The comprehensive diagnosis and evaluation includes a series of examinations and observations performed or validated and approved by professionals leading to conclusions and findings.

The examinations/assessments include, but are not limited to:

A. A thorough medical examination and other evaluations deemed necessary by the physician;

B. A psychological assessment;

C. A social history/sociological examination;

D. An educational assessment;

E. An appraisal of adaptive behavior and

F. All other examinations, assessments and evaluations necessary to describe the individual's needs.

Failure to obtain any required eligibility determination, whether initial or subsequent time bound reassessments, will result in the individual's case being closed.

When an individual's case has been closed, the affected person must make a new request for services through the waiver program intake process in order for services to continue.

234.000 Multi-Agency Plan of Services (MAPS)

During the initial three months of DDS ACS Waiver Services, an individual receives services based on a DDS pre-approved interim plan of care that provides for case management and waiver coordinator services.

Prior to expiration of the interim plan of care, each individual eligible for ACS waiver services must have an individualized, specific, written multi-agency plan of services developed by a multi-agency team and approved by the DDS authority.

The MAPS must be designed to assure that services provided will be:

A. Specific to the individual's unique circumstances and potential for personal growth;

B. Provided in the least restrictive environment possible;

C. Developed within a process assuring participation of those concerned with the individual's welfare;

D. Monitored and adjusted to reflect changes in the individual's need;

E. Provided within a system which safeguards the individual's rights;

F. Documented carefully, with assurance that appropriate records will be maintained, and will

G. Assure the individual's and others' health and safety.

234.100 MAPS for All Category Types

A. General Information: Identification information must include full name and address, date of birth, Medicaid number, Medicare number (if applicable), guardian with address when applicable and the effective date of ACS waiver eligibility; certification of information regarding appropriateness and cost effectiveness of ACS waiver services, and the names, titles and signatures of the multi-agency team members responsible for the development of the recipient's multi-agency plan of service (MAPS).

B. Budget Sheet: Identification of waiver services, responsible person, services provider, rate, unit type, total units, subtotals and total overall;

C. Narrative Justification Initial Plan of Care and Continued Care Reviews: Justification must, at a minimum, identify progress, regression, exceptional events such as major illness, injury, loss of primary caregiver(s), loss of home, graduation, awards, etc., that impacted service delivery and have a direct cause and effect for future needs. It must specify justification for requested services and identify consumer satisfaction level.

234.200 MAPS for Individual, Group and Self Directed Option Categories

A. The MAPS for individual, group, and self directed option categories must include proposed outcomes, immediate and long term needs.

In addition to information in section 234.100, identification of individual outcomes expected, time of review, the provision of medical and other services, including waiver and non-waiver services necessary to obtain expected outcomes, along with their frequency, duration, beginning and ending dates of service and the name of the service provider chosen by the individual and responsible to provide each service; a daily schedule identifying both waiver and non-waiver services and the time of day each service begins and ends.

B. Direct Services Worksheet

Worksheet that identifies direct-care salaries, fringe, waiver coordinator, non-medical transportation and administrative costs.

C. Product and Service Cost Effectiveness Certification

Certification statement with supporting documentation that products, goods and services to be purchased meet applicable codes and standards and are cost competitive for comparable quality.

234.300 MAPS for Moderate and Minimum Supported Living and Supplemental Support Services Categories

MAPS for moderate and minimum supported living and supplemental support services must include proposed outcomes, immediate and long term needs.

In addition to information in section 234.200, identification for individual, group and self-determination option categories with no requirement for a daily schedule or direct services worksheet.

235.000 Documentation

ACS waiver providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

A. A copy of the individual's multi-agency plan of service (MAPS);

B. The specific services rendered;

C. The date and actual time the services were rendered;

D. The name and title of the individual who provided the service;

E. The relationship of the service to the treatment regimen of the individual's MAPS;

F. Updates describing the individual's progress or lack thereof. Updates should be maintained on a daily basis or at each contact with or on behalf of the individual. Progress notes must be signed and dated by the provider of the service;

G. Completed forms as required by DDS;

H. Certification statements, narratives and proofs that support the cost effectiveness and medical necessity of the service to be provided.

Additional documentation and information may be required dependent upon the service to be provided.

236.000 Retention of Records

ACS waiver providers must maintain all records regarding the individual and the provider's participation in the Arkansas Medicaid DDS ACS Waiver Program for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. All documentation must be made available to authorized representatives of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit, representatives of the Department of Health and Human Services and its authorized agents or officials.

At the time of an audit conducted by the Division of Medical Services Medicaid Field Audit Unit all documentation must be made available at the provider's place of service. When an audit determines that recoupment is necessary, additional documentation will be accepted for only thirty days after the date of the notification of recoupment. Additional documentation will not be accepted at a later date.

Failure to furnish records upon request may result in sanctions being imposed.

240.000 PRIOR AUTHORIZATION

ACS Waiver Program services require prior authorization by the Division of Developmental Disabilities Services. **In the absence of prior authorization, reimbursement will be denied and will not be approved retroactively.**

241.000 Approval Authority

For the purpose of plan of care and service approvals, DDS, a Division under the umbrella of the Department of Human Services, is the Medicaid authority.

The DDS prior authorization process requires that all annual plans of care projected to cost over $50,000.00 must have approval by DDS Plan of Care Review authority. This cost threshold is subject to reduction by DDS. Plans of care projected to cost under $50,000.00 will be subject to a more local level approval process. All waiver services must be needed to prevent institutionalization.

All persons receiving medications must also receive appropriate support in the management of medication(s). The use of psychotropic medications will require the development, implementation and monitoring of a written medication management plan.

Service requests that will supplant Department of Education responsibilities WILL NOT be approved.

All plan of care reviews are subject to review by a qualified physician and random audit scrutiny. In addition, the following activities will occur:

A. Review of provider standards actions that provide for the assurance of a person's health and welfare,

B. Monitoring of compliance with standards for any state licensure or certification requirement for persons furnishing services provided under this waiver and assurance that the requirements are met on the date that services are furnished,

C. Quality assurance reviews to include announced and unannounced on-site visits quarterly and

D. Random review equal to a percent as proscribed by DDS Licensure/Certification policy.

All service requests are subject to review by DDS and may necessitate the gathering and submission of additional justification, information and clarification before prior approval is made. In this event, it is the primary responsibility of the case management provider, with cooperation from the procurement source, to satisfy the request(s) within the prescribed time frames.

IT IS THE RESPONSIBILITY OF THE CASE MANAGEMENT SERVICES PROVIDER WITH COOPERATION FROM THE DIRECT SERVICES PROVIDERS TO INSURE THAT ALL REQUESTS FOR SERVICES ARE SUBMITTED IN A TIMELY MANNER TO ALLOW FOR DDS PRIOR AUTHORIZATION ACTIVITIES.

241.000 Approval Authority (continued)

Initially, an individual receives up to three months of DDS ACS Waiver services based on a DDS pre-approved interim plan of care. The pre-approved interim plan of care will include case management and waiver coordination.

At any time during the initial three months, the providers will complete the multi-agency planning process and submit a detailed plan of care that identifies all needed, medically necessary services for the remainder of the annual plan of care year. Once approval is obtained, the additional services may be implemented.

ACS Waiver Services will not be reimbursed for any date of service that occurs prior to the date the individual's plan of care is approved or the date the individual is determined ICF/MR level of care and is deemed Medicaid/waiver eligible, whichever date is last.

All changes of service or service level revisions that occur within an approved annual plan of care must also have prior approval and there will be no reimbursement for any services not prior-approved.

Emergency approvals may be obtained via telephone, facsimile or e-mail with retroactive reimbursement permitted as long as the notice of emergency, with request for service change, is received by DDS within 24 hours from the time the emergency situation was known. All electronically transmitted requests for emergency services must be followed with written notification and requests must be supported with documented proof of emergency.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement

The reimbursement rates for DDS ACS Waiver services will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each procedure.

Supportive living services replaces the former bundled "integrated support services". Although this service is now "unbundled" for purposes of tracking usage as required by the Center for Medicare and Medicaid Services (CMS), the bundle remains intact and is inclusive of community experience services for purposes of the maximum daily rate allowed. The maximum daily rate is inclusive of administration costs that cannot in any event exceed 20% of the total "unbundled" services for an individual. The administration costs are subject to audit and must be documented to support the rate charged. The unbundled services are identified in "Scope" as grouped services, A through E. Administration costs are factored into the monthly rate for the Supported Living Arrangement models.

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 electronic options, timely filing of claims, claim inquiries and supply procedures.

B. Billing Procedures: This section contains information on completing claims via AEVCS or paper. 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.

301.100 Automated Eligibility Verification and Claims Submission (AEVCS) System

The Automated Eligibility Verification and Claims Submission (AEVCS) System is the method of submitting Medicaid claims electronically. Medicaid requires AEVCS submission of the following claim types: UB-92, HCFA-1500, Visual Care, Dental, EPSDT, Pharmacy and Hospice/INH.

Providers have several choices of AEVCS submission methods: personal computer (PC)-based software, point of sale (POS) devices, or adapting their current office management system to submit claims in the proper format to AEVCS.

301.200 Personal Computer (PC) Software

Provider Electronic Solution (PES) Application software is available for any provider who submits Medicaid claims. The software requires, at a minimum, 486/66 processor with 8 MB RAM, 25 MB free space, CD-ROM drive, and Windows 95. We strongly recommend running the software on a Pentium 100 (or greater) processor with 16 MB RAM, 25 MB free space, CD-ROM drive and Windows 95, Windows 98, or Windows NT 4.0 or higher. Claims can be transmitted for processing by almost any Hayes-compatible modem, with the exception of the US Robotics Voice Modem and Hewlett-Packard's HP "Pavillion." Eligibility verifications are part of the base software system. The software supports all claim types: HCFA-1500, UB-92, Dental, EPSDT, Hospice/INH, Pharmacy and Visual Care. The software also supports all Medicare/Medicaid crossover claim types: Inpatient Crossover, Outpatient Crossover, Professional Crossover and Long Term Care Crossover.

301.300 Other AEVCS Solutions

A. Vendor Systems - Providers who have an office management system can opt to have their vendors upgrade their system to support AEVCS on-line transactions. EDS provides vendor specifications to interested vendors. The cost of upgrading the provider's system to support AEVCS is the responsibility of the provider.

B. Batch Solution - Providers who want to transmit a large volume of claims using their existing office management system may request the vendor specifications, which contain the batch specifications, from EDS. The batch solution allows providers to call into a bulletin board system at EDS and upload a batch of claims (transactions). EDS processes the claims, then creates response files on the bulletin board for providers to download.

C. Emerald - This is a stand-alone POS device with a keyboard, printer and card-swipe. The Emerald is designed for use in offices with no other computer-based communication. The Emerald can be used to verify a patient's eligibility for Medicaid on the date of service, to key a claim for processing on-line or to reverse a claim submitted in error. (Reversals can only be processed on the same day the claim was accepted.)

D. Omni 380 - This is a stand-alone POS device with a keypad, printer and card swipe that allows the providers to verify a recipient's eligibility. Omnis can only check eligibility. The Omni can be beneficial in Admissions, Emergency Rooms and busy reception/check-in areas.

EDS maintains a Provider Assistance Center to assist Medicaid providers during regular business hours from 8:00 a.m. to 4:30 p.m. Central Time. See section 119 of this manual for EDS holiday closings. Should you have any questions concerning claims payment, please contact the Provider Assistance Center at 1-800-457-4454 (Toll Free) within Arkansas or locally and out-of-state at (501) 376-2211.

EDS has a staff of representatives available during regular business hours from 8:00 a.m. to 4:30 p.m. (see section 119 of this manual for EDS holiday closings) to assist with any needs concerning POS devices. Please call the AEVCS Help Desk at 1-800-457-4275 (Toll Free) within Arkansas or locally and out-of-state at (501) 375-1025 for help with questions regarding software or POS devices.

EDS has a full time staff of Provider Representatives available for consultation regarding billing problems that cannot be resolved through the Provider Assistance Center. Provider Representatives are available to visit your office to provide training on billing.

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."

Providers may not electronically transmit to EDS any claims for dates of service over 12 months in the past. 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, a completed Adjustment Request Form (form EDS-AR-004, section 330.000 of this manual) must be submitted to the address specified on the form. Attach the documentation necessary to explain why the error has prevented re-filing the claim until more than 12 months have passed after the beginning date of service.

302.520 Claims Denied Incorrectly

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

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 re-filing the claim until more than 12 months have passed after the beginning date of service.

302.520 Claims Denied Incorrectly (Continued)

Send these materials to:

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

302.530 Claims Involving Retroactive Eligibility

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 re-filing the claim until more than 12 months have passed after the beginning date of service.

Send these materials to:

EDS
Provider Assistance Center
P.O. Box 8036
Little Rock, Arkansas 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 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, 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 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 following items on the Medicaid Claim Inquiry Form must be completed. A copy of this form follows these instructions. In order to answer your 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 your 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 your 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.	RA 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 earliest 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 in question 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.	Provider 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 your inquiry.

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 in this section. 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 for each form.

Mail your request to:

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

The Medicaid Program does not provide copies of the HCFA-1500 claim form. The provider may request a supply of this claim form from any available vendor. An available vendor is the U.S. Government Printing Office.

Orders may be submitted to the U.S. Government Printing Office via phone, fax, letter, e-mail or the internet. The contact information is given below:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

Phone: (Toll Free) (866) 512-1800, between 7:30 a.m. and 4:30 p.m.
Fax: (202) 512 2250
Website: http://bookstore.gpo.gov
E-Mail: orders@gpo.gov

EDS requires the use of red-ink (censor coded) HCFA-1500 claim originals instead of copies. A new processing system uses scanners to distinguish between red ink of the form fields and blue or black ink claim data (provider number, Recipient Identification Number (RID), procedure codes, etc.).

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 _____

EDS-MFR-001 (Revised 10/02)

310.000 BILLING PROCEDURES

311.000 Introduction

DDS Alternative Community Services (ACS) Waiver providers use the HCFA-1500 claim format to bill the Arkansas Medicaid Program for services provided to eligible Medicaid recipients. Each claim should contain charges for only one recipient.

Providers submitting claims electronically must maintain a daily electronic claim transaction summary, signed by an authorized individual. Refer to the Medicaid provider contract (form DMS-653).

311.100 Billing Instructions - AEVCS

The Automated Eligibility Verification and Claims Submission (AEVCS) system is the electronic method for verifying a recipient's eligibility and filing claims for payment. A provider may file a claim immediately after providing a service. 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.

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

Section 301.100 of this manual contains information on available AEVCS options.

The following table lists the values/comments for each of the fields associated with a Provider Electronic Solution (PES) Professional claim transaction. The last column provides a cross-reference to Section 311.400 of this manual for specific field requirements and instructions.

311.110 PES Professional Claim Field Descriptions

Field Name	Values/Comments	Refer to Section 311.400
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 #	The 10-digit number assigned by the appropriate state agency to confirm that a procedure, prescription, or other service was authorized in advance. To determine whether the procedure code for which you are billing requires prior authorization, see the procedure code list. Procedure codes are listed in section 311.500 of this manual.	Field 23
Referring Phys ID	The referring physician's 9-digit Medicaid identification number.	Field 17A

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
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. Each code identifies the condition or disease that makes the service medically necessary.	Field 21
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. Required only if medical care being billed is related to an accident.	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	Date of hospital admission for services related to this billing.	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 DDS Alternative Community Services (ACS) Waiver claims.	Field 20
Therapy Services Code	Not applicable to DDS Alternative Community Services (ACS) Waiver claims.	Field 19
School District Code	Not applicable to DDS Alternative Community Services (ACS) Waiver claims.	Field 19
Other Insurance?	If recipient has other insurance coverage, type Y. If not, type N.	N/A

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
Header 2 Information (con't)		
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
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 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	The address of the third party insurance company.	N/A
Second TPL	Indicates whether the recipient has a second third party 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

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
TPL Information (con't)		
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
Insured/Other Than Recipient – Address	If the recipient is not the insured person, type the address of the insured person.	N/A
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. (For a list of codes, see section 311.200.)	Field 24B
TOS	Type of service code. (For a list of codes, see section 311.200.)	Field 24C

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
Detail Information (con't)		
Procedure	The procedure code for the service provided.	Field 24D
Modifier	Type the modifier for the procedure, if applicable.	Field 24D
Hours	Number of hours for anesthesia services.	Field 24D
Minutes	Number of minutes for anesthesia services.	Field 24D
Extreme Age	If type of service is 7 and the second digit of the modifier is 9, type Y or N for Extremes of Age.	N/A
Surgical Avoid	If type of service is 7 and modifier ends with 9, type Y or N for Surgical Field Avoidance.	N/A
Hypothermia	If type of service is 7 and modifier ends with 9, type Y or N for Total Body Hypothermia.	N/A
Hypotension	If type of service is 7 and modifier ends with 9, type Y or N for Controlled Hypotension.	N/A
Pressure	If type of service is 7 and modifier ends with 9, type Y or N for Hyperbaric Pressurization.	N/A
Circulation	If type of service is 7 and the second digit of the modifier is 9, type Y or N for Extracorporeal Circulation.	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	The identity of a condition or disease for which the service is being billed for this detail. Diagnosis codes are listed in the ICD-9-CM code book and are 3 to 5 characters.	Field 24E

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
Detail Information (con't)		
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, type the total charge for all units billed for that detail.	Field 24F
Fund Code	Provider and recipient's non-Medicaid fund code, assigned by the Developmental Disabilities Service office. (The provider and recipient must be eligible for the same plan code.)	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	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	Not applicable to DDS Alternative Community Services (ACS) Waiver claims.
Diagnosis	Displays up to four diagnosis codes and related descriptions.
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	Displays the diagnosis code the detail is referring to.
Charge	Displays the dollar amount billed for the detail submitted.
Number of Units	Displays the number of units for the detail submitted.
Modifier	Displays the modifier number submitted.
Performing Provider	Displays the Performing Provider ID for the detail submitted.
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 Rejected Claims and Claim Reversals

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

311.200 Place of Service and Type of Service Codes

Place of Service	Type of Service
4 – Patient's Home 0 – Other	9 – DDS ACS Waiver

311.300 Billing Instructions - Paper Claims Only

EDS offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.

To bill for DDS Alternative Community Services (ACS) Waiver services, use the HCFA-1500. The numbered items correspond to numbered fields on the claim form. (A sample HCFA-1500 follows these billing instructions.)

The following instructions must be read and carefully adhered to, so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to:

EDS
Claims
P.O. Box 8033
Little Rock, Arkansas 72203

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

311.400 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 patient's last name and first name as it appears 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.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number		Instructions for Completion
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 insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
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.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number		Instructions for Completion
	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.
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 is not required for Medicaid.
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	Required, if applicable. Enter the name of the referring physician. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.

311.400 Completion of HCFA-1500 Claim Form (Continued)

	Field Name and Number	Instructions for Completion
17a.	I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18.	Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.
19.	Reserved for Local Use	Not applicable to DDS Alternative Community Services (ACS) Waiver claims.
20.	Outside Lab?	Not applicable to DDS Alternative Community Services (ACS) Waiver claims.
21.	Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with HCFA diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22.	Medicaid Resubmission Code	Reserved for future use.
	Original Ref No.	Reserved for future use.
23.	Prior Authorization Number	Enter the prior authorization number, if applicable.
24.	A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
	B. Place of Service	Enter the appropriate place of service code. See Section 311.200 for codes.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number	Instructions for Completion
C. Type of Service	Enter the appropriate type of service code. See Section 311.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct HCPCS procedure code from section 311.500.
Modifier	Enter the modifier for the procedure code.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only one diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD- 9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private 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.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number		Instructions for Completion
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#."
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 below 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.)

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number		Instructions for Completion
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 (i.e., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.
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 by 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#."

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 (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
Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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 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 TO MM DD YY

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 TO MM DD YY

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

burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

311.500 Special Billing Procedures

The following procedure codes must be billed for DDS Alternative Community Services (ACS) Waiver Services:

Procedure Code	Description	Unit of Service	Place of Service
Z1918[1]	ACS Supported Employment	15 Minutes	0
Z1920[2]	ACS Specialized Medical Supplies	1 Month	4, 0
Z1921	ACS Case Management Services	1 Month	4, 0
Z1923[3]	ACS Consultation Services	1 Hour	4, 0
Z2334	ACS Crisis Center Services	1 Day	0, 4
Z2335[4]	ACS Crisis Intervention Services	1 Hour	0, 4
Z2799	ACS Supportive Living	1 Day	4, 0
Z3000	ACS Adaptive Equipment	1 Year	4, 0
Z3001	ACS Environmental Modifications	1 Year	4
Z3002	ACS Supplemental Support Services	1 Month	4, 0
Z3005	ACS Community Experiences	1 Day	0
Z3006	ACS Respite Care	1 Day	4, 0
Z3007	ACS Waiver Coordination	1 Month	4, 0
Z3008	ACS Non-Medical Transportation	1 Day	0

[1]Individuals are limited to a maximum of 32 units (8 hours) of supported employment services per date of service.

A breakdown of the units of service include:
One unit = 15 minutes to 21 minutes
Two units = 22 minutes to 37 minutes
Three units = 38 minutes to 52 minutes
Four units = 53 minutes to 67 minutes.

[2]Reimbursement cannot exceed $300 per month.

[3]Individuals may receive twenty-five (25) hours of ACS consultation services per waiver eligible year.

[4]Crisis intervention services may require a maximum of 24 hours of service during any one day.

Refer to Section 311.200 for explanations of the place of service codes listed above.

RESERVED

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 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 in the following sections. 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 Heading

	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	The CPT or HCPCS procedure code billed 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 copay 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 that 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	Does not apply to professional claims, including DDS ACS Waiver claims.
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 advice (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 was 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 processing system but have not reached final disposition. Do not rebill a claim shown in this section, because it is already being processed and will result in a rejection as a duplicate claim. These claims will appear in this section until they are paid or denied.

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 Benefits 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 other recoupment activities that will negatively affect 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 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 Medicaid payments and credits made to the provider for the specific RA pay period entitled "Current Processed" and for the year under "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 check.
6.	CREDIT AMOUNT	Total amount refunded to the Medicaid Program by the provider. EDS posts check 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 transaction 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.

DDS Alternative Community Services (ACS) Waiver sample RA

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

1 PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

2 R/A NUMBER 12345

STATE OF ARKANSAS

3 PROVIDER NUMBER 123456170

4 CNTRL NUM 1

5 REPORT SEQ NUMBER 3

6 DATE 02/01/03 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 123456170 | CNTRL NUM 2 | REPORT SEQ NUMBER 3 | DATE 02/01/03 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 0123456789	CO = 60 1 17 03	RCC = 1 17 03	1 7	CLAIM NUMBER = 0503021123456 Z2334 00 ACS CRISIS CENTER SERVICES	MRN = 187 00	DIAG = 020030 0 00	187 00	SERV PHYS = 123456170 00		ADMIT = 00	187 00	61
3	COST SHARE = 00		PA/LEA =	TPL = 00	187 00	0 00	187 00	00		00	187 00 TAX=00	TAX = 00
********* TOTAL PAID CLAIMS			1 CLAIMS		187 00	0 00	187 00	00		00	187 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 123456170 CNTRL NUM 3 REPORT SEQ NUMBER 3 DATE 02/01/03 PAGE 3

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	TO 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 1	19	03	RCC = 1	19	03	1 7	CLAIM NUMBER = 0503027123456 Z2334 00 ACS CRISIS CENTER SERVICES	MRN = 55 00	DIAG = 022330 55 00	00	SERV PHYS = 123456170 00	ADMIT = 00	00	00	470
	COST SHARE = 00						PA/LEA =	TPL = 00	55 00	55 00	00	00	00	00	00	TAX = 00
1 CLAIMS							1 MEDICAL	**********	55 00	55 00	00	00	00	00	00 TAX=00	
******* TOTAL DENIED CLAIMS							1 CLAIMS		55 00	55 00	00	00	00	00	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 123456170 CNTRL NUM 4 REPORT SEQ NUMBER 3 DATE 02/01/03 PAGE 4

NAME / RECIPIENT ID	SERVICE DATES FROM MM DD DD	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
ADJUSTED CLAIMS PROFESSIONAL ADJUSTMENT												
SMITH, MARY 0112233456	CO = 37 1 16 03	CLAIM NUMBER = 5003020926456 1 16 03		MED REC =	** ADJUSTMENT 190 00		** CREDIT TO 0502289123456	PAID DATE 102802			190 00	336
SMITH, MARY 0112233456	CO = 37 1 16 03	CLAIM NUMBER = 5003020926456 1 16 03	1	** ADJUSTMENT Z2334 00 ACS CRISIS CENTER SERVICES	190 00	3 00	** DEBIT TO 0502289123456 NET ADJUSTMENT 187 00	PAID DATE 102802 00	00	SERV PHYS = 123456170 TAX= 00	3 00CR 187 00 TAX=00	365
	COST SHARE = 00		PA/LEA =	TPL = 00								
1 CLAIMS			1	PROFESSIONAL ADJUSTMENT *****								
*** TOTAL ADJUSTED CLAIMS			1	CLAIMS								
TOTAL NET ADJUSTMENT					190 00	3 00 TOTAL NET TAX = 00	187 00	00	00	00	187 00 3 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 123456170 CNTRL NUM 5 REPORT SEQ NUMBER 3 DATE 02/01/03 PAGE 5

NAME / RECIPIENT ID	SERVICE DATES FROM MM DD DD	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
CLAIMS IN PROCESS PROFESSIONAL	THESE CLAIMS ARE BEING PROCESSED AS LISTED											
2 SMITH, FRANKLIN 1 5544332211	1 22 03	1 22 03 4		ICN 0503026123456 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 123456170 | CNTRL NUM 6 | REPORT SEQ NUMBER 3 | DATE 02/01/03 | 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																
[1] RECIP ID	[2] FROM DOS			[3] TXN DATES			[4] CONTROL NUMBER	[5] REFERENCE			[6] ORIGINAL AMOUNT	[7] BEGINNING BALANCE	[8] APPLIED AMOUNT		[9] NEW BALANCE	[10] EOB
5544332211	01	16	03	01	16	03	2147018	5003020926456			190 00	190 00	190 00		0 00	112
				01	31	03	2255431	AEVCS TRANSACTION FEES			1 00	1 00	1 00		0 00	112
								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 123456170 | CNTRL NUM 7 | REPORT SEQ NUMBER 3 | DATE 02/01/03 | 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								HCFA		2			34			
							[5]	TOTAL CLAIM TRANSACTIONS		2			34			
REVERSAL								HCFA		1						
							[6]	TOTAL REVERSAL TRANSACTIONS		1						
ELIGIBILITY VERIFICATION										10			1 00			
							[7]	TOTAL TRANSACTIONS FOR THIS PROVIDER		13			1 34			

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456170 CNTRL NUM 8 REPORT SEQ NUMBER 3 DATE 2/01/03 PAGE 8

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 PAYMENT SUMMARY							1	2 / 3	4	5	6	7	8	9		
							DAYS OR UNITS	CLAIMS PAID / CLAIMS AMOUNT	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT	TAX AMOUNT	QTR TAX AMOUNT		
CURRENT PROCESSED							3	3 / 374.00	190 00	182 66	00	184 00	00	00		
YEAR-TO-DATE TOTAL							3	3 / 374.00	190 00	182 66	00	184 00	00	00		
							10	11 / 12								
							AEVCS TXN FEES	AEVCS TXN RECOUP AMT / DEF COMP RECOUP AMT								
CURRENT PROCESSED							1.34	1.34 / .00								
YEAR-TO-DATE TOTAL							2.51	2.51 / .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	1	374.00
DENTAL	0	0.00	0	0.00	0	0.00
SCREEN	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. 15

14 CLAIM IN PROCESS. PLEASE DO NOT REBILL.
33 THIS PAYMENT, SUPPLEMENTED BY A PREVIOUS PAYMENT MADE BY MEDICARE, CONSTITUTES THE TOTAL PAYMENT.
61 PAID IN FULL BY MEDICAID.
112 RECOUPMENT – THIS AMOUNT IS WITHHELD FROM YOUR CHECK.
336 ADJUSTMENT TO SERVICES PREVIOUSLY PAID OR DENIED.
365 FEE ADJUSTED TO MAXIMUM AMOUNT.
470 DUPLICATE OF CLAIM PAID.

**** FEDERAL TAX ID EIN 222334455

330.000 ADJUSTMENT REQUEST FORM

Use the Adjustment Request Form to correct a claim payment (even if the paid amount is $0.00) or to correct erroneous information on a paid claim. Include sufficient information on the request form to process the adjustment correctly. 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 proper redlined crossover form must be attached. If a provider 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 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. Read the instructions carefully and be sure to complete all Adjustment Request Forms thoroughly and accurately so that they may be handled efficiently.

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 the 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 recipient identification number exactly 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 the services.
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 06/02)

332.000 Explanation of Check Refund Form

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

Providers may refund to the Medicaid Program 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. Submit a completed Explanation of Check Refund Form 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 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 (as it appears on the RA)
5. Dates of Service on the claim
6. Date of Medicaid Payment
7. Date of Service Being Refunded
8. Services Being Refunded (enter procedure and type of service code)
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 1**		**Claim 3**
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: A 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 from 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 this 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:

A. Medicare (Title XVIII)

B. Railroad Retirement Act

C. Insurance Policies
   1. private health
   2. group health
   3. liability
   4. automobile/medical insurance
   5. family health insurance carried by an absent parent

D. Worker's Compensation

E. Veteran's Administration

F. CHAMPUS

The Medicaid policies concerning the handling of cases involving dual Medicare/Medicaid eligibility and 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.

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 crossover claims that do not cross to Medicaid. Institutional providers and those without electronic billing capability must mail a redlined 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

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

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

Provider Name and Address

Provider Signature

Date

EDS-MC-004

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 with 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.