Arkansas Department of Human Services
Division of Medical Services

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TO: **Arkansas Medicaid Inpatient Psychiatric for Individuals Under Age 21 Providers**

DATE:

SUBJECT: **Provider Manual Update Transmittal No. 53**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
212.000	10-13-03	212.000	7-1-04
212.200	10-13-03	212.200	7-1-04
240.000 – 252.400	10-13-03	240.000 – 262.400	7-1-04

Explanation of Updates

Section 212.000 is included to clarify that inpatient psychiatric services are restricted to individuals with a primary diagnosis of mental illness.

Section 212.200 is included to add the information that services to individuals whose primary diagnosis is substance abuse are excluded from this Medicaid program.

The purpose of this update is to include policy regarding inspections of care and retroactive reviews in the manual. Sections 240.000 through 240.310 now contain information about these reviews.

Sections that were previously numbered 240.000 through 252.400 have been re-numbered and now are numbered 250.000 through 262.400.

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

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

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Roy Jeffus, Director

*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**.*

212.000 Covered Services 7-1-04

Coverage of Inpatient Psychiatric Services for Under Age 21 is restricted to services to individuals with a primary diagnosis of mental illness. Coverage includes all medical, psychiatric and social services required of the admitting facility for licensure, certification and accreditation (Section 202.000). This includes, but is not limited to:

A. Drugs,

B. Evaluations,

C. Therapies,

D. Visits by a physician that are directly related to the remediation of the recipient's psychosocial adjustment,

E. Therapeutic leave days,

F. Absent without permission days and

G. Acute care leave days.

212.200 Exclusions 7-1-04

The following are not considered inpatient psychiatric services and are not covered in this program:

A. Personal allowances,

B. Clothing allowances,

C. Educational evaluations and services,

D. Vocational training,

E. Non-therapeutic leave days and

F. Services to individuals whose primary diagnosis is substance abuse.

240.000 PROVIDER REVIEWS 7-1-04

The Department of Human Services (DHS), Division of Medical Services (DMS) has an agreement with a contractor to complete on-site inspections of care and retrospective reviews of Inpatient Psychiatric Services for Under Age 21 Medicaid enrolled providers. **View or print APS HealthCare Information.**

241.000 On-Site Inspection of Care (IOC) 7-1-04

The Department of Human Services (DHS) requires the contractor to conduct annual On-Site Inspections of Care for acute inpatient and residential services provided to Medicaid recipient under age 21. These inspections will examine on-going medical necessity, quality of care provided, clinical documentation and utilization review programs for each Medicaid recipient who is a patient at the facility at the time of the IOC review.

241.100 Provider Notification of IOC 7-1-04

The contractor will notify the provider no more than 48 hours before the scheduled arrival of the IOC team. It is the responsibility of the provider to provide adequate space for the team to work. When possible, this work space will provide access to the patient care areas and the medical records.

241.200 Information Available Upon Arrival of the IOC Team 7-1-04

The provider will make the following available to the IOC Team upon its arrival at the site:

A. A list of all Arkansas Medicaid recipients who are residents at the time of the review;

B. Written policies, procedures and committee minutes;

C. Data collected for Clinical Administration, Clinical Services, Quality Assurance, Quality improvement, Utilization Review and Credentialing;

D. Program descriptions, manuals, schedules, staffing plans and evaluation studies; and

E. One or more knowledgeable administrative staff member(s) to assist the team.

241.300 Medical Record Review 7-1-04

The IOC Team will review the medical record of each Medicaid eligible resident under the age of 21. The provider is responsible for devising a system that allows the team quick and convenient access to any particular medical record. The IOC Team will review and return records as quickly as possible to avoid unnecessary disruption of ongoing treatment services.

241.400 Resident Interviews 7-1-04

Each resident who is a Medicaid recipient under age 21 must be interviewed by the IOC Team. It is the responsibility of the provider to devise a system that allows access to the residents in a way that is minimally disruptive to the treatment process.

If a Medicaid recipient will be discharged during the review, the provider is responsible for arranging for the resident to be interviewed prior to discharge.

Interviews should be conducted in a place and manner that respects the resident's right to privacy. The provider must provide private interview space for the interviews.

241.500 Exit Conference 7-1-04

The Inspection of Care Team will conduct an exit conference summarizing their findings and recommendations. Providers are free to involve staff in the exit conference.

241.600 Written Reports 7-1-04

A written report of the IOC team's findings will be forwarded to the facility and to the Field Audit Unit of the Division of Medical Services within 14 calendar days of the last day of the review. The written report will clearly identify each area of deficiency that requires submission of a corrective action plan.

241.700 Corrective Action Plans

The facility is required to submit a Corrective Action Plan designed to rectify any area of deficiency noted in the written report of the inspection of care. The Corrective Action Plan must be submitted to the contracted review agency within 14 calendar days after the date on the written report. The contractor will mail the report on the date shown on the report. The contractor will review the Corrective Action Plan and forward it, along with recommendations, to the Field Audit Unit of the Division of Medical Services.

241.800 Other Actions 7-1-04

Other actions that may be taken as a result of the inspection of care include, but are not limited to:

A. Decertification of any recipient determined not to meet medical necessity criteria for continued stay.

B. Follow-up inspections of care may be recommended by the contracted utilization review agency and required by Division of Medical Services to verify the implementation and effectiveness of corrective actions. Follow-up inspections may be focused only on the issues addressed by the corrective action plans or may be a complete re-inspection of care, at the sole discretion of the Division of Medical Services.

C. Review by Field Audit Unit of the Division of Medical Services.

242.000 Retrospective Review 7-1-04

The Division of Medical Services (DMS) of Arkansas Department of Human Services has contracted with a QIO-like entity to perform retrospective (post payment) reviews of for acute and residential services to Medicaid recipients by Inpatient Psychiatric Services for Under Age 21 providers. **View or print APS HealthCare Information**.

The reviews are conducted by licensed mental health professionals and are based on applicable federal and state standards.

242.100 Purpose of the Review 7-1-04

The purpose of the review is to evaluate the medical necessity of the admission to and continued stay in an inpatient setting. Reviewers will examine the medical record for technical compliance with state and federal regulations. Reviewers will also evaluate the clinical documentation to determine if it is sufficient to support the services billed during the requested period of authorized services.

242.200 Cases Chosen for Review 7-1-04

The notification of retrospective review sent to the provider will contain a list of specific cases that must be submitted to the review team chosen by a case selection procedure that combines random sampling and cases identified as "high utilization" and "outliers."

A. High utilizers are recipients with rate of high utilization.

B. Outliers are defined as providers who are providing services in an amount that is over and above the average amount of services being provided by their peers.

The review period will be specified in the provider notification letter. The letter will also state the date by which all records must be received by the contractor.

The list of cases to be reviewed will be sent to the provider with a request for certain components of the records. The information requested includes:

A. Face Sheet

B. Initial Certification of Need (CON) and all subsequent CON decisions

C. Psychiatric Evaluation and all updates

D. History & Physical and all updates

E. Intake Assessment and all updates

F. Psychosocial Assessment and all updates

G. Nursing Assessment and all updates

H. Psychological Testing

I. Psychosexual Assessment if the recipient is in a Sexual Offender Program

J. Treatment Plans: Initial, Master and updates covering the specified period

K. Progress Notes: Nursing, M.D., Therapy, Shift/Milieu for specified period

L. All Physician Orders

M. All Therapeutic Leave of Absence Forms

N. All Special Treatment Procedures Forms

O. Initial and Current PCP Referrals

All records must be mailed to the contractor. **View or print APS HealthCare Information**. Send records to the attention of "Retrospective Review Audits." Records must not be faxed.

The contractor has the right to request other parts of the health record or the entire record if needed.

242.300 Review Report 7-1-04

The contractor will complete a written report of the audit findings and will deliver the report to the facility and to the Division of Medical Services. If the facility does not request reconsideration of the audit report within 30 calendar days, the results of the audit report will be final.

242.310 Reconsideration 7-1-04

If the audit report is unfavorable, the provider has the right to request reconsideration by the contractor within 30 calendar days from the date on the report. The Division of Medical Services accepts reconsideration requests based on the postmark on the envelope from the contractor. The provider is responsible for retaining the envelope containing the postmark.

The provider may furnish the contractor additional documents from the medical record (if additional information is available) or may present a written explanation of why the facility

believes any particular audit finding is in error. Following the receipt of the written request for reconsideration, the contractor will review the findings in question. The reconsideration review is completed by a psychiatrist who was not involved in the original decision.

A written response to the request for reconsideration will be forwarded to the facility and to the Division of Medical Services. The decision of the contractor, upon reconsideration, is final.

250.000 REIMBURSEMENT 7-1-04

The Arkansas Medicaid Program reimburses inpatient psychiatric providers for medically necessary services only. Certification of need and prior authorization are prerequisites for reimbursement. The prior authorization number must appear on all claims submitted for reimbursement.

250.100 Inpatient Psychiatric Hospitals 7-1-04

The per diem rates for inpatient psychiatric hospitals are established at the lesser of: 1) the hospital's per diem cost inflated by the consumer price index for all urban consumers (CPI-U), U.S. city average for all items plus a $69.00 professional component or 2) the upper limit (cap). The $69 professional component is the average of the Arkansas Medicaid maximum allowable rates for the individual psychotherapy procedure codes. The upper limit (cap) is established annually at the 60th percentile of all in-state inpatient psychiatric hospitals' inflation adjusted per diem rates plus the $69 professional component. The calculation of the upper limit (cap) will be rounded up (0.5000 or greater) or down (0.4999 or less) if the 60th percentile is not a whole number. This is a prospective rate with no cost settlement.

Rates are calculated annually and are effective for dates of service occurring during the next state fiscal year (July 1st through June 30th). Per diem costs and the upper limit (cap) are calculated from the most recent submitted hospital cost reports with ending dates occurring in the previous calendar year. Less than full year cost reports and out-of-state provider cost reports are not included when calculating the 60th percentile. For hospitals with a cost report period of less than a full six months, the new state fiscal year per diem rate will be calculated by inflating the previous state fiscal year's per diem rate by the *Consumer Price Index for Urban Consumers (CPI-U).* The upper limit (cap) will not be adjusted after being set should new providers enter the program or late cost reports be received.

New providers are required to submit a full year's annual budget for the current state fiscal year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per day or the upper limit (cap) in effect as of the first day of their enrollment. The interim rate for new providers will be retroactively adjusted to the allowable per diem cost as calculated from the provider's first annual submitted cost report for a period of at least a full six months.

250.110 Private Hospital Inpatient Adjustment 7-1-04

All Arkansas private inpatient psychiatric and rehabilitative hospitals (that is, all inpatient psychiatric and rehabilitative hospitals within the State of Arkansas that are neither owned nor operated by state or local government) shall qualify for a private hospital inpatient rate adjustment.

The adjustment shall be equal to each eligible hospital's pro rata share of a funding pool, based on the hospital's Medicaid discharges. The amount of the funding pool shall be determined annually by Arkansas Medicaid, based on available funding. The adjustment shall be calculated as follows:

A. Arkansas Medicaid shall annually determine the amount of available funding for the private hospital adjustment funding pool.

For each private hospital eligible for the adjustment, Arkansas Medicaid shall determine the number of Medicaid discharges for the hospital for the most recent audited fiscal period.

The most recent **audited fiscal period** is determined per the most recent Medicaid Notice of Provider Reimbursement (NPR) as prepared by the Medicare Intermediary.

For hospitals who, for the most recently audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine their rate adjustment, provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports who were not licensed and providing services throughout an entire cost report year shall receive prorated adjustments based on the partial year data.

For private inpatient psychiatric and rehabilitative hospitals for the SFY 2003 adjustment, discharges will be included as prorated proportional to the August 1, 2002, effective date.

B. For each eligible private hospital Arkansas Medicaid shall determine its pro rata percentage, which shall be a fraction equal to the number of the hospital's Medicaid discharges divided by the total number of Medicaid discharges of all eligible hospitals.

C. The amount of each eligible hospital's payment adjustment shall be its pro rata percentage multiplied by the amount of available funding for the private hospital adjustment pool determined by Arkansas Medicaid.

Arkansas Medicaid shall determine the aggregate amount of Medicaid inpatient reimbursement to private hospitals. Such aggregate amount shall include all private hospital payment adjustments, other Medicaid inpatient reimbursement to private hospitals eligible for this adjustment and all Medicaid inpatient reimbursement to private hospitals not eligible for this adjustment, but shall not include the amount of the pediatric inpatient payment adjustment. Such aggregate amount shall be compared to the Medicare-related upper payment limit for private hospitals specified in 42 C.F.R. §447.272. Respective Case Mix Indexes (CMI) shall be applied to both the base Medicare per discharge rates and base Medicaid per discharge rates for comparison to the Medicare-related upper payment limit. These case mix adjustments are necessary in order to neutralize the impact of the differential between Medicare and Medicaid patients.

To the extent that this private hospital adjustment results in payments in excess of the upper payment limit, such adjustments shall be reduced on a pro rata basis according to each hospital's Medicaid discharges. Such reduction shall be no more than the amount necessary to ensure that aggregate Medicaid inpatient reimbursement to private hospitals is equal to but not in excess of the upper payment limit.

D. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

250.200 Residential Treatment Units 7-1-04

Reimbursement for residential treatment units (RTUs) located within inpatient psychiatric hospitals will be cost settled per provider submitted annual hospital cost reports at the lesser of the audited per diem cost (including the professional component cost) or the upper limit (cap). The professional component cost included in the per diem cost is capped at $69.00, which is the average of the Arkansas Medicaid maximum allowable rates for the individual psychotherapy procedure codes as of August 8, 1991.

The per diem upper limit (cap) is established annually at the average (mean) budgeted per diem cost of the in-state freestanding residential treatment centers with full twelve month budgets and will be effective for dates of service occurring during the state fiscal year for which the budgets were submitted. The upper limit cap will not be adjusted after being set, should new

freestanding residential treatment centers enter the Medicaid Program or late budgets be received.

Interim reimbursement rates will be implemented at the lesser of the per diem cost as calculated from the most recently submitted un-audited cost report or the upper limit (cap) in effect as of the first day after the cost report ending date.

New providers are required to submit a full year's annual budget for the current state fiscal year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per day or the upper limit (cap) in effect as of the first day of their enrollment.

250.300 Residential Treatment Centers 7-1-04

The per diem rates for residential treatment centers (RTCs) are established at the lesser of: 1) the center's budgeted cost per day which includes the professional component or 2) a $350 per day upper limit (cap). This is a prospective rate with no cost settlement.

The budgeted per diem cost is calculated from the annual budget, which all RTC providers are required to submit for the upcoming state fiscal year (July 1st through June 30th). Annual budgets are due by April 30th. Should April 30th fall on a Saturday, Sunday or state or federal holiday, the due date shall be the following business day. Failure to submit the budget by April 30th may result in the suspension of reimbursement until the budget is submitted. Rates are calculated annually and are effective for dates of service occurring during the state fiscal year for which the budgets have been prepared. See this section for a suggested budget format.

New providers are required to submit a full year's annual budget for the current state fiscal year (July 1st through June 30th) at the time of enrollment. This budget is used to set their rate at the lesser of the budgeted allowable cost per day or the upper limit (cap) of $350 per day.

Suggested Budget Format for Inpatient Psychiatric Hospitals, Residential Treatment Units, Residential Treatment Centers and Sexual Offender Programs

ADMINISTRATIVE AND OPERATING EXPENSES	Total Expenses	Less: Cost NOT Related to Patient Care	Total Cost Related to Patient Care
Salaries – Director	-	-	$ -
Salaries – Assistant Director	-	-	$ -
Salaries – Other Administrative	-	-	$ -
Salaries – Nursing, Other Care Related	-	-	$ -
Salaries – Professional – MD	-	-	$ -
Salaries – Housekeeping & Maintenance	-	-	$ -
Salaries – Teachers, Teacher Aides			0
SUB-TOTAL SALARIES (1)	-	-	$ -
Professional Fees – Nursing, Other Care Related	-	-	$ -
Professional Fees – MD	-	-	$ -
Professional Fees – Administrative	-	-	$ -
SUB-TOTAL FEES (2)	-	-	$ -
FICA Tax	-	-	$ -
State Unemployment Tax	-	-	$ -
Workmen's Compensation Insurance	-	-	$ -
Pension Plan	-	-	$ -
Group Insurance	-	-	$ -
Professional Liability Insurance	-	-	$ -
SUB-TOTAL FRINGE BENEFITS (3)	-	-	$ -
Advertising	-	-	$ -

Bad Debts	-	-	$	0
Cable TV	-		$	0
Cleaning Service & Grounds	-	-	$	-
Depreciation	-	-	$	-
Dues & Subscriptions	-	-	$	-
Food	-	-	$	-
Food – USDA	-	-	$	0
Fund Raising	-	-	$	-
Interest	-	-	$	-
Office Equipment	-	-	$	-
Postage	-	-	$	-
Rents & Leases	-	-	$	-
Repairs and Maintenance	-	-	$	-
Supplies – Care Related Program	-	-	$	-
Supplies – Medical	-	-	$	-
Supplies – Office	-	-	$	-
Supplies – School	-	-	$	0
Travel & Entertainment	-	-	$	-
Utilities	-	-	$	-
*Other Expenses	-	-	$	-
SUB-TOTAL OPERATING EXPENSES (4)			$	-
TOTAL EXPENDITURES (1 + 2 + 3 + 4)			$	-

* Please provide a brief description of Other Expenses.

250.400 Sexual Offender Program 7-1-04

Hospital-based and freestanding Sexual Offender Programs are cost settled per provider submitted hospital cost reports at the lesser of the audited per diem cost (includes the professional component) or the upper limit (cap). Cost settlements are calculated using the same methodology as that for residential treatment units with the same professional component cap and the same annual state fiscal year per diem cap. Although they are not hospitals, the freestanding programs are required to report their costs using the hospital cost report format and applicable instructions and reporting requirements.

Interim reimbursement rates are established at the lesser of the per diem cost as calculated from the most recent submitted unaudited cost report or the upper limit (cap) in effect as of the first day after the cost report ending date.

New providers are required to submit a full year's annual budget for the current state fiscal year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per day or the upper limit (cap) in effect as of the first day of their enrollment.

251.000 Cost Report 7-1-04

Inpatient psychiatric hospitals, residential treatment units and Sexual Offender Programs must submit an annual or partial period hospital cost report to the Arkansas Medicaid Program. Providers with less than a full twelve-month reporting period are also required to submit a hospital cost report for the shorter period. Cost reports are due no later than five months following the close of the provider's fiscal year end. Extensions will not be allowed. Failure to file the cost report within the prescribed period may result in suspension of reimbursement until the cost report is filed.

Providers will submit all required hospital cost reports and budgets in accordance with Medicare Principles of Reasonable Cost Reimbursement identified in 42 CFR, Part 413. All cost settlements will be made using these principles.

252.000 Rate Appeal and/or Cost Settlement Process 7-1-04

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days

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

If the decision of the Assistant Director, Division of Medical Services, is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of 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.

260.000 BILLING PROCEDURES 7-1-04

261.000 Introduction to Billing 7-1-04

Inpatient psychiatric providers use the CMS-1450 (formerly UB-92) form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid recipients. Each claim may contain charges for only one recipient.

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

262.000 CMS-1450 (formerly UB-92) Billing Procedures 7-1-04

262.100 Inpatient Psychiatric Revenue Codes 7-1-04

Revenue Code	Revenue Code Description
114	Inpatient Psychiatric Hospital only
124	Residential Treatment Center only
128	Sexual Offender Program only
129	Residential Treatment Unit only

262.200 Place of Service and Type of Service Codes 7-1-04

Not applicable to this program.

262.300 Billing Instructions—Paper Only 7-1-04

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 which require attachments or manual pricing.

Since the CMS-1450 (formerly UB-92) is a uniform claim form to be used nationwide for submitting claims to all third party payers, providers are responsible for purchasing their own forms from approved vendors. Medicaid will not furnish the claim form. **View a CMS-1450 sample form.**

To ensure that claims are processed with a minimal amount of delay, providers should complete all required fields of the CMS-1450 (formerly UB-92) claim form. The CMS-1450 data specifications should be used as a guide. The manual was developed by the National Uniform Billing Committee whose work is coordinated through the offices of the American Hospital Association. **View or print data specifications manual ordering information.**

To bill for Inpatient Psychiatric services, use the claim form CMS-1450 (formerly UB-92). Listed below are instructions for filing the CMS-1450 (formerly UB-92) with the Arkansas Medicaid Program. The numbered items correspond to the numbered locators on the CMS-1450 (formerly UB-92).

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.

Please forward the original of the completed form to EDS Claims Department. **View or print EDS Claims contact information.**

One copy of the claim form should be retained for your records.

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.

262.310 Completion of CMS-1450 (formerly UB-92) Claim Form 7-1-04

Form Locator Number	Name and Description
Form Locator 1	Provider Name, Address and Telephone Number Enter the provider's name, city, state, zip code and (optional) telephone number.
Form Locator 2	Unassigned Data Field.
Form Locator 3	Patient Control Number This is an optional entry that the provider may use for accounting purposes. Up to 16 numeric or alphabetic characters will be accepted. The number will appear on the remittance advice (RA) as "Medical Record Number."
Form Locator 4	Type of Bill Enter the three digit numeric code found in the UB-92 Data Element Specifications Handbook to indicate the specific type of bill.
Form Locator 5	Federal Tax Number This locator is not required for Medicaid.
Form Locator 6	Statement Covers Period

	Enter the beginning and ending service dates of the period covered by this bill. Multiple dates of service may be billed on one claim form by entering "from" and "through" dates in Form Locator 6. Service dates may not span calendar months. "From" and "through" dates of service may not span state fiscal year or the provider's fiscal year. To bill for an inpatient stay that spans a fiscal year, submit an interim claim with a "through" date of the last day of the fiscal year and another interim claim with a "from" date of the first day of the new fiscal year.
Form Locator 7	Covered Days Enter the number of days being billed.
Form Locator 8	Non-Covered Days This locator is not required for Medicaid.
Form Locator 9	Coinsurance Days This locator is not required for Medicaid.
Form Locator 10	Lifetime Reserve Days This locator is not required for Medicaid.
Form Locator 11	Unassigned Data Field.
Form Locator 12	Patient's Name Enter the patient's last name, first name and middle initial.
Form Locator 13	Patient's Address Optional entry. Enter the patient's full mailing address.
Form Locator 14	Patient's Birth Date Enter the patient's date of birth in MM/DD/YY format.
Form Locator 15	Patient's Sex Enter "M" for male or "F" for female.
Form Locator 16	Patient's Marital Status This locator is not required for Medicaid.
Form Locator 17	Admission Date Enter the date of admission.
Form Locator 18	Admission Hour Enter the national code which corresponds to the hour during which the patient was admitted. The corresponding codes are listed in the CMS-1450 Data Specifications Manual.
Form Locator 19	Type of Admission Enter the national code indicating the priority of this admission. The corresponding codes are listed in the CMS-1450 Data Specifications Manual. Medicaid will not accept code 9.
Form Locator 20	Source of Admission This locator is not required for Medicaid.
Form Locator 21	Discharge Hour

	Enter the hour the patient was discharged. The corresponding codes are listed in the CMS-1450 Data Specifications Manual.
Form Locator 22	Patient's Status For inpatient claims only, enter the national code indicating the patient's status as of the statement covers through date. The corresponding codes are listed in the CMS-1450 Data Specifications Manual.
Form Locator 23	Medical Record Number Required. Up to 15 alpha-numeric characters may be entered.
Form Locators 24, 25, 26, 27, 28, 29 and 30	Condition Codes These locators are not required for Medicaid.
Form Locator 31	Unassigned Data Field.
Form Locators 32, 33, 34 and 35	Occurrence Codes and Dates Required, if applicable. Refer to the CMS-1450 Data Specifications Manual for the code and associated date defining a significant event relating to this bill.
Form Locator 36	Occurrence Span Codes and Dates This locator is not required for Medicaid.
Form Locators 37 and 38	Unassigned Data Fields.
Form Locators 39, 40 and 41	Value Codes and Amounts These locators are not required for Medicaid.
Form Locator 42	Revenue Code The following are the revenue codes for inpatient psychiatric providers: Inpatient Psychiatric Hospital 114 Residential Treatment Center 124 Sexual Offender Program 128 Residential Treatment Unit 129 **NOTE: When a patient transfers from an inpatient psychiatric hospital to a RTU, the provider must use a patient status code to show the discharge.**
Form Locator 43	Revenue Description Enter a narrative description of the related revenue categories.
Form Locator 44	HCPCS/Rates This locator is not required for Medicaid.
Form Locator 45	Service Date This locator is not required for Medicaid.
Form Locator 46	Units of Service The cumulative units for accommodation revenue codes 110-210, as shown in Locator 46, must equal the units billed in Locator 7.

Form Locator 47	Total Charges Enter only the ancillary and accommodation charges associated with the Medicaid-covered days.
Form Locator 48	Non-Covered Charges This locator is not required by Medicaid.
Form Locator 49	Unassigned Data Field.
Form Locator 50	Payer Identification Enter the name of the payer from which the provider might expect some payment for the bill, including Medicaid. List the payers in order of responsibility, i.e., primary, secondary, etc.
Form Locator 51	Medicaid Provider Number Enter the 9-digit Medicaid provider number.
Form Locator 52	Release of Information Certificate Indicator This locator is not required by Medicaid.
Form Locator 53	Assignment of Benefits Certification Indicator This locator is not required by Medicaid.
Form Locator 54	Prior Payments Required, if applicable. Enter the amount received toward payment of this bill prior to billing Medicaid. This amount must correspond to the payer as listed in Form Locator 50 in order of responsibility.
Form Locator 55	Estimated Amount Due This locator is not required for Medicaid.
Form Locators 56 and 57	Unassigned Data Fields.
Form Locator 58	Insured's Name
A, B, C	Complete this locator according to the instructions in the CMS-1450 Data Specifications Manual.
Form Locator 59 A, B, C	Patient's Relationship to Insured Enter the appropriate code as referenced in the CMS-1450 Data Specifications Manual indicating the relationship of the patient to the identified insured.
Form Locator 60	Identification Number
A, B, C	Enter the insured's unique identification number assigned by the payer organization on the line corresponding to the payer listed in Form Locator 50. Enter the patient's Medicaid identification number.
Form Locator 61 A, B, C	Insured Group Name Enter the insured's group plan name if the patient is insured by another payer.
Form Locator 62 A, B, C	Insurance Group Number Enter the insured's group plan number if the patient is insured by another payer.

Form Locator 63 A, B, C	Treatment Authorization Code Enter the prior authorization number assigned to the dates entered in Form Locator 6.
Form Locator 64 A, B, C	Employment Status Code This locator is not required by Medicaid.
Form Locator 65 A, B, C	Employer Name If applicable, based upon Form Locators 61 through 64, enter the name of the employer that provides health care coverage for the patient.
Form Locator 66 A, B, C	Employer Location If applicable, enter the specific location of the employer of the patient.
Form Locator 67	Principal Diagnosis Code Enter the ICD-9-CM code for the principal discharge diagnosis.
Form Locators 68, 69, 70, 71, 72, 73, 74 and 75	Other Diagnosis Codes Required, if applicable. Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.
Form Locator 76	Admitting Diagnosis Code Enter the ICD-9-CM diagnosis code corresponding to the diagnosis of the patient's condition which prompted admission to the hospital.
Form Locator 77	E Code This locator is not required by Medicaid.
Form Locator 78	Unassigned Data Field.
Form Locator 79	Procedure Coding Method Used This locator is not required for Medicaid.
Form Locators 80 and 81	Principal and Other Procedure Codes and Dates These locators are not required for Medicaid.
Form Locator 82	Attending Physician ID Enter the name and State License Number of the physician attending a patient. This is the physician primarily responsible for the care of the patient from the beginning of hospitalization.
Form Locator 83 A, B	Other Physician ID **A.** Not required for Inpatient Psychiatric claims. **B.** Enter the PCP provider name and Medicaid number.
Form Locator 84	Remarks This locator is not required for Medicaid.

Form Locator 85	Provider Representative Signature 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.
Form Locator 86	Date Bill Submitted Enter the date the bill was signed or sent to the Arkansas Medicaid Program for payment.

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Not applicable to this program.