Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us
Telephone (501) 682-8292 TDD (501) 682-6789 or 1-877-708-8191
FAX (501) 682-1197

TO: **Health Care Providers - Private Duty Nursing Services**

DATE: **November 1, 2003**

SUBJECT: **Provider Manual Update Transmittal #45**

REMOVE		**INSERT**	
201.000 through 213.112	10-13-03	201.000 through 213.210	11-1-03
215.000	10-13-03	215.000	11-1-03
221.000 and 222.000	10-13-03	221.000 and 222.000	11-1-03
224.000 and 225.000	10-13-03	224.000 and 225.000	11-1-03
242.110 through 242.200	10-13-03	242.110 through 242.200	11-1-03
242.310 and 242.400	10-13-03	242.310 through 242.440	11-1-03

Explanation of Updates

Section 201.000 is organized to clarify provider participation requirements.

Section 201.200 is a new section that includes participation requirements for Arkansas school districts and Education Service Cooperatives (ESC) enrolling as Private Duty Nursing Services (PDN) providers effective November 1, 2003.

Section 202.000 includes information for participation of PDN providers in Arkansas. Information previously included in Section 202.000 has been located in Section 204.000.

Section 203.000 includes participation information for PDN providers in bordering and non-bordering states. Section 203.000 includes an update of the definition of "emergency services." Minor wording changes were made due to grammatical errors and to improve clarity. Information in the previous Section 203.000, "The Private Duty Nursing Services Provider's Role in the Child Health Services (EPSDT) Program", has been deleted.

Section 204.000 includes an additional record requirement for PDN providers and includes wording changes to clarify policy.

Section 204.100 is a new section that provides additional record requirements for school district and ESC providers.

Section 205.000 explains providers' responsibilities in retaining records.

Sections 211.000 and 212.000 clarify policy.

Section 212.100 clarifies PDN service locations.

Section 213.000 is organized for readability. Information pertaining to Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request and Recertification Form (DMS-2692) is located in the Prior Authorization section of this manual.

Explanation of Updates (continued)

Section 213.100 is a new section regarding the coverage of PDN services provided by public schools effective for dates of service on or after November 1, 2003.

Section 213.101 is a new section explaining the policy for public school payment of Medicaid matching funds.

Section 213.210 is a new section updating the process for requesting extension of benefits for PDN medical supplies.

Section 215.000 corrects the outline format in part B.

Section 221.000 contains wording changes to clarify policy.

Section 222.000 includes information deleted from Section 213.000. This section also includes minor wording changes to clarify information.

Section 224.000 includes information on submitting Form DMS 2692 after the 90 days initial approval for recertification of PDN services. Information on the PDN care plan and reference to Home Certification and Plan of Care (Form CMS-485) is included.

Section 225.000 includes information on the process of filing for prior authorization. The changes also reflect minor wording changes for clarity. A reference to Form CMS-485 has been added.

Sections 242.110 and 242.130 include procedure codes for PDN services and medical supplies. These sections have been reorganized for clarity.

Section 242.200 includes type of service code “S” for public school PDN services for recipients under age 21.

Section 242.310 includes a change in the name of field 19 of the CMS-1500.

Section 242.410 is a new section regarding special billing information for PDN services.

Section 242.421 is a new section and includes information on billing for simultaneous care of two patients.

Section 242.422 is a new section regarding billing for PDN care of multiple patients in a public school.

Section 242.430 is a new section including billing of PDN medical supplies.

Section 242.440 explains electronic claim filing for medical supplies that are benefit extended.

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, Interim 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**.

201.000 Arkansas Medicaid Participation Requirements for Providers of Private Duty Nursing Services 11-1-03

The following subsections present Arkansas Medicaid's participation requirements for providers of Private Duty Nursing Services (PDN). A school district or Education Service Cooperative enrolling as a PDN provider has a different set of criteria than other entities enrolling as a PDN provider.

201.100 Private Duty Nursing Services Providers 11-1-03

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

A. The PDN provider must have either a Class A or Class B license issued by the Arkansas Department of Health. It must be designated on the license that the PDN agency is a provider of extended care services.

1. A copy of the license must accompany the provider application and Medicaid contract.
2. Subsequent licensure must be provided when issued by the Arkansas Department of Health.
3. For purposes of review under the Arkansas Medicaid Program, agencies enrolled as Class B operators providing private duty nursing services must adhere to those standards governing quality of care, skill and expertise applicable to Class A operators.

B. The PDN provider must complete a provider application (Form DMS-652), Medicaid contract (Form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (Form DMS-652), a Medicaid contract (Form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

C. The provider application and Medicaid contract must be approved by the Arkansas Medicaid Program.

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

201.200 School District or Education Service Cooperative Private Duty Nursing Services Providers 11-1-03

Effective for dates of service on or after November 1, 2003, Arkansas Medicaid will enroll Arkansas school districts and Education Service Cooperatives (ESC) as Private Duty Nursing Services (PDN) providers when the following criteria are met:

A. The school district or Education Service Cooperative must complete a provider application (Form DMS-652), Medicaid contract (Form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (Form DMS-652), a Medicaid contract (Form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

B. The school district or ESC must be certified by the Arkansas Department of Education (ADE) as a Local Educational Agency (LEA). The ADE will provide verification of LEA certification to the Provider Enrollment Unit of the Arkansas Division of Medical Services. Subsequent certifications must be provided when issued.

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

202.000 Private Duty Nursing Service Providers in Arkansas 11-1-03

Private Duty Nursing Services providers in Arkansas may be enrolled as **routine service providers** if they meet the applicable Arkansas Medicaid participation requirements as outlined in Section 201.000.

A. **Routine service providers** may furnish and claim reimbursement for private duty nursing services subject to the benefit limitations and coverage restrictions set forth in this manual.

B. Claims must be filed according to specifications of this manual. This includes assignment of ICD-9-CM and HCPCS codes for all services rendered.

203.000 Private Duty Nursing Service Providers in Bordering and Non-Bordering States 11-1-03

Private Duty Nursing Services (PDN) providers in bordering and non-bordering states may be enrolled only as **limited service providers**.

Limited service providers may be enrolled in the Arkansas Medicaid Program to provide emergency services or prior authorized services only.

A. "Emergency services" are defined as inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.
Source: 42 U.S. Code of Federal Regulations §422.2 and §424.101.

B. "Prior authorized services" are those that are medically necessary and not available in Arkansas. Each request for these services must be made in writing, forwarded to the Utilization Review Section and approved before the care is provided. A provider number will be assigned upon receipt and approval of the provider application and Medicaid contract. **View or print the Utilization Review Section contact information.**

The prior authorization request must be approved before PDN services are provided.

Limited service provider claims are manually reviewed before processing to ensure that only emergency or prior authorized services are approved for payment. These claims must be mailed to: Arkansas Division of Medical Services Program Communications Unit. **View or print DMS Program Communications Unit contact information.**

204.000 Records Requirements 11-1-03

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

A. Medicaid contract (form DMS-653) to participate in the Arkansas Medicaid Program.

B. Copy of the license of the registered nurse (RN) and/or licensed practical nurse (LPN) providing private duty nursing services.

C. Documentation verifying that RNs or LPNs are CPR certified.

D. Documentation that the RN or LPN has received in-service training on the particular patient's equipment and care needs.

E. Written contracts between contract personnel and the agency.

F. Statistical, fiscal and other records necessary for reporting and accountability.

G. Copies of the approved Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification (Form DMS-2692). **View or print form DMS-2692 and instructions for completion.**

H. Signed and dated notes on the condition and progress of each patient.

I. The patient's PDN care plan (Home Health Certification and Plan of Care (form CMS-485), including written justifications of any modification in the PDN care plan or prescription of service by the physician. **View or print form CMS-485.**

J. Any additional or special documentation deemed necessary by the provider or required by DMS.

K. Documentation of PDN services provided to each eligible recipient, including the date, the actual time of day each service was delivered and the signature of the person who actually provided the service.

204.100 Additional Record Requirements for School District and Education Service Cooperative Providers 11-1-03

In addition to the record requirements in Section 204.000, the school district or Education Service Cooperatives (ESC) provider of Private Duty Nursing Services (PDN) is responsible for keeping on file the following information:

A. Written contracts between the school district or ESC and the contract personnel.

B. The PDN care plan (*Home Health Certification and Plan of Care*—Form CMS-485) with updates signed by the school district or ESC supervising RN. **View or print form CMS-485.** The Individualized Education Program (IEP) may not supersede or substitute for the PDN care plan.

205.000 Retention of Records 11-1-03

Private Duty Nursing Services providers must maintain all records for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer.

All documentation must be made available, upon request, to authorized representatives of the Arkansas Division of Medical Services, the state Medicaid Fraud Control Unit, representatives of the Department of Medicare and Medicaid Services and its authorized agents or officials.

At the time of an audit by the Division of Medical Services, Medicaid Field Audit Unit, all documentation must be available at the provider's place of business during normal business hours. In the case of recoupment, there will be no more than thirty days allowed after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the thirty-day period.

Failure to furnish records upon request may result in sanctions.

210.000 PROGRAM COVERAGE 10-13-03

211.000 Introduction 11-1-03

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

212.000 Scope 11-1-03

Private duty nursing services are those medically necessary services that are provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician, to a recipient in his or her place of residence, a Division of Developmental Disabilities Services (DDS) community provider facility or a public school. For purposes of the Medicaid program, private duty nursing services are those medically necessary services related to the coverage described in Section 213.000 and delivered by a registered nurse or licensed practical nurse, as required by the State Nurse Practice Act.

212.100 Private Duty Nursing Service Locations 11-1-03

A. Medicaid-eligible ventilator-dependent recipients age 21 and older, may receive Private Duty Nursing Services (PDN) services. PDN services may be provided only in the recipient's own home and as necessary when the Medicaid recipient's normal life activities temporarily take the recipient away from the home. For purposes of this rule, normal life activity means routine work, school, church, office or clinic visits, shopping and social interactions with friends and family. The private duty nurse may accompany the recipient but may not drive. Normal life activities do not include non-routine or extended home absences.

B. For Medicaid eligible recipients under the age of 21, PDN services are covered in the following locations:

1. The recipient's home. PDN services may be provided only in the recipient's own home and as necessary when the Medicaid recipient's normal life activities temporarily take the recipient away from the home. For purposes of this rule, normal life activity means routine work, school, church, office or clinic visits, shopping and social interactions with friends and family. The nurse may accompany the recipient but may not drive. Normal life activities do not include non-routine or extended home absences.
2. A public school. A school's location may be an area on or off-site based on accessibility for the student. When a student's education is the responsibility of the school district in which that student resides, "school" as a place of service for Medicaid-covered services is *any* location, on-site or away from the site of an actual school building or campus, at which the school district is discharging that responsibility.
    a. When a child is attending school at a DDS community provider facility because the school district has contracted with the facility to provide educational services, the place of service is "school".
    b. When the home is the educational setting for a child who is enrolled in the public school system, "school" is considered the place of service.
    c. The student's home is **not** considered a "school" place of service when a parent elects to home school a child.
3. A DDS community provider facility.

C. PDN services are **not** covered at/or in a hospital, boarding home, nursing facility, residential care facility, or an assisted living facility.

213.000 Coverage of Private Duty Nursing Services 11-1-03

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

A. Medicaid-eligible ventilator-dependent recipients when determined medically necessary and prescribed by a physician.

B. Medicaid-eligible recipients under age 21 who are:

1. In the Child Health Services (EPSDT) Program, and
2. High technology non-ventilator dependent recipients requiring at least two (2) of the following services, unless the recipient requires an extremely high level of one (1) service making a home care plan impossible without private duty nursing services:
   a. Intravenous Drugs (e.g. chemotherapy, pain relief, or prolonged IV antibiotics)
   b. Respiratory – Tracheostomy or Oxygen Supplementation
   c. Total Care Support for ADLs and close patient monitoring
   d. Hyperalimentation – parenteral or enteral

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

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

213.100 Coverage of Private Duty Nursing Services Provided by Public Schools 11-1-03

Effective for dates of service on or after November 1, 2003, the public schools will provide PDN services to Medicaid-eligible students who meet the following requirements:

A. The requirements in Section 213.000.

B. An Individualized Education Program (IEP) that includes and describes the PDN services for the Medicaid-eligible student.

C. A PDN care plan (*Home Health Certification and Plan of Care*—Form CMS-485) has been developed. **View or print form CMS-485.** The IEP does not substitute for the PDN care plan.

213.101 Public School Payment of Medicaid Matching Funds 11-1-03

Effective for dates of service on or after November 1, 2003, public schools are deemed to be the provider of service, and will pay the state match for Medicaid covered services that are included in a student's Individualized Education Program (IEP) and provided under this Medicaid Program manual.

This policy applies unless the student's parent or guardian has, in accordance with federal law, independently selected a certified Medicaid provider other than the school ("other provider"). This exception requires the existence of each of the following conditions:

A. Neither the school nor anyone acting on behalf of the school referred the student, or the student's parent or guardian, to the other provider.

B. There is no arrangement by the school or persons or entities in privity with the school for the other provider to furnish the services.

C. The other provider does not, either directly or through another person or entity, have a contract with the school or persons or entities in privity with the school for referrals, consulting, or the provision of Medicaid-covered services.

D. The other provider is not under control or supervision of the school or persons or entities in privity with the school.

For purposes of this rule, "privity" means a derivative interest growing out of a contract, mutuality of interest, or common ownership or control.

213.200 Coverage of Private Duty Nursing Medical Supplies 11-1-03

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

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

213.210 Extension of Benefits for Private Duty Nursing Medical Supplies 11-1-03

With substantiated medical necessity, the maximum reimbursement for PDN medical supplies may be extended.

To request an extension of benefits for private duty nursing medical supplies, the PDN service provider must submit the following information to the Division of Medical Services Utilization Review Section:

A. A completed *Request for Extension of Benefits* (Form DMS-699). **View or print form DMS-699.**

B. Medical records and PDN service provider records that substantiate the medical necessity for extension of benefits.

C. Physician prescription, which is dated within the past 12 months.

View or print Utilization Review Section contact information.

Within 30 working days, the PDN service provider will be notified in writing of the approval or denial of the request for extension of benefits or a request for additional information will be made. See Section 227.000 of this manual for the recipient's appeal process when adverse action is received.

215.000 Criteria For Coverage of High Technology, Non-Ventilator Dependent Recipients In the Child Health Services (EPSDT) Program 11-1-03

Specific factors to be assessed:

A. Medical

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

B. Social/Emotional/Environmental

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

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

221.000 Prior Authorization 11-1-03

Prior authorization (PA) is required for private duty nursing services.

222.000 Request for Prior Authorization 11-1-03

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

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

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

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

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

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

224.000 Recertification of Private Duty Nursing Services for Home Ventilator-Dependent and Non-Ventilator Patients 11-1-03

If there is a change in the prescription for care, the provider must submit a new Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification (Form DMS-2692). **View or print form DMS-2692**. Include the following information after the 90 days initial approval and every six (6) months thereafter for Medicaid recertification:

A. Current physician/developmental assessment – Include changes since last certification.

B. Psychosocial/Family assessment.

1. How is patient responding to home environment?
2. How is family responding to patient being home?
3. If caregivers work, give their work schedule.
4. Include changes since last certification.

C. Results of teaching plan – List specific hours and days family cares for child and specific hours and days agency cares for the child.

D. PDN care plan (Home Health Certification and Plan of Care – Form CMS-485) for continued care – Reflect any changes in child's nutritional methods since last certification. **View or print form CMS-485.**

E. Summary of other disciplines treatment and goals utilized.

F. Emergency plan.

If there is no change in the prescription for care, provider must submit a copy of existing nursing care plan and note "no change."

225.000 Filing for Prior Authorization 11-1-03

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

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

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

A. Current medical and surgical history

B. Current psychosocial assessment

C. Current PDN care plan (Home Health Certification and Plan of Care – Form CMS-485) **View or print form CMS-485**

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

Providers must submit requests for prior authorization of PDN services within 30 days of the beginning date of service. Providers assume the risk of services ultimately being found not

medically necessary. When PDN services are approved by UR at the level requested, the effective date of the prior authorization will be retroactive to the beginning date of service.

242.110 Private Duty Nursing Services Procedure Codes 11-1-03

The following procedure codes are applicable when billing the Arkansas Medicaid Program for private duty nursing services.

National Code	Local Code	Local Code Description
S9123	Z1513	Private Duty Nurse, R.N.
S9124	Z1514	Private Duty Nurse, L.P.N.

NOTE: Where both a national code and a local code ("Z code") are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a national code is available, it can be used indefinitely for both electronic and paper claims.

242.120 Simultaneous Care of Two Patients 11-1-03

When a private duty nurse is caring for two patients simultaneously in the same location, the following procedure codes are to be used for the care provided to the second patient:

National Code	Required Modifier	Local Code	Local Code Description
S9123	52	Z2627	Private duty nurse, RN, 2nd patient. Medicaid maximum allowable is 50% of the rate for S9123 (Z1513).
S9124	52	Z2628	Private duty nurse, LPN, 2nd patient. Medicaid maximum allowable is 50% of the rate for S9124 (Z1514).

NOTE: Where both a national code and a local code ("Z code") are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a national code is available, it can be used indefinitely for both electronic and paper claims.

242.130 Medical Supplies Procedure Codes 11-1-03

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

National HCPCS Codes				
A4206	A4214	A4221	A4222	A4253
A4256	A4259	A4265	A4310	A4311

A4312	A4313	A4314	A4315	A4316
A4320	A4322	A4323	A4326	A4327
A4328	A4330	A4338	A4340	A4344
A4346	A4348	A4351	A4352	A4354
A4355	A4356	A4357	A4358	A4359
A4361	A4362	A4364	A4367	A4369
A4371	A4397	A4398	A4399	A4400
A4402	A4404	A4405	A4406	A4454
A4455	A4558	A4560	A4561	A4562
A4622	A4623	A4624	A4625	A4626
A4628	A4629	A4772	A4927	A5051
A5052	A5053	A5054	A5055	A5061
A5062	A5063	A5071	A5072	A5073
A5081	A5082	A5093	A5102	A5105
A5112	A5113	A5114	A5119	A5121
A5122	A5126	A5131	A6154	A6234
A6241	A6242	A6248	B4086	E0776

National Code	Local Code	Local Code Description
A6257	Z1938	Transparent Film, each (16 square inches or less)
A6258	Z1939	Transparent Film, each (more than 16, but less than 48 square inches)
A6259	Z1940	Transparent Film, each (more than 48 square inches)
A6216 A6219 A6228	Z1941	Gauze Pad, Medicated or Non-Medicated, each (16 square inches or less)
A6220 A6229 A6217	Z1942	Gauze Pads, Medicated or Non-Medicated, each (more than 16, but less than 48 square inches)
A6221 A6230 A6218	Z1943	Gauze Pads, Medicated or Non-Medicated, each (more than 48 square inches)
A6421 A6422 A4450 A6426 A6428	Z1944	Gauze, Non-Elastic, Per Roll (1 linear yard)
A6245 A6242	Z1945	Hydro gel Dressing, each (16 square inches or less)
A6246	Z1946	Hydro gel Dressing, each (more than 16, but less than 48 square inches)

A6247 A6244	Z1947	Hydro gel Dressing, each (more than 48 square inches)
A6248	Z1948	Hydro gel Dressing, each (1 ounce)
A6237 A6234	Z1949	Hydrocolloid Dressing, each (16 square inches or less)
A6238 A6235	Z1950	Hydrocolloid Dressing, each (more than 16, but less than 48 square inches)
A6236 A6239	Z1951	Hydrocolloid Dressing, each (more than 48 square inches)
A6196	Z1952	Alginate Dressing, each (16 square inches or less)
A6197	Z1953	Alginate Dressing, each (more than 16, but less than 48 square inches)
A6198	Z1954	Alginate Dressing, each (more than 48 square inches)
A6197	Z1955	Alginate Dressing, each (1 linear yard)
A6209	Z1956	Foam Dressing, each (16 square inches or less)
A6210	Z1957	Foam Dressing, each (more than 16, but less than 48 square inches)
A6211	Z1958	Foam Dressing, each (more than 48 square inches)
A6200	Z1959	Composite Dressing, each (16 square inches or less)
A6201	Z1960	Composite Dressing, each (more than 16, but less than 48 square inches)
A6202	Z1961	Composite Dressing, each (more than 48 square inches)
A4253	Z1963	Blood Glucose test or reagent strip for home blood glucose monitor, per 25 strips
A4353	Z1964	Urinary intermittent catheter with insertion tray
A4394	Z1965	Ostomy deodorant, all types, per ounce
A4365	Z1966	Adhesive remover wipes, 50 per box
A4368	Z1967	Ostomy filters, any type, each
A6430 A6432 A6434 A6436	Z1969	Gauze elastic, all types, per roll (linear yard)
A4483	Z1993	Tracheostomy vent-heat moisture device
Bill on paper	Z2481	Thick-It per 8 oz. can
L8239*	Z2483	Stocking (Jobst)

NOTE: Where both a national code and a local code ("Z code") are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a

national code is available, it can be used indefinitely for both electronic and paper claims.

242.200 Place of Service and Type of Service Codes 11-1-03

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

Type of Service (paper only)
1-Private Duty Nursing Services
S-Public School (for recipients under age 21) **NOTE:** Type of service code "S" requires the LEA number of the school district in Field 19 of the CMS-1500

242.310 Completion of CMS-1500 (formerly HCFA-1500) Claim Form 10-13-03

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.
2.	Patient's Name	Enter the patient's last name and first name.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name, (post office box or RFD), city name, state name and zip code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if 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.

	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	Primary Care Physician (PCP) referral is required for Private Duty Nursing services. Enter the referring physician’s name.
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	Local Education Agency (LEA) code that identifies the school district in which therapy services are provided.
20.	Outside Lab?	This field is not required for Medicaid.
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 CMS 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. On a single claim detail (one charge on one line), bill only for services within a single calendar month.
B. Place of Service	Enter the appropriate place of service code. See Section 242.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 242.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code.
Modifier	A modifier is required when billing for a second patient's PDN services.
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 <u>one</u> 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.
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 the 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 Field 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 co-pay. In such a case, enter the sum of the insurer's payment and the recipient's co-pay. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 28 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
31.	Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and zip code of the facility where services were performed.
33.	Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
	PIN #	This field is not required for Medicaid.
	GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."

242.410 Private Duty Nursing Billing Procedures 11-1-03

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

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

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

242.420 Care of Multiple Patients 11-1-03

242.421 Simultaneous Care of Two Patients in the Recipients' Home or a DDS Facility 11-1-03

When a private duty nurse is caring for two patients simultaneously in a location other than a public school, Arkansas Medicaid reimburses 100% of the maximum allowable rate for the first patient and 50% of the maximum allowable rate for the second patient.

Providers must file separate claims indicating the number of hours of care for each patient.

Providers must request prior authorization for procedure codes **S9123 (Z2627)** and **S9124 (Z2628)**.

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242.422 PDN Care of Multiple Patients in a Public School 11-1-03

Arkansas Medicaid will reimburse the public schools based on the actual amount of cumulative time during the day used to provide PDN services to each Medicaid-eligible child. A separate claim must be filed indicating the total number of hours of PDN care for each child.

242.430 Private Duty Nursing Medical Supplies 11-1-03

Procedure codes **L8239 (Z2483)** must be prior authorized. Form DMS-679 may be used to request prior authorization. **View or print form DMS 679.**

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

242.440 Electronic Claim-Filing for Benefit-Extended Medical Supplies 11-1-03

The Division of Medical Services (DMS) permits electronic filing of claims for benefit-extended medical supplies.

Upon notification of a benefit extension approval, the provider will file the claim electronically, entering the assigned Benefit Extension Control Number in the Prior Authorization (PA) number field. Subsequent benefit extension requests to UR will be necessary only when the benefit extension control number expires or when a patient's need for services unexpectedly exceeds the amount or number of services granted under the benefit extension.