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Division of Medical Services
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Little Rock, Arkansas 72203-1437
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Telephone (501) 682-8292 TDD (501) 682-6789 or 1-877-708-8191
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TO: **Arkansas Medicaid Alternatives for Adults with Physical Disabilities Waiver Providers**

DATE:

SUBJECT: **Provider Manual Update Transmittal No. 19**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
213.200	10-13-03	213.200	6-1-04
220.000	10-13-03	220.000	6-1-04
240.000-242.400	10-13-03	240.000-243.400	6-1-04
		Form AAS-9559	2-04

Explanation of Updates

Section 213.200, part A, is relocated to part B and part B information is relocated to part A. This is to clarify policy.

Section 213.200, part C, is revised to clarify receipt of personal care services when a client is also receiving Alternatives for Adults with Physical Disabilities Waiver (APD) services. A statement is added to advise of the APD Waiver Counselor's responsibility to attach a copy of the personal care service plan to the APD plan of care.

Section 213.200, part F, is revised to change a reference from section 242.100 to a new section 243.100. Minor wording changes and format changes are made to clarify policy.

Section 220.000 is revised to include new prior authorization requirements for APD services.

Section 241.000 is revised to reference the new form, Alternatives Attendant Care Provider Claim Form (AAS-9559), required when filing paper claims for attendant care services.

Section 242.100 has been revised because procedure code S5125 for attendant care is relocated to a new section, 243.100.

Section 242.300 now includes text regarding the required use of form CMS-1500 when filing claims for environmental accessibility adaptation/adaptive equipment.

Section 242.310, form CMS-1500, field 23, instructions are revised. Providers must enter the required prior authorization number in field 23 of form CMS-1500.

"The Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act."

Sections 243.000, 243.100, 243.200, 243.300, 243.310 and 243.400 are new to this manual. These sections provide billing instructions for filing paper claims for procedure code S5125 for attendant care services. A sample copy of a new form, Alternatives Attendant Care Provider Claim Form, (AAS-9559), is included. A provider may only obtain form AAS-9559 from their client employer who receives the form from their Alternatives Counselor. Providers are instructed to refer to the Division of Aging and Adult Services Alternative Attendant Care Provider Manual for complete instructions in using the new form and filing claims.

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 in-state WATS 1-800-457-4454 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**.

213.200 Attendant Care Service 6-1-04

Attendant care service is assistance to a medically stable, physically disabled individual in accomplishing tasks of daily living that the individual is unable to complete independently. Assistance may vary from actually doing a task for the individual, to assisting the individual to perform the task or to providing safety support while the individual performs the task. Housekeeping activities that are incidental to the performance of care may also be furnished.

A. If consumer-directed care is selected then a consumer-directed approach will be used in the provision of attendant care services. Each individual who elects to receive attendant care services must agree to and be capable of recruiting, hiring, training, managing and terminating attendants. The client must also monitor attendant service timesheets and approve payment to the attendant for services provided by signing the timesheets.

   Clients who can comprehend the rights and accept the responsibilities of consumer-directed care may wish to have alternatives attendant care services included on their plan of care. The client's plan of care will be submitted to the client's attending physician for his or her review and approval.

B. The Evaluation of Need for Nursing Home Care Form (DHS-703) completed by the waiver counselor for each Alternatives Waiver applicant will contain information relative to the client's functional, social and environmental situation.

C. Clients receiving attendant care will not be able to access personal care that is a duplication of APD services. However, receiving attendant care services does not automatically preclude the client from receiving personal care services. Medically necessary personal care may be provided, but only if it is included in the evaluation and plan of care and is not a duplication of services. The personal care service plan must be attached to the APD plan of care.

D. To aid in the attendant care recruitment process, clients will be apprised of the minimum qualifications set forth for provider certification (See section 213.220) and the Medicaid enrollment and reimbursement process. The client will be instructed to notify the waiver counselor when an attendant has been recruited. The waiver counselor will facilitate the development of a formal service agreement between the client and the attendant, using the form AAS-9512, Attendant Care Service Agreement.

E. When the AAS-9512, Attendant Care Service Agreement, is finalized, the attendant will apply for DAAS certification and Medicaid provider enrollment. The waiver counselor will assist as needed to expedite this process. As an enrolled Medicaid provider, the attendant will be responsible for all applicable Medicaid participation requirements, including claims submission.

F. Refer to section 243.100 of this manual for the procedure code to be used with filing claims for this service.

220.000 PRIOR AUTHORIZATION 6-1-04

An authorized plan of care signed by the client's physician is required to determine medical necessity for receiving Alternatives for Adults with Physical Disabilities Waiver (APD) services. Payment of claims must be approved by the waiver counselor responsible for the development and monitoring of the APD client's plan of care. (Refer to section 212.220.)

For dates of service on and after June 1, 2004, APD services require assignment of a prior authorization (PA) number. When prior authorization of service delivery is approved, Division of Aging and Adult Services (DAAS) central office staff will assign a PA number and notify the provider, recipient and the waiver counselor. The PA number must be entered in the prior authorization number field of the paper claim form or the electronic software screen.

240.000 BILLING PROCEDURES 6-1-04

241.000 Introduction to Billing 6-1-04

Alternatives for Adults with Physical Disabilities Waiver providers use the CMS-1500 (formerly HCFA-1500) form and the Alternatives Attendant Care Provider Claim Form (AAS-9559) 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 claims submission.

242.000 CMS-1500 (formerly HCFA-1500) Billing Procedures 6-1-04

242.100 Alternatives Waiver Procedure Codes 6-1-04

The following procedure codes must be billed with a type of service "9":

National Code	Local Code	Local Code Description
S5165	Z2292	Environmental Accessibility Adaptations/Adaptive Equipment

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 10-13-03

Place of Service	Paper Claims	Electronic Claims	Type of Service (paper only)
Patient's Home	4	12	9 - Alternatives Waiver

242.300 Billing Instructions - Paper Only 6-1-04

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 that require attachments or manual pricing.

To bill for environmental accessibility adaptations/adaptive equipment services, use the CMS-1500 (formerly HCFA-1500). The numbered items correspond to numbered fields on the claim form. **View a sample CMS-1500 form.** The following instructions must be read and carefully followed 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 the EDS Claims Department. **View or print EDS Claims Department contact information**.

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.

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 related to employment (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	Not required.
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 not required for Alternatives for Adults with Physical Disabilities waiver services.
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	Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims.
19.	Reserved for Local Use	Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims.
20.	Outside Lab?	Not applicable to Alternatives for Adults with Physical Disabilities 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 receipt dates.
22.	Medicaid Resubmission Code	Reserved for future use.
	Original Ref No.	Reserved for future use.
23.	Prior Authorization Number	Enter the prior authorization number.

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 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 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 from Section 242.100.
	Modifier	Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims.
	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	Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims.
	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	Not required.
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 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 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
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#."

242.400 Special Billing Procedures 6-1-04

All environmental accessibility adaptation/adaptive equipment claims must be filed on paper using form CMS-1500 and with attached documentation verifying the services provided.

243.000 Alternatives Attendant Care Provider Claim Form (AAS-9559) Billing Instructions 6-1-04

243.100 Alternatives Waiver Attendant Care Procedure Codes 6-1-04

The following procedure codes must be billed for attendant care services. Paper claims require a type of service code "9".

National Code	Local Code	Local Code Description
S5125	Z2291	Attendant Care

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.

243.200 Place of Service and Type of Service Codes 6-1-04

Place of Service	Paper Claims	Electronic Claims	Type of Service (paper only)
Patient's Home	4	12	9 – Alternatives Waiver

243.300 Billing Instructions – Paper Only 6-1-04

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 that require attachments or manual pricing.

To bill for attendant care services, use the Alternatives Attendant Care Provider Claim Form (AAS-9559). View a sample Alternatives Attendant Care Provider Claim Form (Form AAS-9559). The following instructions must be read and carefully followed 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.

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.

243.310 Completion of Alternatives Attendant Care Provider Claim Form (AAS-9559) 6-1-04

Form AAS-9559 is obtained from the client employer after the top portion of the form is completed by the Division of Aging and Adult Services (DAAS) Waiver Counselor. The form must be signed by the client or an authorized person.

The middle portion of the form is used by the provider to record the amount of time worked by entering the information requested on the form.

The bottom section of the form is provider identification information. The prior authorization number for authorized services must be entered on the line where indicated. The provider must sign the form. Refer to the DAAS Attendant Care Provider Manual for complete billing information.

243.400 Special Billing Procedures 6-1-04

Attendant care services may be billed either electronically or on paper. Refer to Section III of this manual for information on electronic billing.

When filing paper claims for attendant care, form AAS-9559 must be used.

PROPOSED

ALTERNATIVES ATTENDANT CARE
PROVIDER CLAIM FORM

1. MEDICARE	MEDICAID	CHAMPUS	CAMPVA	GROUP HEALTH PLAN	FECA	OTHER BLK LUNG	1a. MEDICAID NUMBER (for program in item 1)
☐ (Medicare #)	☒ (Medicaid #)	☐ (Sponsor's SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	☐ (ID)	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM / DD / YY	Gender M ☐ F
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other	
CITY / STATE	8. PATIENT STATUS: Single ☐ Married ☐ Other	
ZIP CODE / TELEPHONE (Include Area Code)	Full-Time ☐ Part-Time ☐	

FOR BILLING OFFICE USE ONLY

Procedure Code: S5125

Type of Service Code: 9

Diagnosis Code:

9

CLIENT OR AUTHORIZED PERSON'S SIGNATURE (Must Be Signed)

I authorize the release of any medical or other information necessary to request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned.

SIGNED _____ **DATE:** _____

ATTENDANT CARE BILLING

DATES OF SERVICE						
DATE	DAY OF WEEK	TIME IN	TIME OUT	HOURS WORKED	UNITS WORKED (Hours X 4)	BILLING AMOUNT (Units X $2)
			TOTALS			

PROVIDER INFORMATION

NAME:	PIN #	SSN#
ADDRESS:		
PHONE #	PRIOR AUTHORIZATION (PA) #	

Provider Signature and Date

Mail Claim Form to EDS, Alternatives Claims,
P.O. Box 709, Little Rock, AR 72203
Phone: 1 (800) 457-4454

AAS-9559 (2/04)