26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a **service** plan, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home **or, at the State's option, another location**.

(a) Effective for dates of service on and after July 1, 2004, Personal Care Aide Services are reimbursed per unit of service, based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. One unit equals fifteen (15) minutes. The Title XIX maximum charge allowed is $13.84 per hour, which is $3.46 per 15-minute unit.

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: **Arkansas Medicaid Personal Care Providers**

DATE: **July 1, 2004**

SUBJECT: **Provider Manual Update Transmittal No. 56**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
217.110	10-13-03	217.110	7-1-04
250.000	10-13-03	250.000	7-1-04
262.310	10-13-03	262.310	7-1-04
262.410	10-13-03	262.410	7-1-04

Explanation of Updates

Arkansas Act 17 of 2003, Section 18, 1st Extraordinary Session, requires the Arkansas Department of Human Services to increase the maximum allowed hourly reimbursement in the Arkansas Medicaid Personal Care Program from $12.35 to $13.84. Effective for dates of service on and after July 1, 2004, Arkansas Medicaid defines a unit of service in the Personal Care Program as 15 minutes of personal care aide service. Reimbursement for a 15-minute unit of service will be the lesser of the amount billed or the Medicaid maximum allowable fee, which is $3.46.

Section 217.110, part A, 2: References to “service-time increments” have been changed to “units”.

Section 250.000: In part B, the reference to one hour as a unit of service has been changed to 15 minutes. Parts C, D and E have been deleted.

Section 262.310: This section has been renamed. It replaces former sections 262.310, 262.311 and 262.312.

Section 262.410, Field 24, items F and G: References to “service-time increments” have been changed to “units”. Other revisions to section 262.410 have been made only to improve the readability and relevance of the text and do not represent new policy.

Paper versions of this update transmittal include pages to file in your provider manual. See Section I for instructions on updating the paper version of the manual. The changes made in this update transmittal will be incorporated automatically into electronic versions of the Personal Care provider manual.

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

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

Thank you for your participation in the Arkansas Medicaid Program.

_____
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**.

217.110 Provider Notification of Benefit Extension Determinations 7-1-04

A. DMS will approve or deny the request—or ask for additional information—within two weeks.

B. DMS reviewers will advise the provider of their decision by means of the Provider Notification page of form DMS-618. **View or print form DMS-618**.

1. Notification of benefit extension approval includes:
   a. The procedure code approved,
   b. The total number of units approved for the procedure code,
   c. The benefit extension control number and
   d. The approved beginning and ending dates of service.
2. The DMS reviewers who approved or denied the request sign and date the notification.

PROPOSED

250.000 REIMBURSEMENT 7-1-04

A. Reimbursement for personal care services is the lesser of the amount billed or the Arkansas Title XIX (Medicaid) maximum allowed fee.

B. Reimbursement for Arkansas medicaid Personal Care services is based on a 15-minute unit of service.

PROPOSED

262.310 Unit Billing 7-1-04

A. Fifteen minutes of authorized, documented and logged personal care equals one unit of personal care aide service.

B. Providers may not bill for less than fifteen minutes of service; however personal care aides' time spent providing services for a single client may be accumulated during a single, 24-hour calendar day, and the sum divided by 15 to calculate the number of units of service provided during that day.

C. The estimated daily maximum service time in the client's service plan is the upper limit for daily billing.

D. In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single client.

E. There is no "carryover" of time from one day to another or from one client to another.

F. The aide's time spent on documentation and logging activities may be included as service time for the service being documented. No other administrative activities qualify as service time.

PROPOSED

262.410 Completion of CMS-1500 Claim Form 7-1-04

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 personal care client'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 name of the other insured's employer or school, when applicable.
	d. Insurance Plan Name or Program Name	Enter the name of the other insured's insurance company.
10.	Is Patient's Condition Related to:	
	a. Employment	Check "YES" if the patient's condition is employment related (current or previous). If the condition is not employment related, check "NO."

PROPOSED

	b. Auto Accident	Check the appropriate box if the beneficiary's condition is auto accident related. If "YES", enter the place (two letter state postal abbreviation) where the accident occurred. Check "NO" if the condition is not auto accident related.
	c. Other Accident	Check "YES" if the beneficiary's condition is other accident related. Check "NO" if it is 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 name of the insured's employer or school.
	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 the services provided are related to an accident. When applicable, 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	Enter the referring physician's name. A primary care physician (PCP) referral is required for Arkansas Medicaid Personal Care services, unless the beneficiary is exempt from PCP enrollment.
17a.	I.D. Number of Referring Physician	Enter the referring physician's 9-digit Arkansas Medicaid individual provider number.
18.	Hospitalization Dates Related to Current Services	Not applicable to the Personal Care Program.
19.	Reserved for Local Use	**LEA#** - When the provider is a public school or an education service cooperative that is billing for services performed in a public school, enter the Local Education Agency (LEA) number of the school district in which the client resides.
20.	Outside Lab?	This field is not required for Medicaid.

PROPOSED

21. Diagnosis or Nature of Illness or Injury	Enter the pertinent diagnosis codes from ICD-9-CM. Up to four diagnoses may be listed.
22. Medicaid Resubmission Code	Not required by Medicaid
Original Ref No.	Not required by Medicaid
23. Prior Authorization Number	Enter the prior authorization or benefit extension control number when applicable.
24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See Section 262.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 262.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 262.100 through 262.140.
Modifier	Enter the applicable modifier(s).
E. Diagnosis Code	Enter a diagnosis code that corresponds to a diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only one diagnosis code or one diagnosis code line number on each claim detail. If two or more diagnosis codes apply to a service, use the code most appropriate to that service.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If billing for more than one unit of service, enter the total charge for the number of units in the claim detail.
G. Days or Units	Enter the applicable units of service (in whole numbers) for the period indicated in Field 24A.
H. EPSDT/Family Plan	Enter "E" if the personal care services are 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	Not applicable to the Arkansas Medicaid Personal Care Program.

PROPOSED

25.	Federal Tax I.D. Number	Federal Employer Identification Number (FEIN). This field is not required for Medicaid. The information is carried in the provider's Medicaid file. If it changes, please contact the Provider Enrollment Unit.
26.	Patient's Account No.	This optional entry is for accounting purposes. Enter the beneficiary's account number. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Providers automatically accept assignment 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 received from other sources toward payment of this claim. The source(s) 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 beneficiary, unless the beneficiary has an insurer that requires co-pay. In such a case, enter the sum of the insurer's payment and the beneficiary's co-pay, without regard to whether the beneficiary has remitted the co-pay amount. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge, which is calculated by subtracting the amount indicated in Field 29 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	An authorized individual must sign and date the claim, certifying that the services were furnished in accordance with the rules and regulations set forth in this provider manual and official Medicaid correspondence. "Provider's signature" is defined as a 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 the personal care provider (i.e., school, agency etc.) is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	Enter the name and address of the service location (if other than the beneficiary's home) specifying the street, city, state and zip code.
33.	Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the personal care provider's name and complete address. A telephone number is requested but not required.

PROPOSED

PIN #	This field is not required for Arkansas Medicaid Personal Care.
GRP #	Enter the 9-digit Arkansas Medicaid Personal Care provider number.

PROPOSED