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 Health Care Providers - Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)**

DATE: **March 15, 2005**

SUBJECT: **Provider Manual Update Transmittal No. 70**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
217.060 – 217.068	10-13-03	217.060 – 217.069	3-15-05
244.000 – 245.000	10-13-03	244.000 – 245.200	3-15-05
250.710 – 270.714	10-13-03	250.710 – 250.717	3-15-05
272.430 – 272.439	10-13-03	272.430 – 272.435	3-15-05

Explanation of Updates

Section 217.060: This section has been expanded to include generic information regarding organ transplants and to give an overview of Medicaid coverage.

Section 217.061: This section explains Arkansas Medicaid's hospital coverage of bone marrow transplants.

Section 217.062: This section explains Arkansas Medicaid's hospital coverage of corneal transplants.

Section 217.063: This section explains Arkansas Medicaid's hospital coverage of heart transplants.

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Sections 245.000 through 245.200: These sections are included for informational purposes.

Section 250.710: This section provides an overview of Arkansas Medicaid's organ transplant reimbursement methodologies, effective for dates of service on and after December 3, 2004.

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Section 250.715: This section explains Arkansas Medicaid's reimbursement methodologies for organ acquisition related to "other covered transplants."

Section 250.716: This section explains that beneficiaries may not be charged for Medicaid-covered charges in excess of the State's reimbursement.

Section 250.717: This section was formerly section 250.714.

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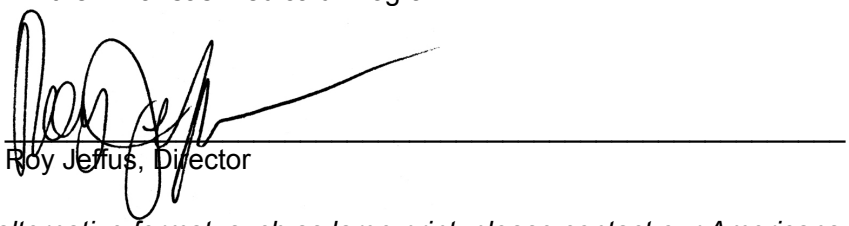

Roy Jeffus, Director

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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.

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.

217.060 Transplants 3-15-05

A. All transplants require prior approval.

B. Medicaid covers the following transplants for beneficiaries of all ages: bone marrow, corneal, heart, kidney, liver and lung.

C. Medicaid covers the following transplants for beneficiaries under the age of 21 who are participating in the Child Health Services (EPSDT) Program: liver/bowel (effective for dates of service on and after December 3, 2004), pancreas/kidney and skin transplants for burns.

D. Inpatient hospital stays for corneal, kidney, pancreas/kidney and skin transplants are subject to Medicaid Utilization Management Program—MUMP—precertification.

E. Regarding inpatient stays related to all organ transplants *except* bone marrow, corneal, kidney, pancreas/kidney and skin:

1. Hospital days in excess of transplant length of stay averages require medical review and approval by the Quality Improvement Organization (QIO), which is Arkansas foundation for Medical Care, Inc. (AFMC).

2. AFMC's reference sources for organ transplant length-of-stay (LOS) averages are the *Centers for Medicare and Medicaid Services (CMS) Acute Inpatient Prospective Payment System (PPS)*—using the "Arithmetic Mean LOS" method—and/or the most recently published *Medicare National Coverage Decisions*.

F. With the exception of cornea, kidney and pancreas/kidney acquisition, Medicaid covers hospitals' organ acquisition costs by means of the reimbursement methodologies explained in detail in section 250.714.

G. With the exception of bone marrow transplants, inpatient days between the admission date and the date of the transplant procedure are subject to MUMP guidelines.

217.061 Bone Marrow Transplants 3-15-05

A. Medicaid covers the following hospital services related to bone marrow transplantation.

1. Hospital services related to harvesting the bone marrow from a living donor.
2. Hospital services related to transplantation of the bone marrow into the receiver.
3. Post-operative services for the donor and the recipient.

B. Inpatient stays for bone marrow transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of admission for the transplant procedure to the date of discharge.

217.062 Corneal Transplants 3-15-05

A. Medicaid covers hospitalization related to corneal transplants from the date of the transplant procedure until the date of discharge, subject to the beneficiary's inpatient benefit utilization status if he or she is aged 21 or older and subject to MUMP precertification requirements.

B. Coverage includes the preservation of the organ from a cadaver donor but not the harvesting of the organ.

217.063 Heart Transplants 3-15-05

A. Medicaid covers the following hospital services related to heart transplantation.

1. Hospital services related to the transplantation of the heart into the receiver.
2. Post-operative services.

B. Inpatient stays for heart transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from AFMC medical review. (See Section 217.060, part E.)

217.064 Liver Transplants 3-15-05

A. Medicaid covers the following hospital services related to liver transplantation.

1. Hospital services related to harvesting a partial organ from a living donor.
2. Hospital services related to the transplantation of the liver (or of a partial liver from a living donor) into the receiver.
3. Post-operative services (including those for the donor, when applicable).

B. Inpatient stays for liver transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from AFMC medical review. (See Section 217.060, part E.)

217.065 Liver/Bowel Transplants 3-15-05

A. Effective for dates of service on and after December 3, 2004, Medicaid covers liver/bowel transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

B. The following hospital services related to liver/bowel transplants are covered:

1. Hospital services related to the transplantation of the liver/bowel into the receiver.
2. Post-operative services.

C. Inpatient stays for liver/bowel transplants are exempt from the MUMP. The services that are excluded from the MUMP are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from AFMC medical review. (See Section 217.060, part E.)

217.066 Lung Transplants 3-15-05

A. The following conditions and diseases are those for which it is believed patients can benefit significantly from a lung transplant when the disease has reached an end-stage cycle or level.

1. Pulmonary vascular diseases:
   a. Primary pulmonary hypertension
   b. Eisenmenger's Syndrome (ASD, VSD, PVA, truncus, other complex anomalies)
   c. Pulmonary hypertension secondary to thromboembolic disease
2. Obstructive lung diseases:
   a. Emphysema (idiopathic)
   b. Emphysema (alpha antitrypsin deficiency)
   c. Bronchopulmonary dysplasia

d. Post-transplant obliterative bronchiolitis
e. Bronchiolitis obliterans organizing pneumonia (BOOP)

3. Restrictive lung diseases:
a. Idiopathic pulmonary fibrosis
b. Sarcoidosis
c. Asbestosis
d. Eosinophilic granulomatosis
e. Desquamative interstitial pneumonitis
f. Lymphangioleiomyomatosis

B. Medicaid covers the following hospital services related to lung transplantation.

1. Hospital services related to the transplantation of the lung into the receiver.
2. Post-operative services.

C. Inpatient stays for lung transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from AFMC medical review. (See Section 217.060, part E.)

217.067 Kidney (Renal) Transplants 3-15-05

A. When a candidate for a renal transplant is not eligible under Medicare, but is eligible under the Medicaid program, Medicaid will cover a prior-approved transplant.

B. Medicaid covers the following hospital services related to renal transplantation.

1. Hospital services related to the surgical procedure for the removal of the organ from a living donor.
2. Hospital services related to the transportation and/or preservation of the organ from a living donor.
3. Hospital services related to the transplantation of the kidney into the receiver.
4. Post-operative services (including those for a living donor, when applicable.)

C. Renal transplants are subject to the same inpatient hospital and outpatient hospital benefit limits (including MUMP) as all other inpatient and outpatient services, for both donor and receiver.

217.068 Pancreas/Kidney Transplants 3-15-05

A. Medicaid covers prior-approved pancreas/kidney transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program who have a diagnosis of juvenile diabetes with renal failure.

B. Inpatient stays for pancreas/kidney transplants are subject to the MUMP.

217.069 Skin Transplants 3-15-05

A. Medicaid covers prior-approved skin transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program who have burns of greater than 70% of the body's surface area with more than 50% of that area being full-thickness or third-degree burns.

B. Medicaid covers the following hospital services related to skin transplantation.

1. Hospital services related to the removal of the skin from the donor site.
2. Hospital services related to the transplantation of the skin.
3. Post-operative services, subject to the limitations of the MUMP.

244.000 Procedures that Require Prior Authorization 3-15-05

A. The procedures represented by the CPT and HCPCS codes in the following table require prior authorization (PA). The performing physician or dentist (or the referring physician or dentist, when lab work is ordered or injections are given by non-physician staff) is responsible for obtaining required PA and forwarding the PA control number to appropriate hospital staff for documentation and billing purposes. A claim for any hospital services that involve a PA-required procedure must contain the PA control number assigned by Medicaid or EDS will deny it.

D9220	J1565	J7340	Q0182	11960	11970	11971	15342
15343	15831	19318	19324	19325	19328	19330	19340
19342	19350	19355	19357	19361	19364	19366	19367
19368	19369	19370	19371	19380	20974	20975	21076
21077	21079	21080	21081	21082	21083	21084	21085
21086	21087	21088	21089	21120	21121	21122	21123
21125	21127	21137	21138	21139	21141	21142	21143
21145	21146	21147	21150	21151	21154	21155	21159
21160	21172	21175	21179	21180	21181	21182	21183
21184	21188	21193	21194	21195	21196	21198	21199
21208	21209	21244	21245	21246	21247	21248	21249
21255	21256	22520	22521	22522	30220	30400	30410
30420	30430	30435	30450	30460	30462	33140	33282
33284	36470	36471	37785	37788	38242	42820	42821
42825	42826	42842	42844	42845	42860	42870	43842
43846	43847	43848	43850	43855	43860	43865	50320
50340	50360	50365	50370	50380	51925	54360	54400
54415	54416	54417	55400	57335	58150	58152	58180
58260	58262	58263	58267	58270	58275	58280	58290
58291	58292	58293	58294	58345	58550	58552	58553
58554	58672	58673	58750	58752	59135	59840	59841
59850	59851	59852	59855	59856	59857	59866	61850
61860	61870	61875	61880	61885	61886	61888	63650
63655	63660	63685	63688	64573	64585	64809	64818
65710	65730	65750	65755	67900	69300	69310	69320
69714	69715	69717	69718	69930	87901	87903	87904
92607	92608	93980	93981				

B. The following revenue codes require prior authorization.

Revenue Code	Description
92393	Ocular prosthesis
0361	Outpatient dental surgery, Group I
0360	Outpatient dental surgery, Group II
0369	Outpatient dental surgery, Group III
0509	Outpatient dental surgery, Group IV

245.000 Prior Approval and Due Process Information 3-15-05

A. Organ transplants in Arkansas and in states that border Arkansas require prior approval from Arkansas Medicaid.

B. In states that do not border Arkansas, organ transplants *and* organ transplant evaluations require prior approval from Arkansas Medicaid.

245.010 Organ Transplant Prior Approval in Arkansas and Bordering States 3-15-05

The attending physician is responsible for obtaining prior approval for organ transplants.

A. The attending physician submits his or her transplant evaluation (workup) results to the Utilization Review (UR) Section, requesting approval of the transplant. **View or print the UR Section contact information.**

B. UR forwards the request and its supporting documentation to Arkansas Foundation for Medical Care, Inc. (AFMC) for a determination of approval or denial.

C. AFMC advises the requesting physician and the beneficiary of its decision.

245.020 Organ Transplant and Evaluation Prior Approval in Non-Bordering States 3-15-05

A. In states that do not border Arkansas, prior approval is required for organ transplant evaluations and organ transplants.

B. The attending physician is responsible for obtaining prior approval for organ transplant evaluations and organ transplants.

1. The attending physician must request from the UR Section prior approval of a transplant evaluation, identifying the facility at which the evaluation is to take place and the physician who will conduct the evaluation. **View or print the UR Section contact information.**
2. UR reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.
3. The evaluation results must be forwarded to UR with a request for approval of the transplant procedure.
4. UR forwards the request and the supporting documentation to AFMC for a determination of approval or denial.
5. AFMC advises the requesting physician and the beneficiary of its decision.

245.100 Requests to Reconsider Denied Prior Approvals 3-15-05

A. Medicaid allows only one reconsideration of a denied approval request.

B. Reconsideration requests that do not include required documentation will be denied automatically.

C. Requests to reconsider transplant prior approval denials must be received by UR within 30 calendar days of the date of the **NOTICE OF ACTION** denial letter. When requesting reconsideration:

1. Return all previously submitted documentation and pertinent additional information to justify the medical necessity of the denied transplant.

2. Include a copy of the **NOTICE OF ACTION** denial letter with the resubmission.

245.200 Beneficiary Appeal Process for Denied Prior Approvals 3-15-05

When DMS or its designee (AFMC in this case) denies a request for prior approval of a transplant or transplant evaluation, the beneficiary may appeal the denial and request a fair hearing.

A. An appeal request must be in writing.

B. The appeal request must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the **NOTICE OF ACTION** denial letter. **View or print the Department of Human Services, Appeals and Hearings Section contact information.**

250.710 Organ Transplant Reimbursement 3-15-05

Effective for dates of service on and after December 3, 2004, Arkansas Medicaid reimburses hospitals for organ transplants in accordance with one of four methodologies.

A. Three of the reimbursement methodologies apply to all in-state acute care/general hospitals, all bordering city hospitals and all out-of-state hospitals, except for in-state pediatric hospitals and Arkansas state-operated teaching hospitals.

B. With the exception of inpatient stays for bone marrow transplants, inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

C. Organ transplant reimbursement methodologies are explained in sections 250.711 through 250.717.

250.711 Bone Marrow Transplants 3-15-05

A. Interim reimbursement for bone marrow transplants is 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed.

1. Total reimbursement for all covered transplant-related services (except any services specifically exempted in this section) may not exceed $150,000.00.

2. Medicaid's remittance includes reimbursement for all covered inpatient hospital services related to the transplant procedure (unless excluded in this section) from the date of admission for the bone marrow transplant procedure to the date of discharge.

B. The hospital claims and the physician claims are manually priced simultaneously after all participating providers have filed their claims.

C. When the combined total of 80% of all participating providers' billed charges exceeds the $150,000.00 maximum allowed reimbursement, each provider's reimbursement is decreased by an equal percentage until the combined total does not exceed the $150,000.00 limit.

D. Medicaid's reimbursement of the medical expenses of a bone marrow donor is not included in the $150,000.00 maximum reimbursement. Providers may submit charges for services related to the donor's participation as those services occur.

E. Medicaid reimbursement for outpatient donor tissue typing is not included in the $150,000.00 maximum reimbursement allowed for bone marrow transplants. Providers may submit charges for outpatient donor tissue typing services as the services occur.

F. Medicaid reimbursement for donor medical transportation related to a bone marrow transplant is not included in the $150,000.00 maximum reimbursement allowed for bone marrow transplants.

250.712 Corneal, Kidney and Pancreas/Kidney Transplants 3-15-05

The Arkansas Medicaid Program reimburses each hospital for inpatient services related to corneal, kidney and pancreas/kidney transplants in accordance with the same methodology that the Program employs to reimburse the hospital for any other inpatient service.

250.713 Other Covered Transplants in all Hospitals Except In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals 3-15-05

A. Hospital services (not including organ acquisition) related to other covered transplant procedures (i.e., all but bone marrow, corneal, kidney and pancreas/kidney) are reimbursed at 45% of submitted charges.

1. Reimbursement includes all medical services related to the covered transplant procedure from the date of the transplant procedure to the date of discharge.

a. Transplant hospitalization days in excess of transplant length-of-stay averages must be approved through Arkansas Foundation for Medical Care, Inc. (AFMC) medical review.

b. Transplant length-of-stay averages for each transplant type will be determined from the most current written *Medicare National Coverage Decisions*.

2. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

B. Medically necessary (as determined by AFMC) readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same methodology as the initial transplant service at 45% of submitted charges.

250.714 Other Covered Transplants in In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals 3-15-05

A. Hospital services provided by in-state pediatric hospitals and Arkansas state-operated teaching hospitals related to other covered transplant procedures (does not include bone marrow, corneal, kidney or pancreas/kidney) are reimbursed in the same manner as other inpatient hospital services with interim reimbursement and final cost settlement.

B. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

C. Medically necessary (as determined by AFMC) readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same reimbursement methodology as the initial transplant service.

250.715 Organ Acquisition Related to "Other Covered Transplants 3-15-05

Organ transplants other than bone marrow, corneal, kidney and pancreas/kidney are considered "other covered transplants" for the purposes of this rule.

A. Reimbursement for the acquisition of the organ to be transplanted is at:

1. 100% of the submitted organ invoice amount from a third-party organ provider organization or

2. The hospital's reasonable cost with interim reimbursement and year-end cost settlement.

B. The hospital may choose either of the two methods.

1. Under the invoice method, Medicaid will reimburse the hospital 100% of the invoice amount, with no additional reimbursement.

2. Under the interim reimbursement method, Medicaid will remit an interim payment and calculate a year-end cost settlement in a manner consistent with the method used by the Medicare Program for organ acquisition costs.

250.716 Beneficiary Financial Responsibility 3-15-05

The beneficiary may not be billed for Medicaid-covered charges in excess of the State's reimbursement.

250.717 Transportation Related to Transplants 3-15-05

A. Transportation is available for the Medicaid beneficiary through the Arkansas Medicaid Program.

B. Transportation costs are not included in the $150,000.00 maximum reimbursement for bone marrow transplant services.

272.430 Billing for Organ Transplants 3-15-05

A. All associated claims for a transplant evaluation (e.g., physician, lab and X-ray, dental, etc.) must be forwarded to EDS. **View or print EDS Claims Department contact information.**

B. All claims associated with a transplant procedure must be submitted to the Division of Medical Services, Utilization Review (UR) Section. **View or print Utilization Review contact information.** A copy of any third-party payer Explanation of Benefits must be attached to the claim when applicable.

272.431 Billing for Bone Marrow Transplants 3-15-05

All claims associated with a bone marrow transplant must be filed for payment within 60 calendar days from the discharge date of the inpatient stay for the transplant procedure.

A. No claims will be considered for payment after the 60 calendar days have elapsed.

B. If an HIPAA Explanation of Benefits (HEOB) is received from a third-party payer after the 60 calendar days have elapsed, you must forward a copy of the HEOB to the UR Transplant Coordinator.

272.432 Billing for a Living Bone Marrow Donor 3-15-05

You must file a separate claim for the inpatient hospital stay of a living bone marrow donor.

A. If the donor is not an eligible Medicaid beneficiary, file the claim under the eligible Medicaid beneficiary's name and Medicaid ID number.

1. Use ICD-9-CM diagnosis code V59.3 (Donors, bone marrow) for the bone marrow donor.
2. Use ICD-9-CM diagnosis code V70.8 (Other specified general medical examination–examination of potential donor of organ or tissue) for the tissue typing of the donor.

B. If the donor is an eligible Medicaid beneficiary, file the claim under the donor's Medicaid ID number and use the same diagnosis codes listed above.

272.433 Billing for a Living Kidney Donor 3-15-05

You must file a separate claim for the inpatient hospital stay of a living kidney donor.

A. If the donor is not an eligible Medicaid beneficiary, file the claim under the eligible Medicaid beneficiary's name and Medicaid ID number.

1. Use ICD-9-CM diagnosis code V59.4 (Donors, kidney) for the renal donor.
2. Use ICD-9-CM diagnosis code V70.8 (Other specified general medical examination–examination of potential donor of organ or tissue) for the tissue typing of the donor.

B. If the donor is an eligible Medicaid beneficiary, file the claim under the donor's Medicaid ID number and use the same diagnosis codes listed above.

272.434 Billing for a Living Partial-Liver Donor 3-15-05

You must file a separate claim for the transplant-related inpatient hospital stay of a living donor of a partial liver.

A. If the donor is not an eligible Medicaid beneficiary, file the claim under the eligible Medicaid beneficiary's name and Medicaid ID number.

1. Use ICD-9-CM diagnosis code V59.4 (Donors, kidney) for the renal donor.

2. Use ICD-9-CM diagnosis code V70.8 (Other specified general medical examination–examination of potential donor of organ or tissue) for the tissue typing of the donor.

B. If the donor is an eligible Medicaid beneficiary, file the claim under the donor's Medicaid ID number and use the same diagnosis codes listed above.

272.435 Tissue Typing 3-15-05

A. CPT procedure codes **86805**, **86806**, **86807**, **86808**, **86812**, **86813**, **86816**, **86817**, **86821** and **86822** are payable for the tissue typing for both the donor and the receiver.

B. The tissue typing is subject to the $500.00 annual lab and X-ray benefit limit.

1. Extensions will be considered for beneficiaries who exceed the $500.00 annual lab and X-ray benefit limit.

2. Providers must request an extension.

C. Medicaid will authorize up to 10 tissue-typing lab procedures to determine a match for an unrelated bone marrow donor.

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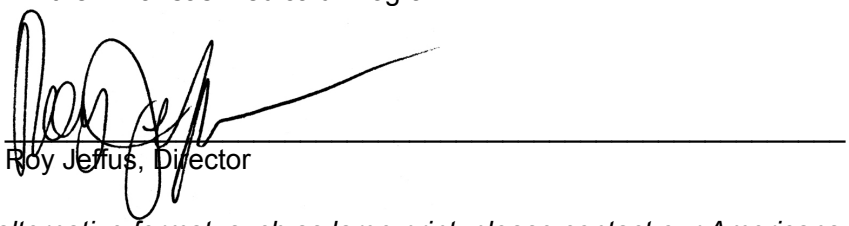

Roy Jeffus, Director

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.

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.

Arkansas Division of Medical Services
DDTCS Transportation Survey

DDTCS Transportation Provider Name _____
Medicaid DDTCS Transportation Provider Number _____
Fiscal Reporting Period/Survey Period _____ **through** _____
(Information not required if less than 6 months)

Total DDTCS Loaded Miles _____
Total DDTCS Unloaded _____
Total DDTCS Miles _____

Unduplicated Count of Medicaid DDTCS Clients Transported _____
Unduplicated Count of Non-Medicaid DDTCS Clients Transported _____

Medicaid DDTCS Transportation Revenue _____
Non-Medicaid DDTCS Transportation Revenue _____
Total DDTCS Transportation Revenue _____

Direct Costs – DDTCS Transportation

Drivers Salaries	$_____
Drivers Fringes/Payroll Taxes	$_____
Escorts Salaries	$_____
Escorts Fringes/Payroll Taxes	$_____
Other Salaries	$_____
Other Fringes/Payroll Taxes	$_____
Program Supplies	$_____
Vehicle Repairs/Maintenance	$_____
Gas and Oil	$_____
Vehicle Rent	$_____
Vehicle Insurance	$_____
Vehicle Depreciation	$_____
Vehicle Interest	$_____
Training	$_____
Direct Utilities	$_____
Direct Telephone	$_____
Direct Building Rent	$_____
Direct Building Utilities	$_____
Direct Building Depreciation	$_____
Direct Building Interest	$_____
Other - _____	$_____
Other - _____	$_____
Other - _____	$_____

Total Direct Costs – DDTCS Transportation $_____

Indirect/Overhead Costs – DDTCS Transportation $_____

Total DDTCS Transportation Costs $_____

(Report Cost in Dollars Only, No Cents)

Name (print) of person completing survey _____

Title/Position _____

Signature _____ Date _____

DDTCS Transportation Survey Instructions

The Survey revenue and expense information is to be reported using the accrual basis of accounting.

If your financial reporting period is less than six (6) months, you are not required to submit the survey. However, you must notify the Division of Medical Services, in writing, that no survey is being submitted due to this reason.

The survey information requested includes direct and indirect/overhead costs, revenues and client mileage information associated with and applicable to the DDTCS transportation program only. Costs, revenues and mileage information not applicable to DDTCS client transportation should not be included on the survey.

The following line item descriptions are provided to help you complete the Survey:

- "Total DDTCS Loaded Miles" is the total odometer mileage driven when DDTCS clients (Medicaid or Non-Medicaid) are riding in the vehicle to and from the DDTCS facility where they receive DDTCS Program services. For pick up, loaded miles include the odometer mileage driven from the location where the first DDTCS client (Medicaid or Non-Medicaid) is picked up and ending at the facility location where the DDTCS clients are taken. For delivery, loaded miles include the odometer mileage driven from the facility location where the DDTCS clients board the vehicle and ending at the location where the last DDTCS client (Medicaid or Non-Medicaid) is dropped off.

- "Total DDTCS Unloaded Miles" (no clients riding in vehicle) is the total odometer mileage driven from the DDTCS facility or other parked vehicle location to the location of the first DDTCS client (Medicaid or Non-Medicaid) picked up and odometer mileage driven in returning to the DDTCS facility or other parked vehicle location after dropping off the last DDTCS client (Medicaid or Non-Medicaid).

- Total DDTCS Miles - The sum of the "Total DDTCS Loaded Miles" plus the "Total DDTCS Unloaded Miles"

- Unduplicated Count of Medicaid DDTCS Clients Transported – Use this line to report the total number of eligible Medicaid DDTCS clients transported during the survey period. Each client is counted only once when determining this client count.

- Unduplicated Count of Non-Medicaid DDTCS clients transported – use this line to report the total number of Non-Medicaid DDTCS clients transported during the survey period. Each client is counted only once when determining this client count.

- Medicaid DDTCS Transportation Revenue – Total Medicaid DDTCS Transportation income receivable for dates of service occurring during the survey period

- Non-Medicaid DDTCS Transportation Revenue – Total Non-Medicaid DDTCS client transportation income received for dates of service occurring during the survey period

- Total DDTCS Transportation Revenue – The sum of the Medicaid and Non-Medicaid DDTCS Transportation Revenue

- Direct Costs – DDTCS Transportation – Allowable costs per each line item cost center for providing Medicaid and Non-Medicaid DDTCS Transportation during the survey period

- Total Direct Costs – DDTCS Transportation – The total of all survey period direct allowable costs

- Indirect/Overhead Costs – DDTCS Transportation – Use this line to report the total indirect/overhead costs allocated to the DDTCS Transportation Program; these costs are not already included in a direct line item cost.

- Total DDTCS Transportation Costs – The total of direct and indirect/overhead costs

When completing the survey please keep in mind that (1) "Total DDTCS Unloaded Miles" can never be more than "Total DDTCS Loaded Miles", (2) "Total DDTCS Loaded Miles" and "Total DDTCS Unloaded Miles" cannot be equal (50% of Total DDTCS Miles" each) unless one and only one pick up and drop off site is transported to and from per every van route, and (3) There must always be "Total DDTCS Unloaded Miles" reported with "Total DDTCS Loaded Miles" unless all vans are parked at residential sites where the first DDTCS (Medicaid or Non-Medicaid) client is picked up and the last DDTCS (Medicaid or Non-Medicaid) client is dropped off. **Also, mileage cannot be calculated and reported by simply dividing the Medicaid total DDTCS reimbursement for the period by the per mile rate.**

Please send the completed (1) survey/information or (2) notification of less than a 6 month reporting period to the following address:

Arkansas Department of Human Services
Division of Medical Services, Provider Reimbursement Unit
P.O. Box 1437, S416
Little Rock, AR 72203 – 1437

Providers must also send any additional required allocation and narrative information with their survey. This should include a narrative describing how program costs, revenues and mileage information for programs other than DDTCS were calculated and removed. Providers must also submit with the survey a written general description of what costs are included with indirect/overhead costs and how these costs were identified, calculated and allocated to the DDTCS transportation program. Indirect/overhead cost allocation methods used for survey purposes must be consistent with the method used by the provider in completing their annual financial statements.