18. Hospice Care

Arkansas Medicaid reimburses hospice providers in accordance with the Medicaid fee schedule and hospice wage index requirements published annually by CMS. For the Routine Home Care and Continuous Home Care rates, the hospice wage index to be applied to the wage component subject to index is based on the location of the individual's home. For the Inpatient Respite Care and General Inpatient Care rates, the hospice wage index to be applied to the wage component subject to index is based on the location of the hospice. Public and private providers are reimbursed the same rates.

18. Hospice Care

! The hospice patient must be terminally ill which is defined as having a medical prognosis with a life expectancy of six months or less. The terminal illness must be certified by the patient's attending physician and hospice services prescribed.

! Patients must voluntarily elect to receive hospice services and choose the hospice provider. Hospice election is by Aelection periods≅. Election periods in the Arkansas Medicaid Hospice Program correspond to the election periods established for Medicare. The initial hospice election period is of 90 days duration and is followed by a second 90-day election period. The patient is then eligible for an unlimited number of 60-day election periods.

! Election of the hospice benefit results in a waiver of the **beneficiary's** rights to payment for only those services which are related to the treatment of the terminal illness or related conditions and common to both Title XVIII and Title XIX. The **beneficiary** does not waive rights to payment for services related to the terminal illness that are unique to Title XIX.

! Hospice services must be provided primarily in a patient's residence.

A patient may elect to receive hospice services in a nursing facility **or an intermediate care facility for the mentally retarded (ICF/MR)** if the hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the patient's hospice care, and the facility agrees to provide room and board to the patient.

! Hospice services must be provided consistent with a written plan of care.

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Arkansas Department Of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers - Hospice**

DATE: **November 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #55**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.100	12-1-05	201.100	11-1-06
201.110	10-13-03	201.110	11-1-06
202.000	10-13-03	202.000	11-1-06
210.200	10-13-03	210.200	11-1-06
211.210	10-13-03	211.210	11-1-06
211.220	10-13-03	211.220	11-1-06
211.230	10-13-03	211.230	11-1-06
214.000	10-13-03	214.000	11-1-06
218.000	10-13-03	218.000	11-1-06
240.300	10-13-03	240.300	11-1-06
240.400	10-13-03	240.400	11-1-06
252.100	12-1-05	252.100	11-1-06
252.300	10-13-03	252.300	11-1-06
252.410	10-13-03	252.410	11-1-06
252.420	10-13-03	252.420	11-1-06
253.300	10-13-03	253.300	11-1-06
253.310	10-13-03	253.310	11-1-06

Explanation of Updates

Section 201.100 is included to revise the language regarding the enrollment criteria for Hospice providers.

Section 201.110 is included to change the Department of Health to the *Division* of Health.

Section 202.000 is included to add additional documentation that all providers are required to maintain.

Sections 210.200, 211.210, 211.220, 211.230, 214.000, 240.300, 252.100, 252.410, 253.300 and 253.310 have been updated to include intermediate care facilities for the mentally retarded (ICF/MR's) in the language with nursing facilities. Arkansas Medicaid will reimburse for hospice patients residing in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR).

Section 218.000 is included to replace the word "recipient" with "beneficiary".

Section 240.400 is included to make some grammatical changes and to change the department name to the Department of Health and Human Services along with the abbreviation from DHS to DHHS.

Section 252.100 has also been included to remove obsolete information and to make minor wording changes for clarity.

Sections 252.300, 252.410 and 252.420 have been included to remove obsolete information.

Sections 253.300 and 253.310 have also been included to make a minor wording change for clarity. The word “recipient” has been changed to *patient.*

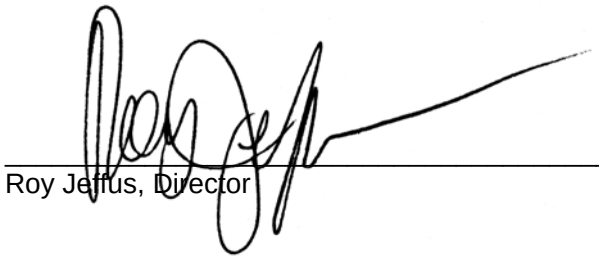
Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

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.

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.

Thank you for your participation in the Arkansas Medicaid Program.



Roy Jeffus, Director

SECTION II - HOSPICE

CONTENTS

200.000 HOSPICE GENERAL INFORMATION 10-13-03

201.000 Arkansas Medicaid Participation Requirements for Hospice Providers 10-13-03

201.100 Enrollment Criteria 11-1-06

Providers of hospice services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program:

A. The hospice provider must be certified as a Title XVIII (Medicare) hospice provider.

1. The provider must submit a copy of the Medicare certification to Provider Enrollment when submitting the Hospice Program application and contract.
2. Subsequent Medicare certifications must be forwarded to Provider Enrollment within 30 days of issuance.
3. Failure to ensure that current Medicare certification is on file with Provider Enrollment will result in termination from the Arkansas Medicaid Program.

B. The hospice provider must be licensed by the Division of Health Facility Services, Arkansas Division of Health. The provider must submit a copy of their current license. The provider must submit copies of license renewals when they are issued.

C. The hospice provider must complete a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

D. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

E. The Hospice provider must adhere to all applicable professional standards of care and conduct.

201.110 Hospice Inpatient Facilities 11-1-06

A. Providers of short-term inpatient care for hospice patients must be certified by the Division of Health Facility Services, Arkansas Division of Health, as hospice inpatient facilities.

1. The patient's designated hospice provider pays the provider of short-term inpatient services and bills Medicaid for reimbursement.
2. Hospices that have arrangements with certified hospice inpatient facilities must maintain documentation of each such facility's current certification status.

B. Acute care hospitals enrolled in the Arkansas Medicaid Program may provide short-term inpatient care under arrangements with hospice providers. Medicaid requires no additional licensing or certification.

C. Hospices may make arrangements for inpatient respite care with skilled nursing facilities that meet the standards at 42 CFR, 418.100, (a) and (e). Hospices making such arrangements must maintain documented assurances that the facilities meet the referenced standards.

202.000 Record Retention Requirements 11-1-06

A. The hospice provider must keep all required documentation and 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 period is longer.

B. The hospice provider must contemporaneously establish and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities in connection with any Medicaid beneficiary. Failure to furnish records upon request may result in sanctions being imposed.

C. The hospice provider must immediately make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary.

D. All documentation must be available at the provider's place of business.

E. Hospice providers furnishing any Medicaid-covered good or service for which a prescription is required by law, by Medicaid rule, or both, must have a copy of the prescription for such good or service. The provider must obtain a copy of the prescription within five (5) business days of the date the prescription is written.

F. The hospice provider must maintain a copy of each relevant prescription in the Medicaid beneficiary's records and follow all prescriptions and care plans.

G. In the event of post-payment denials with subsequent recoupment of payment for services, DMS will only accept additional documentation received within thirty calendar days following the date of the recoupment letter. No documentation will be accepted after thirty days.

H. See Section 220.000 for a complete listing of required documentation.

210.200 Conditions for Provision of Hospice Service 11-1-06

A. Hospice services require primary care physician (PCP) referral unless the patient is exempt from PCP referral requirements.

B. The hospice patient must be terminally ill. "Terminally ill" is defined as having a medical prognosis with a life expectancy of six months or less. The hospice must obtain the certification that an individual is terminally ill in accordance with the following requirements:

1. For the first 90-day election period of hospice coverage, the hospice must obtain, no later than two days after the initiation of hospice care, written certification statements signed by the hospice medical director or the physician member of the hospice interdisciplinary group and the individual's attending physician or PCP.
    a. If the hospice does not obtain a written certification within two days after the initiation of hospice care, an oral certification may be obtained within these two days, and a written certification obtained no later than eight days after care is initiated.
    b. If these requirements are not met, the provider is not eligible for reimbursement of hospice services furnished before the date that written certification is obtained.
2. For any subsequent election period, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the hospice medical director or the physician member of the hospice's interdisciplinary group.

C. Patients must voluntarily elect to receive hospice services and choose their hospice provider.

D. Patients who elect to receive hospice services must receive hospice services instead of certain other Medicaid benefits. See Section 214.000, subpart D, for more details in this regard.

E. Hospice services must be provided primarily in a patient's place of residence.

1. A patient may elect to receive hospice services in a nursing facility or intermediate care facility for the mentally retarded (ICF/MR) if:

a. The Department of Health and Human Services has determined that the patient is eligible for nursing facility or ICF/MR care and

b. The hospice and the facility have a written agreement under which:

i. The hospice takes full responsibility for the professional management of the patient's hospice care and

ii. The facility agrees to provide room and board to the patient.

2. When a patient elects to receive hospice care in a nursing facility or ICF/MR, the hospice pays the nursing facility or ICF/MR for the patient's room and board and bills Medicaid for reimbursement.

F. Hospice services must be provided in accordance with a written plan of care.

211.210 Routine Home Care 11-1-06

Each day the patient is at his or her place of residence or at a nursing facility or ICF/MR, and the patient receives less than eight hours of hospice care in one calendar day (midnight to midnight), it is a routine home care day.

211.220 Continuous Home Care 11-1-06

A. Continuous home care is to be provided only during a period of crisis in which more than routine care is required to achieve palliation or management of the patient's acute medical symptoms.

B. For a day of hospice care to qualify as a continuous home care day, a minimum of eight hours of care must be provided during a twenty-four-hour day which begins and ends at midnight.

1. This care need not be continuous, e.g., four hours of care could be provided in the morning and another four hours in the evening of that day.

2. A nurse must be providing care for more than half of the period of care each day.

3. Homemaker and aide services may also be provided to supplement the nursing care.

C. Continuous home care is a covered service for hospice patients who reside in nursing facilities or ICF/MR's.

211.230 Inpatient Respite Care 11-1-06

A. Inpatient respite care is short-term inpatient care provided to the patient only when necessary to relieve the family members or other persons caring for the individual at home.

1. Inpatient respite care may be provided only twice and is not covered for more than five consecutive days per stay.

2. The sixth and subsequent days of an inpatient respite stay are covered only as routine home care days.

B. A hospice patient may receive inpatient respite care at an acute care hospital, in a hospice inpatient facility or in a skilled nursing facility that meets the standards at 42 CFR, 418.100, (a) and (e).

C. Hospice patients residing in nursing facilities or ICF/MR's are not eligible for inpatient respite care.

214.000 Election 11-1-06

A. A patient electing hospice care must file an election statement with the designated hospice.

1. The provider must furnish a printed statement that meets all the conditions of this section.
2. The patient must sign and date the election statement.

B. An election to receive hospice care continues through the initial election period and through any subsequent election periods without a break in care as long as the patient remains in the care of the hospice.

C. A patient must designate an effective date for the election period.

1. The effective date may be the first day of hospice care or any subsequent day of hospice care.
2. A patient may not designate an effective date that is earlier than the date on which the election is made.

D. A patient must waive all rights to Medicaid coverage of the following services for the duration of the election of hospice care:

1. Hospice care provided by a hospice other than the hospice designated by the patient, unless provided under arrangements made by the designated hospice.
2. Any Medicaid services that are related to treatment of the terminal condition for which hospice care was elected or of a related condition; or that are equivalent to hospice care except for services:
    a. Provided (either directly or under arrangement) by the designated hospice.
    b. Provided as room and board by a nursing facility or ICF/MR if the individual is a resident.
    c. Provided by the patient's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.
3. Home Health Program services and drugs and biologicals obtained through the Arkansas Medicaid Pharmacy Program for the palliation and management of symptoms related to the patient's terminal illness,

E. When an election period ends, the patient's waiver of other Medicaid benefits expires and regular Medicaid coverage is possible if the patient revokes hospice care for the subsequent election period.

F. An individual eligible for both Medicare and Medicaid must elect the hospice benefit simultaneously under both programs.

G. When a hospice discharges a patient because the patient's condition is no longer considered terminal, the patient's waiver of other Medicaid benefits expires immediately and regular Medicaid coverage is possible.

218.000 Plan of Care 11-1-06

A written plan of care must be established and maintained for each individual admitted to a hospice program and the care provided to an individual must be in accordance with the plan.

A. The attending physician, the medical director or physician designee and the interdisciplinary group must establish the plan of care before hospice care begins.

B. The attending physician, the medical director or physician designee and the interdisciplinary group must review and update the plan at intervals specified in the plan. Reviews must be documented.

C. The plan of care must:

1. Include an assessment of the individual's needs and identification of the services, including
    a. Management of discomfort
    b. Symptom relief
2. State in detail the scope and frequency of services needed to meet the patient's and family's needs.

D. In establishing the initial plan of care, the member of the interdisciplinary group who assesses the patient's needs must meet or confer by telephone with at least one other IDG member before writing the initial plan of care.

1. At least one of the persons developing the initial plan of care must be a nurse or physician.
2. The plan must be established on the same day as the assessment if the day of the assessment is to be a covered day of hospice care.
3. The other two members of the IDG must review the initial plan of care and provide their contributions to it within two calendar days following the day of assessment.

E. Waiver Services

1. Waiver Eligibility

    Some Medicaid beneficiaries are eligible under special programs known as waivers. The claims system will indicate waiver eligibility status with "NO" (not a waiver client) or the letter "W" followed by a number currently (1 or 2).

    Waiver clients may receive only services listed in the plan of care designed for them under the guidelines of the waiver program in which they participate.

2. ElderChoices Waiver Clients
    a. If the hospice provider intends to initiate care to a W2 waiver client, contact must be made with the DHHS County Office in the client's county of residence for the name and location of the DHHS R.N. responsible for the client's ElderChoices plan of care. Through contact with the DHHS R.N., the hospice services may be included in the plan of care before rendering the service.
    b. The ElderChoices plan of care supersedes any other plan of care previously developed by another Medicaid provider for the beneficiary. The ElderChoices plan of care must be obtained from the client's family.
    c. The ElderChoices plan of care must include all appropriate ElderChoices services and certain non-waiver services appropriate to the applicant, such as Hospice.
    d. The hospice provider must report services to an ElderChoices client to the DHHS RN. The services must be included on the ElderChoices plan of care prior to beginning services. All changes in services or changes in the ElderChoices client's circumstances must be reported promptly to the DHHS RN. Services provided that are not included on the ElderChoices plan of care

may be subject to recoupments by the Arkansas Medicaid Program.

240.300 Method of Service Reimbursement for Hospice Patients Residing in Nursing Facilities or ICF/MR's 11-1-06

A. Reimbursement for Medicaid-eligible patients residing in nursing facilities or ICF/MR's is limited to room and board.

1. Medicaid pays the hospice provider an amount equal to 95% of the Medicaid nursing facility/ICF/MR room and board payment.
2. The hospice pays that amount to the nursing facility or ICF/MR.

B. Nursing facility or ICF/MR residents may elect hospice if their nursing facility or ICF/MR has an agreement with a Medicaid hospice provider.

1. Medicaid pays the hospice for their care along with a separate rate to cover room and board.
2. Medicaid will not pay the nursing facility or ICF/MR directly for room and board.

C. The Arkansas Medicaid Program remits reimbursement for room and board to the hospice.

D. The hospice then remits that amount to the nursing facility or ICF/MR.

1. Room and board services include the performance of personal care services including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.
2. Room and board is reimbursable only in conjunction with routine home care or continuous home care.

E. Billing for routine home care and continuous home care for patients residing in nursing facilities or ICF/MR's requires a special procedure. See Section 252.410 for special billing instructions.

F. See Section 253.300 for billing instructions related to nursing facility or ICF/MR room and board reimbursement.

240.400 Rate Appeal Process 11-1-06

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

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days

after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

252.000 CMS-1450 (formerly UB-92) Billing Procedures 12-1-05

252.100 Hospice Revenue Codes 11-1-06

The following revenue codes must be used to bill for hospice services for Medicaid-eligible beneficiaries:

Revenue Code	Description
651	Routine Home Care
652	Continuous Home Care
655	Inpatient Respite Care
656	General Inpatient Care

See section 253.300 for billing instructions to claim reimbursement for nursing facility room and board for hospice patients who reside in nursing facilities or ICF/MR's.

252.300 Billing Instructions – CMS-1450 Paper Only 11-1-06

EDS offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those which require attachments or manual pricing.

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

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

Out-of-state providers should be aware of instructions for completing the CMS-1450 claim form. These instructions may be found in the Arkansas Medicaid Manual and the CMS-1450 data specifications manual.

To bill for hospice services, use the claim form CMS-1450. Listed below are instructions for filing the CMS-1450 with the Arkansas Medicaid Program. More comprehensive instructions are contained in the CMS-1450 data specifications manual. The numbered items correspond to the numbered locators on the CMS-1450.

The following instructions must be read and carefully adhered to, so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Please forward the original of the completed form to EDS Claims Department. **View or print the EDS Claims contact information.** One copy of the claim form should be retained for your records.

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

252.400 Special Billing Procedures 10-13-03

252.410 Billing for Hospice Services for Residents of Nursing Facilities or ICF/MR's 11-1-06

A. Pursuant to Public Law 105-33, Medicaid must make payment to hospices with respect to the geographical location of the patient.

1. Please comply with the following instructions when billing for hospice services for patients residing in nursing facilities or ICF/MR's.
2. These instructions apply only to the hospice provider billing on a CMS-1450 claim form or billing electronically in the CMS-1450 claim format.

B. When billing for routine home care or continuous home care for hospice patients residing in nursing facilities and ICF/MR's:

1. Enter **Z9** as a Condition Code and
2. Enter the Arkansas Medicaid Long Term Care provider number of the nursing facility or ICF/MR in one of the following fields:
   a. The data field labeled "Other Physician ID" in PES.
   b. The first field of Form Locator 83, labeled "Other Phys ID" (First line of Form Locator 83).

C. Compliance with the above special billing instructions is required.

252.420 Billing for Short-Term Inpatient Care for Hospice Patients 11-1-06

A. Pursuant to PL 105-33, Medicaid must make payment to hospices with respect to the geographical location of the patient.

1. Please comply with the following instructions when billing for short-term inpatient services for hospice patients.
2. These instructions apply only to the hospice provider, billing on a CMS-1450 claim form or billing electronically in the CMS-1450 claim format.

B. When billing for inpatient respite care or general inpatient care:

1. Enter **Z9** as a Condition Code and
2. Enter the Arkansas Medicaid Hospital provider number of the hospital to which the patient has been admitted in one of the following fields:
   a. The data field labeled "Other Physician ID" in PES.
   b. The first field of Form Locator 83, labeled "Other Phys ID" (First line of Form Locator 83).

253.300 Billing Instructions - Hospice/INH Claim Form 11-1-06

The Hospice/INH claim form (DHS-754) must be used when billing for room and board for all patients receiving hospice care in a nursing facility or an ICF/MR. A separate claim must be submitted for each month of service billed. Listed below are instructions for filing the Hospice/INH claim form with the Arkansas Medicaid Program. The numbered items correspond to the numbered fields on the Hospice/INH claim form. The following instructions must be adhered to, so that claims for payment can be processed efficiently. Accuracy, completeness and clarity are important since a claim cannot be processed if all information is not supplied or is unreadable. **View a Hospice/INH Claim DHS-754 sample form.**

Forward Hospice claims (DHS-754) to EDS Claims Department. **View or print the EDS Claims contact information.**

253.310 Completion of the Hospice/INH Claim Form 11-1-06

Field Name and Number		Description
1.	Provider Medicaid ID	Enter the 9-digit Medicaid Hospice provider number.
2.	Medicaid Number and Name of the Facility the Patient Resides in	Enter the full name and 9-digit Medicaid provider number of the nursing facility/ICF/MR in which the patient resides.
3.	Provider Name and Address	Enter the Hospice provider's name and address.
4.	Patient Medicaid ID Number, Last Name and First Name	Enter the patient's Medicaid ID number, last name and first name exactly as it appears on the Medicaid ID card.
5.	Medical Record Number (MRN)	Optional entry. Up to 10 alphanumeric characters may be entered. The MRN appears on the Remittance Advice exactly as it is entered on the claim form.
6.	Patient Status on Last End Date of Service	Enter the two-digit patient status code effective for the beneficiary on the ending date of service. 01 - Discharged to home 02 - Discharged to hospital 03 - Discharged to a Residential Care Facility (RCF) 04 - Discharged to other 05 - Transferred to Nursing Facility 06 - Transferred to ICF/MR 20 - Expired 30 - Still a patient
7.	Patient Admit Date	Enter the date of admission into the nursing facility or ICF/MR in CCYYMMDD (e.g., 19950101) format.
8.	Primary Diagnosis	Required. Enter the ICD-9-CM code for the primary diagnosis.
9.	Secondary Diagnosis	Required, if applicable. Enter additional appropriate ICD-9-CM diagnosis codes.
10.	Total Beds Occupied in Facility	This field is not required by Medicaid.
11.	TPL Information	Required, if applicable. The name, address and policy number of the primary insurance carrier must be entered in this field. Enter the amount received toward payment of this bill prior to billing Medicaid. If no payment was received, enter the date of denial (CCYYMMDD format) from the primary insurance carrier and attach a copy of the EOMB.

Field Name and Number		Description
12.	Beginning Date of Service	Enter the beginning date of service of the period covered by this bill in CCYYMMDD format. Service dates may not span calendar months. A separate claim form must be submitted for each month of service billed.
13.	Ending Date of Service	Enter the ending date of service of the period covered by this bill in CCYYMMDD format. Service dates may not span calendar months. A separate claim form must be submitted for each month of service billed.
14.	Total Days	Enter the total number of days being billed from the beginning to the ending dates of service for each claim detail.
15.	Leave of Absence (LOA) Code	Enter the Medicaid LOA code for the type of leave being reported for the patient on the claim detail. LOA and non-LOA days cannot be billed on the same claim detail. 1 - LOA to Home 2 - LOA to Hospital >85% occupancy 3 - LOA to Hospital <85% occupancy 4 - LOA no pay to HDC 5 - LOA no pay, Medicare covered
16.	Remarks	This field is not required by Medicaid.
17.	Provider Representative Signature	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service.
18.	Date	Enter the date the bill was signed or sent to the Arkansas Medicaid Program for payment.