ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers**

DATE: **July 15, 2009**

SUBJECT: **Section V Provider Manual Update Transmittal**

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REMOVE

Form	Date
DMS-694 chart	4-07
DMS-694 sample	4-07

INSERT

Form	Date
DMS-694 chart	3-00
DMS-694 sample	3-00

Explanation of Updates

Documentation of Form DMS-694 was revised in error. This update restores the original, accurate images and descriptions of Form DMS-694, which bears an effective date of March 2000.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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

Provider Inter-office Use
Patient Charting and Electronic Billing Documention Version Only
This Copy Not To Be Used For Paper Claim Billing

MAIL TO:
EDS CORPORATION
P O BOX 8034
LITTLE ROCK, AR 72203-8034

EPSDT

Section 1 - Patient Identification

PATIENT'S LAST NAME (1)	FIRST (2)	MI (3)	SEX (4) ☐ M ☐ F	PATIENT'S MEDICAID ID NO. (5)

CASEHEADS NAME (6)	COUNTY OF RESIDENCE (7)	DATE OF BIRTH (8) MO DAY YEAR	STREET ADDRESS (9)	CITY (10)

IF PATIENT IS A REFERRAL (11) ENTER NAME OF REFERRING PHYSICIAN	PROVIDER NUMBER	MEDICAL RECORD NUMBER (12)	PROVIDER PHONE NUMBER
			PAY TO: PROVIDER NAME AND ADDRESS (13)

OTHER HEALTH INSURANCE COVERAGE (14) (ENTER NAME OF PLAN AND POLICY NUMBER)	WAS CONDITION RELATED TO: (15) A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B. AN ACCIDENT ☐ YES ☐ NO	PAY TO PROVIDER NUMBER

PRIMARY DIAGNOSIS OR NATURE OF INJURY (16)	DIAGNOSIS CODE	APPOINTMENT DATE (17) MO.____ DAY____ YR.____ TIME____	TYPE OF SCREEN (18) INITIAL____ PERIODIC____

SECTION II - Social Worker Identification (19)

Signature_____ EPSDT Request Date or Certification Date_____

Telephone No._____ Date SS-694 Sent to Provider_____

Section III - Examination Report (20)

Type of Test or Examination		NORMAL	ABNORMAL	NOT INDICATED	COUNSELED	TREATED	REFERRED	COMMENTS (21)
A. Basic Screening —								
1. Growth and Nutrition	(A)							
2. Development Assessment	(B)							
3. Unclothed Physical	(C)							
a. Neurological Exam	(D)							
b. Cardiac Status	(E)							
4. Vision	(F)							
5. Hearing	(G)							
6. Teeth (Children under 3 years)	(H)							
7. Lab Tests (Appropriate for age and population group)	(I)							
a. Hematologic	(J)							
b. Urinalysis	(K)							
c. Other (Specify)	(L)							
B. Immunization Status	(M)							
C. Other (Specify)	(Z)							

(22) A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	MODIFIER 1	2	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G# T O S	PERFORMING PROVIDER NUMBER

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements of documents, or concealment of a material fact may be prosecuted under applicable Federal or State laws. No additional charges for compensable services will be made against anyone; payment will be accepted as payment in FULL, that the above services claimed for payment have been completed and that the above services have been furnished in full compliance (without discrimination) within the provisions of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

(26) PROVIDER'S SIGNATURE_____ BILLING DATE (27)

(23) TOTAL CHARGES	
(24) COVERED BY INSURANCE	
(25) BALANCE DUE	

FOR OFFICE USE (28)

SS-694 (Rev. 3/00)

Instructions for Completion of the EPSDT Claim Form – DMS-694

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.

To bill for a Child Health Services (EPSDT) screening service, use the claim form DMS-694. The numbered items correspond to numbered fields on the claim form. The DMS-694 is used as a combined referral, screening results document and a billing form. Each screening should be billed separately, providing the appropriate information for each of the screening components. The following numbered items correspond to numbered fields on the claim form.

Medical services such as immunizations and laboratory procedures may also be billed on the DMS-694 when provided in conjunction with a Child Health Services (EPSDT) screening, as well as other treatment services provided.

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.

Completed claim forms should be forwarded to the EDS Claims Department. **View or print the 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.

Field Name and Number	Instructions for Completion
1. Patient's Last Name	Enter the patient's last name.
2. Patient's First Name	Enter patient's first name.
3. Patient's Middle Initial	Enter patient's middle initial.
4. Patient's Sex	Check "M" for male or "F" for female.
5. Patient's Medicaid ID No.	Enter the entire 10-digit patient Medicaid identification number.
6. Casehead's Name	Enter the casehead name for TEA children only. Patient's name has been requested in Blocks 1, 2 and 3.
7. County of Residence	Enter the patient's county of residence.
8. Date of Birth	Enter the patient's date of birth in month and year format as it appears on the Medicaid identification card.
9. Street Address	Enter the patient's street address.
10. City	Enter the patient's city of residence.
11. If a Patient is a Referral Enter Name of Referring Physician Provider Number	If the patient is a referral, enter the name of the referring physician and his or her provider number.

Field Name and Number	Instructions for Completion
12. Medical Record Number	This is an optional entry that the provider may use for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alpha characters will be accepted. This number will appear on the Remittance Advice (RA) and is a method of identifying payment of the claim.
13. Provider Phone Number Pay To: Provider Name and Address Pay To: Provider Number	Enter the provider's complete name, address, and provider number. If a clinic billing is involved, use the clinic provider number. Telephone number is requested but not required.
14. Other Health Insurance Coverage (Enter Name of Plan and Policy Number)	If applicable, enter the name of the insurance plan and the policy number of any health insurance coverage carried by the patient other than Medicaid. The patient's Medicaid identification card should indicate "Yes" if other coverage is carried by the beneficiary.
15. Was Condition Related to:	
A. Patient's Employment	Check "Yes" if the patient's condition was employment related. If the condition was not employment related, check "No."
B. An Accident	Check "Yes" if the patient's condition was related to an accident. Check "No" if the condition was not accident related.
16. Primary Diagnosis or Nature of Injury	Enter the description of the primary reason for treatment of the patient.
Diagnosis Code	Enter the ICD-9-CM Code that identifies the primary diagnosis.
18. Type of Screen Periodic Interperiodic	Not required for Medicaid. Completed by Human Services, if applicable.
SECTION II	
19. Social Worker Identification	Not required for Medicaid. Completed by Human Services, if applicable. This section is used by school districts and education service cooperatives enrolled in the EPSDT program to include an LEA code.
SECTION III	
20. Examination Report	To be completed by screening provider at time of screen.
A. Basic Screening	
Item A, Numbers 1 through 6	Check "Normal" or "Abnormal" for each component. Check "Counseled," "Treated" or "Referred" as applicable.
Item A, Number 7	Give results of the lab tests performed at the time of screen.

Field Name and Number	Instructions for Completion
Item B	Immunization status appropriate for age and health history. If immunization cannot be performed, note the reason along with the return appointment in “Comments” section.
Item C	Enter any other services rendered.
21. Comments	Briefly explain any problems identified and describe treatment or referral. If referred, indicate the name of the provider to whom the referral was made.
22. A. Date of Service	Enter the “from” and “to” dates of service for each service provided in MM/DD/YY format. A single date of service need not be entered twice on the same line.
B. Place of Service	Enter the appropriate place of service code. See Section 242.200 for codes.
C. Fully Describe Procedures, Medical Services or Supplies Furnished For Each Date Given *(Explain Unusual Services or Circumstances)*	Enter the appropriate HCPCS, CPT and state assigned procedure code and describe any services or circumstances, e.g., what age periodicity screen has been provided and describe procedures performed (including screen, lab test, immunizations, etc.).
Procedure Code (Identify)	
D. Diagnosis Code	Enter the ICD-9-CM code, which corresponds with the procedures performed.
E. Charges	Enter the charges for the rendered services. These charges should be the provider’s current usual and customary fee to private clients.
F. Days or Units	Enter days or units of service rendered.
G. TOS	Enter the appropriate type of service code. See Section 242.200 for codes.
H. Performing Provider Number	If the billing provider noted in Block 13 is a clinic or group, enter the attending provider’s provider number.
23. Total Charges	Enter the total of Column 22E. This block should contain a sum of charges for all services indicated on the claim form.
24. Covered by Insurance	Enter the total amount of funds received from other sources. The source of payment should be indicated in Block 14. If payment was received from the patient, indicate in Block 14, but DO NOT include the amount in Block 24.
25. Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge.

Field Name and Number	Instructions for Completion
26. Provider's Signature	The provider or designated authorized individual must sign 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, 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.
27. Billing Date	Enter date signed.

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TO: **Arkansas Medicaid Health Care Providers – Child Health Services/Early Periodic Screening, Diagnostic and Treatment (EPSDT)**

DATE: **July 15, 2009**

SUBJECT: **Provider Manual Update Transmittal #120**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
213.000	3-1-06	213.000	7-15-09
242.310	7-1-07	242.310	7-15-09

Explanation of Updates

Section 213.000 is included to add information regarding the Local Education Agency (LEA) code in section 19 of the DMS-694.

Section 242.310 is included to provide information about the LEA code to the instructions for Completion of the EPSDT DMS-694 Claim Form at #19.

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Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

TOC not required

213.000 Provider's Role in the Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program 7-15-09

The following steps are necessary in order to complete a Child Health Services (EPSDT) screen:

A. When a child arrives for a Child Health Services (EPSDT) screening appointment, ask to see the current Medical Assistance Identification Card (Medicaid Card). Verify Medicaid eligibility electronically before services are rendered.

B. Screen the child according to the procedures outlined in Sections 215.000, 216.000, 217.000, 218.000 or 219.000 of this manual. All elements of the screen must be completed and documented before the screen is considered complete. This includes the evaluation of lab results and the provision of or referral for immunizations.

A full medical screen must, at a minimum, include: a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed physical exam; appropriate immunizations according to age and health history; laboratory tests (including appropriate blood lead level assessment); and health education (including anticipatory guidance).

All parts of the screening package must be furnished to the Child Health Services (EPSDT) participant in order for the screening to qualify as a full medical Child Health Services (EPSDT) screening service.

Immunizations that are appropriate based on age and health history, but which are contraindicated at the time of the screening, may be rescheduled at an appropriate time or referred to another provider.

C. Record the screening findings on the DMS-694 or on the American Dental Association (ADA) form for dental screens. **View or print a DMS-694 sample form**. The DMS-694 screening form or the ADA (dental) form must be completed on each individual screened for Child Health Services (EPSDT) in order to comply with federal reporting and Child Health Services (EPSDT) requirements. The DMS-694 will record whether each of the recommended screening procedures required by the periodicity schedule is performed, whether referral is necessary for health problems discovered during the screen and the date of the required referral appointment if one is made. Providers must be careful to complete Section I of Form DMS-694 or the ADA (dental) form using the beneficiary's name and Medicaid ID number exactly as shown on the Medicaid card.

D. Talk to the parent about the screening results, explaining in detail the findings and any recommendations for diagnosis and treatment.

E. If the child needs further diagnosis and/or treatment, complete the referral section of the DMS-694 by checking the appropriate referral box.

F. Upon completion of the EPSDT screening, mail the original DMS-694 form to the EDS Claims Department, or file electronically using the 694 format. Retain copy 3 for the provider files. **View or print the EDS Claims Department contact information.**

G. If the screener provides treatment as a result of the screening, the charges for the treatment procedures may be submitted on the DMS-694 form. Do not submit charges for office visit services on the DMS-694.

H. Treatment services offered as a result of a Child Health Services (EPSDT) screen are not limited to the Medicaid services specified under "Scope of Program" in Section I of this manual. If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services will also be considered for reimbursement.

I. When a provider performs a Child Health Services (EPSDT) screen and/or refers the patient to another provider for services not covered by Arkansas Medicaid, the referring provider must give the beneficiary a prescription for the services. The prescription must indicate the services being prescribed and state the services are being prescribed due to a Child Health Services (EPSDT) screen.

The prescription for services must be dated by the provider referring the patient. The prescription for the non-covered service is acceptable if services were prescribed and the prescription is dated within the applicable periodicity schedule, not to exceed a maximum of 12 months.

J. The provider may verify whether a periodic screen is due under the appropriate periodicity schedule by means of an electronic eligibility verification transaction. The system's response display will reveal each type of screen, e.g., medical, visual, dental and hearing and the date of the last screen of each type indicated by the provider initiating the eligibility verification transaction.

K. School districts and education service cooperatives enrolled in the EPSDT program and providing EPSDT screenings must include a Local Education Agency (LEA) code in section 19 of the DMS-694. The LEA code is used to determine federal matching funds to the Child Health Services (EPSDT) program.

The Department of Human Services (DHS) county offices will continue to refer Medicaid beneficiaries to providers for Child Health Services (EPSDT) screens. However, a provider may initiate the health screen for an eligible beneficiary at the appropriate time without a referral from the DHS county office.

An eligible child must be referred by the PCP, if the child is to be screened by a provider who is not the PCP.

242.310 Completion of the EPSDT (DMS-694) Claim Form 7-15-09

Field Name and Number	Instructions for Completion
1. Patient's Last Name	Enter the patient's last name.
2. Patient's First Name	Enter patient's first name.
3. Patient's Middle Initial	Enter patient's middle initial.
4. Patient's Sex	Check "M" for male or "F" for female.
5. Patient's Medicaid ID No.	Enter the entire 10-digit patient Medicaid identification number.
6. Casehead's Name	Enter the casehead name for TEA children only. Patient's name has been requested in Blocks 1, 2 and 3.
7. County of Residence	Enter the patient's county of residence.

Field Name and Number	Instructions for Completion
8. Date of Birth	Enter the patient's date of birth in month and year format as it appears on the Medicaid identification card.
9. Street Address	Enter the patient's street address.
10. City	Enter the patient's city of residence.
11. If a Patient is a Referral Enter Name of Referring Physician Provider Number	If the patient is a referral, enter the name of the referring physician and 9-digit Medicaid provider number, if available.
12. Medical Record Number	This is an optional entry that the provider may use for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alpha characters will be accepted. This number will appear on the Remittance Advice (RA) and is a method of identifying payment of the claim.
13. Provider Phone Number Pay To: Provider Name and Address Pay To: Provider Number	Enter the provider's complete name, address and 9-digit Arkansas Medicaid provider number. If a clinic billing is involved, use the 9-digit clinic provider number. Telephone number is requested but not required.
14. Other Health Insurance Coverage (Enter Name of Plan and Policy Number)	If applicable, enter the name of the insurance plan and the policy number of any health insurance coverage carried by the patient other than Medicaid. The patient's Medicaid identification card should indicate "Yes" if other coverage is carried by the beneficiary.
15. Was Condition Related to:	
A. Patient's Employment	Check "Yes" if the patient's condition was employment related. If the condition was not employment related, check "No."
B. An Accident	Check "Yes" if the patient's condition was related to an accident. Check "No" if the condition was not accident related.
16. Primary Diagnosis or Nature of Injury	Enter the description of the primary reason for treatment of the patient.
Diagnosis Code	Enter the ICD-9-CM Code that identifies the primary diagnosis.
18. Type of Screen Periodic Interperiodic	Not required for Medicaid. Completed by Human Services, if applicable.
SECTION II	

Field Name and Number	Instructions for Completion
19. Social Worker Identification	This section is used by school districts and education cooperatives enrolled in the EPSDT program to include a Local Education Agency (LEA) code.
SECTION III	
20. Examination Report	To be completed by screening provider at time of screen.
A. Basic Screening	
Item A, Numbers 1 through 6	Check “Normal” or “Abnormal” for each component. Check “Counseled,” “Treated” or “Referred” as applicable.
Item A, Number 7	Give results of the lab tests performed at the time of screen.
Item B	Immunization status appropriate for age and health history. If immunization cannot be performed, note the reason along with the return appointment in “Comments” section.
Item C	Enter any other services rendered.
21. Comments	Briefly explain any problems identified and describe treatment or referral. If referred, indicate the name of the provider to whom the referral was made.
22. A. Date of Service	Enter the “from” and “to” dates of service for each service provided in MM/DD/YY format. A single date of service need not be entered twice on the same line.
B. Place of Service	Enter the appropriate place of service code. See Section 242.200 for codes.
C. Fully Describe Procedures, Medical Services or Supplies Furnished For Each Date Given *(Explain Unusual Services or Circumstances)* Procedure Code (Identify)	Enter the appropriate HCPCS, CPT and state assigned procedure code and describe any services or circumstances, e.g., what age periodicity screen has been provided and describe procedures performed (including screen, lab test, immunizations, etc.).
D. Diagnosis Code	Enter the ICD-9-CM code, which corresponds with the procedures performed.
E. Charges	Enter the charges for the rendered services. These charges should be the provider’s current usual and customary fee to private clients.
F. Days or Units	Enter days or units of service rendered.
G. Performing Provider Number	If the billing provider noted in Block 13 is a clinic or group, enter the attending provider’s 9-digit Arkansas Medicaid provider number.

Field Name and Number	Instructions for Completion
23. Total Charges	Enter the total of Column 22E. This block should contain a sum of charges for all services indicated on the claim form.
24. Covered by Insurance	Enter the total amount of funds received from other sources. The source of payment should be indicated in Block 14. If payment was received from the patient, indicate in Block 14, but DO NOT include the amount in Block 24.
25. Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge.
26. Provider's Signature	The provider or designated authorized individual must sign 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, 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.
27. Billing Date	Enter date signed.