ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Private Duty Nursing**

DATE: **September 15, 2011**

SUBJECT: **Provider Manual Update Transmittal #PDN-2-10**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
222.000	4-1-09	222.000	9-15-11

Explanation of Updates

Section 222.000 is updated to include requirements regarding the CMS-1500 form.

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Eugene I. Gessow, Director

TOC not required

222.000 Request for Prior Authorization 9-15-11

A request for prior authorization for private duty nursing services must originate with the provider. The provider is responsible for completion of the Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification (form DMS-2692) and obtaining the required medical information. Form DMS-2692 must be signed by the beneficiary's physician with documentation that a physical examination was performed within 12 months of the beginning of the initial request or the recertification. **View or print form DMS-2692 and instructions for completion.**

For PDN services in the beneficiary's home, a social/environmental evaluation indicating a commitment on the part of the beneficiary's family to provide a stable and supportive home environment must accompany the request for prior authorization. Refer to Section 224.000 of this manual for additional information required for the initial request.

All PA requests for Medicaid-eligible beneficiaries will be evaluated by the Division of Medical Services, Utilization Review (UR) Section, to determine the level of care and amount of nursing services to be authorized. **View or print Utilization Review Section contact information.**

The UR Section will notify the provider of the approval or denial of the PDN services PA request within 15 working days following the receipt of the PA request. If the PA request for PDN services is approved, page 5 of form DMS-2692 will be returned to the provider with the number of hours approved indicated on the form. The PA number will be assigned after the provider sends in documentation of the actual hours worked. The provider is responsible for monthly completion of a CMS-1500 form. The provider shall attach a calendar to the CMS-1500 form documenting the following: nurses' full name, title, time in, time out, and number of hours worked for each shift.

Prior authorization is required for private duty nursing supervisory visits. The Prior Authorization request must be submitted with the monthly service billing along with supporting documentation. The PA number will be assigned after the provider sends in documentation of the actual hours worked.

NOTE: The prior authorization number MUST be entered on the claim form filed for payment of these services. The initial PA approval will only be authorized for a maximum of 90 days. A new request must be made for services needed for a longer period of time. Recertification may be authorized for a maximum of six (6) months. Refer to Section 224.000 of this manual for information regarding recertification of PDN services. The effective date of the PA will be the date the patient begins receiving PDN services or the day following the last day of the previous PA approval.

Providers are cautioned that a prior authorization approval does not guarantee payment. Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time service is provided and upon completeness and timeliness of the claim filed for the service. The provider is responsible for verifying the beneficiary's eligibility.