ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
Mark Martin
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Little Rock, Arkansas 72201-1094
(501) 682-5070
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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Brad Nye E-mail brad.nye@dhs.arkansas.gov Phone 501-320-6306

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: Section III 2-17

Intended Effective Date (Check One)		Date
☐ Emergency (ACA 25-15-204)	Legal Notice Published	08/14/2017
☑ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	09/12/2017
☐ Other _____ (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	
	Adopted by State Agency	11/01/2017

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Becky Murphy (Contact Person) becky.murphy@dhs.arkansas.gov (E-mail Address) _____ (Date)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Rose M Naff
Signature

(501) 371-2165 (Phone Number) rose.naff@dhs arkansas.gov (E-mail Address)

Director
Title

10/19/17
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE 501-537-2064 **FAX** 501-682-3889 **EMAIL:** Brian.Jones@dhs.arkanas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Section III

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	0.00	General Revenue	0.00
Federal Funds	0.00	Federal Funds	0.00
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	0.00	Total	0.00

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ 0.00

No fiscal impact associated with this rule

Next Fiscal Year
$ 0.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: November 1, 2017

SUBJECT: Provider Manual Update Transmittal SecIII-2-17

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
ALL	Various	ALL	11-1-17

Explanation of Updates

Due to the implementation of the new Medicaid Management Information System (MMIS) on November 1, 2017, the Section III of your provider manual has been updated to reflect the new billing information and instructions.

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 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 the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

Rose M. Naff
Director

TOC required

300.000 GENERAL INFORMATION

301.000 Introduction 11-1-17

The purpose of Section III of the Arkansas Medicaid Manual is to explain the general procedures for billing in the Arkansas Medicaid Program.

Two major areas are covered in this section:

A. General Information: This section contains information about electronic options, timely filing of claims, claim inquiries and supply procedures.

B. Financial Information: This section contains information on the Remittance Advice (RA), reports, adjustments, refunds and additional payment sources.

301.100 Electronic Claims Submission 11-1-17

The Arkansas Medicaid fiscal agent furnishes both an online portal and software for electronic claims submissions. X.12 companion documents are also offered at no charge to the provider for transactions utilized by Arkansas Medicaid.

When submitting claims electronically, Medicaid providers should use the claim type information found in the Section II of their program's provider manual.

The Arkansas Medicaid fiscal agent processes payments for each week's accumulations of claims during a weekend cycle. The deadline for each weekend cycle is midnight Friday. Providers are paid the following week.

301.105 Modifiers For Electronic Billing 11-1-17

Electronic claims may require modifiers in addition to National Standard Codes. Please refer to the Section II of your program's provider manual to determine the appropriate modifiers.

301.110 Arkansas Provider Portal 11-1-17

Providers with PCs can submit claims via the web using an internet browser. (Please see **https://www.medicaid.state.ar.us/Provider/faq/faq.aspx#sysreqportal** for system requirements.) Dental, Professional, and Institutional claim types can be submitted via the web, including long-term care census. Claims can only be submitted interactively (one at a time). Access the provider portal via the Arkansas Medicaid website at **https://www.medicaid.state.ar.us/**. The web-based provider portal was designed to integrate seamlessly with the Arkansas Medicaid Management Information System (MMIS) and is, therefore, the preferred method for electronic transactions.

Instructions for submitting claims and verifying eligibility via the portal are available by using the site's online Help feature.

301.120 Provider Electronic Solutions (PES) Software 11-1-17

Provider Electronic Solutions (PES) software is available at no cost to any provider who submits Medicaid claims. PES supports submission of claims in a batch mode only. (Please see **https://www.medicaid.state.ar.us/Provider/faq/faq.aspx#sysreqpes** for system requirements.) The software supports dental, institutional and professional claim types. In addition to submitting claims, providers can also view claim responses using PES software. Instructions for using PES software are available by using the application's Help feature.

301.130 Vendor Systems 11-1-17

Providers who have office management systems can opt to have their vendors upgrade their systems to support online transactions. The Arkansas Medicaid fiscal agent provides X.12 companion guides to interested vendors. The cost of upgrading the provider's system to support online transactions is the responsibility of the provider.

301.200 Electronic Transactions 11-1-17

The Arkansas Medicaid fiscal agent offers electronic transactions that are compliant with Health Insurance Portability and Accountability Act (HIPAA) regulations through both the provider portal and Provider Electronic Solutions (PES) software.

301.210 Eligibility Verification 11-1-17

Providers can check a beneficiary's eligibility through the provider portal via the web, using PES software or through the Voice Response System (VRS). To access the VRS, providers can call the Provider Assistance Center automated help line. **View or print the Provider Assistance Center contact information.**

Eligibility requests can be submitted interactively through the provider portal via the web or in a batch using PES software. Instructions for verifying eligibility through the provider portal are available using the site's online Help feature. Instructions for using PES are available by using the application's Help feature or the PES Handbook on the Arkansas Medicaid website at **https://www.medicaid.state.ar.us/Download/provider/software/pes/peshandbook.pdf**.

301.220 Claim Status Inquiry 11-1-17

Providers can check the status of one or more claims through the provider portal or PES software. Claim status requests can be submitted interactively (one at a time) via the provider portal or through PES in a batch mode. Claim status requests can be submitted interactively (one at a time) via the web. Instructions for checking a claim status via the provider portal are available by using the site's online Help feature. Instructions for checking a claim status using PES software are available using the application's Help feature or the PES Handbook on the Arkansas Medicaid website at **https://www.medicaid.state.ar.us/Download/provider/software/pes/peshandbook.pdf**.

Providers with vendor systems can also check a claim's status by utilizing the ASC X.12 5010A 276/277 transactions with the appropriate X.12 companion guide.

301.230 Remittance Advice Reports 11-1-17

Providers can retrieve their electronic Remittance Advice (RA) reports through the provider portal or with PES software. Instructions for retrieving RAs using PES software are available using the application's Help feature.

Providers with vendor systems can also receive remittance advice reports by utilizing the ASC X.12 5010A 835 transaction with the appropriate X.12 companion guide.

301.240 Prior Authorization Request 11-1-17

Providers can review instructions for Prior Authorization Requests in the Section II of their program's provider manual.

Some prior authorizations are processed by other Medicaid contractors:

A. Arkansas Foundation for Medical Care (AFMC) can assist with the Medicaid Utilization Management Process, surgical procedures, assistant surgeons, transplants, anesthesia, orthotics and prosthetics, inpatient services, lab and radiology, lab-molecular pathology, rehabilitation hospitals, personal care for beneficiaries under age 21, Child Health Management Services, and Professional Services including extension of benefits for Podiatry and Professional level visits. **View or print contact information for Arkansas Foundation for Medical Care, Retrospective Review for Therapy and Prior Authorization for Personal Care for Under Age 21.**

B. Beacon Health Options can assist with PAs for Inpatient Psychiatric Services, Outpatient Behavioral Health Services and Substance Abuse Services. **View or print contact information for Beacon Health Options**.

301.300 Contacts 11-1-17

The Arkansas Medicaid fiscal agent maintains a Provider Assistance Center (PAC) to assist Medicaid providers during regular business hours from 8:00 a.m. to 5:00 p.m. Central Standard Time. **View or print PAC contact information.**

The Arkansas Medicaid fiscal agent also has a staff of representatives available during regular business hours from 8:00 a.m. to 5:00 p.m. to assist with any needs concerning electronic solutions. **View or print PAC contact information.**

302.000 Timely Filing 11-1-17

The *Code of Federal Regulations* (42 CFR), at 447.45 (d) (1), states "The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service." The 12-month filing deadline applies to all claims, including:

A. Claims for services provided to beneficiaries with joint Medicare/Medicaid eligibility.

B. Adjustment requests and resubmissions of claims previously considered.

C. Claims for services provided to individuals who acquire Medicaid eligibility retroactively.

There are no exceptions to the 12-month filing deadline policy. However, the definitions and additional federal regulations in the next section will permit some flexibility for those who adhere closely to them.

302.100 Medicare/Medicaid Crossover Claims 11-1-17

Federal regulations dictate that providers must file the Medicaid portion of claims for dually eligible beneficiaries within 12 months of the beginning date of service. The Medicare claim will establish timely filing for Medicaid, if the provider files with Medicare during the 12-month Medicaid filing deadline. Medicaid may then consider payment of a Medicare deductible and/or coinsurance, even if the Medicare intermediary or carrier crosses the claim to Medicaid after more than a year has passed since the date of service. Medicaid may also consider such a claim for payment if Medicare notifies only the provider and does not electronically forward the claim to Medicaid. Federal regulations permit Medicaid to pay its portion of the claim within six (6) months after the Medicaid "agency or the provider receives notice of the disposition of the Medicare claim."

Providers may not electronically transmit any claims for dates of service over 12 months in the past to the Arkansas Medicaid fiscal agent. To submit a Medicare/Medicaid crossover claim meeting the timely filing conditions in the above paragraph, please refer to *Patients With Joint Medicare/Medicaid Coverage*, Section 332.000 of this manual. In addition to following the billing

procedures explained in Section 332.000, enclose a signed cover memo or Medicaid Claim Inquiry Form requesting payment for the Medicaid portion of a Medicare claim filed to Medicare within 12 months of the date of service and adjudicated by Medicare more than 12 months after the date of service.

302.200 Clean Claims and New Claims 11-1-17

The definitions of the terms *clean claim* and *new claim* help to determine which claims and adjustments Medicaid may consider for payment when more than 12 months have passed since the beginning date of service.

42 CFR, at 447.45 (b), defines a clean claim as a claim that Medicaid can process "...without obtaining additional information from the provider of the service or from a third party." The definition "...includes a claim with errors originating in a State's claims system."

A claim that denies for omitted or incorrect data or for missing attachments is not a clean claim. A claim filed more than 12 months after the beginning date of service is not a clean claim, except under the special circumstances described below.

A new claim is a claim that is unique, differing from all other claims in at least one material fact. It is very important to note that identical claims received by Medicaid on different days differ in the material fact of their receipt date and are both new claims unless defined otherwise in the next paragraph.

302.300 Claims Paid or Denied Incorrectly 11-1-17

Sometimes a clean claim pays incorrectly or denies incorrectly. When a provider files an adjustment request for such a claim, or refiles the claim after 12 months have passed from the beginning date of service, the submission is not necessarily a new claim. The adjustment or claim may be within the filing deadline. Instructions for resubmitting these claims can be found in Section 302.500. For Medicaid to consider that the submission is not a new claim and therefore within the filing deadline, the adjustment or claim must meet two requirements:

A. The only material fact that differs between the two filings is the claim receipt date because the Medicaid agency or its fiscal agent processed the initial claim incorrectly.

B. The provider includes documentation that the Medicaid agency or fiscal agent error prevented resubmittal within the 12-month filing deadline.

302.400 Claims With Retroactive Eligibility 11-1-17

Retroactive eligibility does not constitute an exception to the filing deadline policy. If an appeal or other administrative action delays an eligibility determination, the provider must submit the claim within the 12-month filing deadline. If the claim is denied for beneficiary ineligibility, the provider may resubmit the claim when the patient becomes eligible for the retroactive date(s) of service. Medicaid may then consider the claim for payment because the provider submitted the initial claim within the 12-month filing deadline and the denial was not the result of an error by the provider.

Occasionally the State Medicaid agency or a federal agency, such as the Social Security Administration, is unable to complete a Medicaid eligibility determination in time for service providers to file timely claims. Arkansas Medicaid's claims processing system is unable to accept a claim for services provided to an ineligible individual or to suspend that claim until the individual is retroactively eligible for the claim dates of service.

To resolve this dilemma, Arkansas Medicaid considers the pseudo beneficiary identification number 9999999999 to represent an "...error originating within (the) State's claims system."

Therefore, a claim containing that number is a clean claim if it contains all other information necessary for correct processing.

By defining the initial timely filed claim as a clean claim denied because of agency processing error, we may allow the provider to refile the claim when the government agency completes the eligibility determination. With the claim, the provider must submit proof of the initial filing and a letter or other documentation sufficient to explain that administrative processes (such as determination of SSI eligibility) prevented the resubmittal before the filing deadline.

To submit a claim for services provided to a patient who is not yet eligible for Medicaid, enter, on the claim form or on the electronic format (PES or billing vendor/trading partner), a pseudo Medicaid beneficiary identification number, 9999999999. Medicaid will deny the claim. Retain the denial or rejection for proof of timely filing if eligibility determination occurs more than 12 months after the date of service.

Providers have 12 months from the approval date of the patient's Medicaid eligibility to resubmit a clean claim after filing a pseudo claim.. After the 12-month filing deadline (12 months from the Medicaid approval date) claims will be denied for timely filing and will not be paid. It is the responsibility of the provider to verify the eligibility approval date.

302.410 Claims Involving Retroactive Eligibility 11-1-17

Submit a paper claim to the address below, attaching:

A. A copy of the Remittance Advice (RA) report page, documenting a denial of the claim dated within 12 months after the beginning date of service, or

B. A copy of the error response to an electronic transmission of the claim computer-dated within 12 months after the beginning date of service and

C. Any additional documentation necessary to explain why the error has prevented refiling the claim until more than 12 months have passed after the beginning date of service.

Send these materials to the Provider Assistance Center (PAC). **View or print PAC contact information.**

302.500 Submitting Adjustments and Resubmitting Claims 11-1-17

When it is necessary to submit an adjustment or resubmit a claim to Medicaid after 12 months have passed since the beginning date of service, the procedures below must be followed.

302.510 Adjustments 11-1-17

If the fiscal agent has incorrectly paid a clean claim and the error has made it impossible to adjust the payment before 12 months have passed since the beginning date of service, a completed Adjustment Request Form (AR-004) must be submitted to the address specified on the form. Attach the documentation necessary to explain why the error has prevented refiling the claim until more than 12 months have passed after the beginning date of service. **View or print form AR-004 and instructions for completion.**

NOTE: Pharmacy providers will need to complete form DMS-802 and submit it directly to the DMS Pharmacy Program by mail or fax.

View or print the DMS Pharmacy Unit contact information.

View or print form DMS-802.

302.520 Claims Denied Incorrectly

11-1-17

Submit a paper claim to the address below, attaching:

A. A copy of the Remittance Advice (RA) report page that documents a denial within 12 months after the beginning date of service, or

B. A copy of the error response to an electronic transmission, computer-dated within 12 months after the beginning date of service and

C. Additional documentation to prove that the denial or rejection was due to the error of the Division of Medical Services or the fiscal agent. Explain why the error has prevented refiling the claim until more than 12 months have passed after the beginning date of service.

Send these materials to the Provider Assistance Center (PAC). **View or print PAC contact information.**

302.600 ClaimXten® Enhancement

11-1-17

To solve some of the billing problems associated with differing interpretations of procedure code descriptions, the Arkansas Medicaid fiscal agent implemented the ClaimXten® enhancement to the Arkansas Medicaid Management Information System (MMIS). This software analyzes procedure codes and compares them to nationally accepted published standards to recommend more accurate billing. If you think your claim was paid incorrectly, see Section 320.000 for information about how to use the Adjustment Request Form. If you think your claim was denied incorrectly, contact the Provider Assistance Center (PAC).

ClaimXten® developers based the software's edits on the guidelines contained in the *Physicians' Current Procedural Terminology* (CPT) book, and Arkansas Medicaid customized the software for local policy and procedure codes. Please note that ClaimXten® implementation does not affect Medicaid policy.

If there are other questions regarding the function of ClaimXten® edits, contact the Provider Assistance Center (PAC). **View or print PAC contact information.**

303.000 Claim Inquiries

11-1-17

The Arkansas Medicaid Program distributes weekly Remittance Advice (RA), reports, to each provider with claims paid, denied or pending, as of the previous weekend processing cycle. (Sections 310.000 through 314.800 of this manual contain a complete explanation of the RA.) Use the RA to verify claim receipt and to track claims through the system. Adjudicated claims will appear on the RA within the weekly financial cycle.

If a claim does not appear on the RA within the amount of time appropriate for its method of submission, contact the Provider Assistance Center (PAC). **View or print PAC contact information.** A Provider Assistance Center representative can explain what system activity, if any, regarding the submission has occurred since the Arkansas Medicaid fiscal agent printed and mailed the last RA. If the transaction on the RA cannot be understood or is in error, the representative can explain its status and suggest remedies when appropriate. If there is no record of the transaction, the representative will suggest that the claim be resubmitted.

A provider can also perform a claim status inquiry via the provider portal or with PES software, as described in Section 301.220.

303.100 Claim Inquiry Form 11-1-17

When a written response to a claim inquiry is preferred, use the Medicaid Claim Inquiry Form, CI-003, provided by the Arkansas Medicaid fiscal agent. **View or print form CI-003.** A separate form for each claim in question must be used. The Arkansas Medicaid fiscal agent is required to respond in writing only if they can determine the nature of the questions. The Medicaid Claim Inquiry Form is for use in locating a claim transaction and understanding its disposition. If help is needed with an incorrect claim payment, refer to Section 320.000 of this manual for the Adjustment Request Form (AR-004) and information regarding adjustments. **View or print form AR-004 and instructions for completion.**

View or print form CI-003 and instructions for completion.

303.200 Completion of the Claim Inquiry Form 11-1-17

To inquire about a claim, providers must complete the following items on the Medicaid Claim Inquiry Form (CI-003). In order for your inquiry to be answered as quickly and accurately as possible, please follow these instructions:

A. Submit one Medicaid Claim Inquiry Form (CI-003) for each claim inquiry.

B. Include supporting documents for your inquiry. (Use claim copies, electronic transaction printouts, RA copies and/or medical documents as appropriate.)

C. Provide as much information as possible in Field 9. This information makes it possible to identify the specific problem in question and to answer your inquiry.

View or print form CI-003 and instructions for completion.

304.000 Supply Procedures

304.100 Ordering Forms from the Arkansas Medicaid Fiscal Agent 11-1-17

To order the Arkansas Medicaid fiscal agent supplied forms, please use the Medicaid Form Request (MFR-001). **View or print form MFR-001.** **View or print a list of supplied forms.** Complete the Medicaid Form Request and indicate the quantity needed for each form. Send these materials to the Provider Assistance Center (PAC). **View or print PAC contact information.**

The Medicaid Program does not provide copies of the CMS-1500 claim form. The provider may request a supply of this claim form from any available vendor. **View a CMS-1500 sample form.**

The Medicaid Program does not provide copies of the CMS-1450 claim form. The provider may request a copy of this claim form from any available vendor. **View a CMS-1450 sample form.**

An available vendor is the U.S. Government Printing Office. Orders may be submitted to the U.S. Government Printing Office via phone, fax, letter, e-mail or the Internet. **View or print the U.S. Government Printing Office contact information.** The Arkansas Medicaid fiscal agent requires the use of red-ink (sensor coded) CMS-1500 claim originals instead of copies. The processing system uses scanners to distinguish between red ink of the form fields and blue or black ink claim data (provider identification number, procedure codes, etc.).

310.000 REMITTANCE ADVICE REPORTS

311.000 Introduction of Remittance Advice Reports 11-1-17

Remittance Advice (RA) reports are computer-generated documents that detail the status and payment breakdown of all claims submitted to Medicaid for processing. The RA is designed to simplify provider accounting by facilitating reconciliation of claim and payment records. Arkansas Medicaid encourages providers to select electronic delivery of their RAs to increase efficiency and environmental awareness.

An RA is generated each week a provider has claims paid, denied or in process. Once a week, all claims completed in a daily cycle are processed through the financial cycle. The RA is produced at the time checks are issued. The RA explains the provider's payment on a claim-by-claim basis. Only providers who have finalized claims or claims in process (claims that have been through at least one financial cycle) will receive an RA. The RA is delivered electronically or mailed to the provider.

Since the RA is a provider's only record of paid and denied claims, it is necessary for the provider to retain all copies of the RAs, either electronically or on paper.

311.100 Electronic Funds Transfer (EFT) 11-1-17

Electronic Funds Transfer (EFT) allows providers to have their Medicaid payments automatically deposited. Arkansas Medicaid no longer mails paper checks for Medicaid payment. Providers are required to submit a completed Authorization for Electronic Funds Transfer (Automatic Deposit) form with their enrollment application. Provider Enrollment will deny applications that do not include a completed Authorization for Electronic Funds Transfer (Automatic Deposit) form. **View or print the Authorization for Electronic Funds Transfer (Automatic Deposit) form**. See Section I of the provider manual for additional information regarding participation requirements.

312.000 Purpose of Remittance Advice Reports 11-1-17

The Remittance Advice (RA) is a status report of active claims. It is the first source of reference to resolve questions regarding a claim. If the RA does not resolve the question, it may be necessary to contact the Provider Assistance Center (PAC). The PAC will need the claim number from the RA to research the question. **View or print the PAC contact information.**

If a claim does not appear on the RA within six weeks after submission, then contact PAC. If PAC can find no record of the claim, then the representative will suggest resubmitting it.

313.000 Remittance Advice Reports 11-1-17

There are eleven (11) possible reports in a remittance advice report series:

A. Report Heading

B. Banner Messages

C. Claims Paid

D. Claim Adjustments

E. Claims Denied

F. In Process

G. Payment Hold

H. Financial Transactions

I. Summary

J. EOB Code Descriptions

K. Service Code Descriptions

313.100 Descriptions and Samples of Remittance Advice Reports 11-1-17

Samples of each type of remittance advice report and descriptions of the fields are described to help in reading the RA.

View or print Remittance Advice samples for the following claim types: **Dental**, **Institutional**, **Pharmacy** or **Professional**.

View or print Remittance Advice field names and descriptions for the following claim types: **Dental**, **Institutional**, **Pharmacy** or **Professional**.

314.000 Explanation of the Remittance and Status Report 11-1-17

There are three different claim types for remittance advice reports issued by the fiscal agent: Institutional, Professional, Pharmacy and Dental. The remittance advice a provider receives will depend upon the claim types submitted. Each remittance type contains the same categories of information. These categories are described in the following subsections. Detailed descriptions of each remittance type, as well as samples of each type, are located in Section 313.100.

314.100 Report Heading 11-1-17

The report heading appears at the top of every page in the RA report series. The heading contains the MMIS reporting system, report name and provider information. Other information in the header includes the page number, RA number, run date, payment date and EFT number.

314.110 Banner Messages 11-1-17

This report lists all remittance advice messages in order (newest to oldest) that are applicable for the provider on the remittance advice reports.

314.120 Claims Paid 11-1-17

The purpose of the Claims Paid report is to give the provider a list of all claims that are paid along with explanations on any discrepancies between the billed and the paid amount.

The report is separated by individual claims and displays both header and detail data. EOB codes are also displayed on this report.

314.130 Claim Adjustments 11-1-17

Payment errors, such as underpayments and overpayments as well as payments for the wrong procedure code, wrong dates of service, wrong place of service, etc., can be adjusted by canceling ("voiding") the incorrectly adjudicated claim and processing the claim as if it were a new claim.

The purpose of the claim adjustments report is to give the provider a list of all claims that are adjusted along with explanations on why the claims are adjusted. The report is separated by individual claims and displays the header data for the claim that is being adjusted and both header and detail data for the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded money. EOB codes are displayed on this report.

Most adjustment transactions appear in the *Claim Adjustments* section of the RA. Denied adjustments appear at the end of the *Denied Claims* section of the RA.

The simplest explanation of an adjustment transaction is:

A. The Arkansas Medicaid fiscal agent subtracts from today's check total the full amount paid on a claim that contained at least one payment error.

B. The Arkansas Medicaid fiscal agent reprocesses the claim – or processes the corrected claim – and pays the correct amount.

C. The Arkansas Medicaid fiscal agent adds the difference to the remittance advice (or subtracts the difference if it is a negative amount).

Adjustments sometimes appear complicated because the necessary accounting and documentation procedures add a number of elements to an otherwise routine transaction. Also, there are variations in the accounting and documentation procedures, because there is more than one way to submit an adjustment and there is more than one way to adjudicate and record adjustments. There are positive (additional payment is paid to the provider) and negative (the provider owes the Arkansas Medicaid fiscal agent additional funds) adjustments, adjustments involving withholding of previously paid amounts, adjustments submitted with check payments and denied adjustments. The following section thoroughly explains adjustments, how they appear on the RA, and the meaning, from a bookkeeping perspective, of each significant element.

314.131 The Adjustment Transaction 11-1-17

The *Claim Adjustments* report has two parts. The first includes the adjustment transaction header elements. In this section, the Arkansas Medicaid fiscal agent identifies the adjustment transaction with an internal control number (ICN). Adjustment ICNs are formatted in the same way as claim numbers; the first two digits of an adjusted claim ICN indicate the type of adjustment:

50	Adjustments – Non-Check Related
51	Adjustments – Check Related
52	Mass Adjustments – Non-Check Related
53	Mass Adjustments – Check Related
54	Mass Adjustments – Void Transaction
55	Mass Adjustments – Provider Retro Rates
56	Adjustments – Void Non-Check Related
57	Adjustments – Void Check Related
58	Adjustment – Processed by DXC System Engineer
59	Adjustments/Voids Web – 837
60	Adjustments by State – Non-Check Related
61	Adjustments by State – Check Related
63	Adjustments Non Check History Only Adjustment
64	Void by State – Non-Check Related
65	Void by State – Check Related
66	History Only Non-Check Related Adjustment

67	History Only Check Related Adjustment
68	Adjustments Check Related History Only Adjustment
72	Encounter Adjustments
73	Encounter Mass Adjustments
74	Adjustments – Encounter
75	Adjustments – Encounter Void

Displayed to the right of the ICN are the provider's patient control number or medical record number from the original claim, the claim beginning and ending dates of service and the original billed amount. Keep in mind that the Arkansas Medicaid fiscal agent adjusts the entire claim, even if only one detail paid in error, so the total billed amount shown here is the total billed amount of the entire claim being adjusted. Other withheld or credited amounts that impact the paid amount are listed and can include insurance, spenddown, copay (coinsurance) and deductible amounts. The Adjustment EOB code entered when the claim was adjusted indicates the reason for initiating the claim adjustment.

The second part of the adjustment transaction displays the claim details and the adjudication of the reprocessed claim. Detail EOBs for each procedure code are shown.

Additional payment, overpayment to be withheld, refund amount applied as well as total claim adjustments are shown at the bottom of the *Claim Adjustments* report. The actual withholding of the original paid amount does not occur in the *Claim Adjustments* report; it occurs in the *Financial Transactions* report of the RA. Adjustments are listed in the *Accounts Receivable* section, with the appropriate amounts displayed under the field headings "A / R (Action/Reason) Number," "Setup Date,": "Original Amount," "Recoupment Amount to Date," "Balance," "Reason Code," "Adjustment ICN," "Previous ICN," and "Amount Recouped in Current Cycle." (See the discussion of *Financial Transactions* in Section 314.170.)

Finally, the total of all adjusted amounts paid or withheld from the remittance are displayed in the *Summary* report of the RA under the field header *Claims Data* "Claim Adjustments" and *Earnings Data* "Payments: Claim Specific: Current Cycle."

314.132 Adjustment Submitted with Check Payment 11-1-17

Some providers prefer to send a check for the overpayment amount with their adjustment request. In such a case, the original paid amount is listed in the *Financial Transactions* report of the RA with an EOB code indicating that the Arkansas Medicaid fiscal agent has received a check for that amount. Also, since the Arkansas Medicaid fiscal agent does not withhold that amount from the remittance, it appears in the *Summary* section under "Credit Amount" (instead of appearing under "Withheld Amount"). If the Arkansas Medicaid fiscal agent acknowledges more than one payment by check in *Financial Items*, the total of those check payments appears under "Credit Amount" in the *Claims Payment Summary* section. Amounts shown under "Credit Amount" are never deducted from the remittance because they are already paid.

314.133 Denied Adjustments 11-1-17

Occasionally an adjusted claim is denied. Adjustments can be denied for any of the reasons for which any other claim can be denied. Denied adjustments do not appear in the *Claim Adjustments* section. Denied adjustments do not reflect a cross-reference to the original claim. Denied adjustments appear at the end of the *Claims Denied* report. The original paid amount of the claim intended to be adjusted is withheld from the remittance and it is so indicated in the *Financial Transactions* section, listed under the adjustment ICN.

314.140 Claims Denied

11-1-17

This report identifies denied claims and denied adjustments. Denial reasons may include ineligible status, non-covered services and claims billed beyond the filing time limits. Claims in this section will be referenced alphabetically by the beneficiary's last name, thereby facilitating reconciliation with provider records. Up to four code numbers appear in the column for EOB (Explanation of Benefits) codes. Definitions of EOB codes are included in report CRA-EOBM-R of the RA report series. The EOB messages regarding denied claims specify the reason the Arkansas Medicaid fiscal agent is unable to further process the claims. Only fully denied claims report here; claims with partial detail denials appear either on the paid or adjustment RA forms as appropriate.

Denied claims are final. No additional action will be taken on denied claims.

Denied claims are listed on the RA in the same format as paid claims.

314.150 Claims In Process

11-1-17

The purpose of the Claims in Process report is to give the provider a list of all claims that are in suspense along with explanations on why they were suspended. The report is separated by individual claims and displays both header and detail data. EOB codes are displayed on this report.

This section lists claims that have been entered into the processing system but have not reached final disposition. Do not rebill a claim shown in this section, because it is already being processed and will result in a rejection as a duplicate claim. These claims will appear in this section until they are paid or denied.

314.160 Payment Hold

11-1-17

This report lists all ICNs whose payment is on hold in financial.

314.170 Financial Transactions

11-1-17

The purpose of this report is to give the provider a full accounting of their financial activity for the payment cycle period. This report is separated into three sections: non-claim specific payouts to the provider, non-claim specific refunds from the provider and accounts receivable. The sections detail the financial activity for expenditures and non-claim specific refunds received and applied during the current financial cycle. In addition, it lists all "automatic" (system recoverable) outstanding accounts receivables in A/R (Action/Reason) number order. Reason Codes for each item indicate why the action was taken.

314.180 Summary

11-1-17

This report summarizes all claim and financial activity for the provider for each financial cycle as well as year-to-date totals. In addition, it supplies the provider with information regarding lien and IRS backup withholding payments which are made to lien holders by the MMIS during the current cycle and year-to-date.

314.190 EOB Code Descriptions

11-1-17

This report lists all the Explanation of Benefits (EOB) codes and/or Adjustment Reasons (special EOB codes used to identify the primary reason for a claim adjustment) used in the RA report series and displays their corresponding descriptions.

The purpose of this report is to give the provider a better explanation of the reasons why claims are either suspended or denied. The EOB codes are also used to explain any discrepancies between amounts billed and amounts paid on paid claims.

314.200 Service Code Descriptions 11-1-17

This report lists procedure and/or revenue codes and descriptions for those that appear in the provider's RA report series.

320.000 ADJUSTMENT REQUEST 11-1-17

Adjustments can be completed using the provider portal or the Adjustment Request Form (AR-004) to correct a claim payment (even if the paid amount is $0.00) or to correct erroneous information on a paid claim. Include sufficient information on the request form to process the adjustment correctly. A copy of the corrected claim or transaction and a copy of the page of the RA it was paid on may be attached to offer further clarification. However, on joint Medicare/Medicaid claims, see Section 332.100 for instructions on adjustments. If a provider submits an Adjustment Request Form that is not valid, the Arkansas Medicaid fiscal agent Adjustment Unit will notify the provider by mail.

Adjustment Request Forms should be filed as soon as the incorrect payment has been identified. Requests for correction or review must be submitted to the Arkansas Medicaid fiscal agent within the 12-month timely filing deadline. Adjustment requests cannot be processed if more than 12 months have passed since the date of service.

View or print form AR-004 and instructions for completion. Read the instructions carefully. Be sure to complete all Adjustment Request Forms thoroughly and accurately so that they may be processed efficiently and correctly.

321.000 Explanation of Check Refund Form 11-1-17

If an overpayment occurs, then the provider is responsible for refunding the Medicaid Program.

Providers may refund the Medicaid Program by sending a check in the amount of the overpayment, made payable to the Arkansas Medicaid Program or by returning the original check issued by the Arkansas Medicaid fiscal agent. Submit a completed Explanation of Check Refund Form (CR-002) with the refund. **View or print form CR-002 and instructions for completion.**

In instances of underpayment, some providers prefer returning the original check or forwarding a check in the amount of the underpayment instead of requesting an adjustment. When the Arkansas Medicaid fiscal agent posts the refund, the amount of the refund appears in the *Claims Payment Summary* section of the RA. Once the refund is posted, the provider may resubmit the original or corrected claim for correct adjudication and payment.

Provide the following information in the appropriate fields on an Explanation of Check Refund Form (CR-002) for each refund you send to the Arkansas Medicaid fiscal agent:

A. Provider Name and Provider Identification Number

B. Refund Check Number, Check Date and Check Amount

C. 13-digit Claim Number (from RA)

D. Beneficiary ID Number and Name (as it appears on the RA)

E. Dates of Service on claim

F. Date of Medicaid Payment

G. Date of Service Being Refunded

H. Services Being Refunded (Enter procedure code with modifier if applicable.)

I. Amount of Refund

J. Amount of Insurance Received

K. Insurance Name, Address and Policy Number

L. Reason for Return (from codes listed on form)

M. Signature, Date and Telephone Number

This information allows the refund to be processed accurately and efficiently.

330.000 ADDITIONAL PAYMENT SOURCES

331.000 Introduction 11-1-17

The Medicaid Program is required by federal regulations to access all third-party payment sources and to seek reimbursement for services that have also been paid by Medicaid. "Third party" means an individual, institution, association, corporation or public or private agency that is liable for payment of all or part of the medical cost of injury, disease or disability of a Medicaid beneficiary. Arkansas Code Annotated § 20-77-306 incorporates the requirements of the federal Deficit Reduction Act of 2005 (DRA).

Examples of third-party resources are:

A. Medicare (Title XVIII) including Medicare Advantage Programs

B. Railroad Retirement Act

C. Insurance Policies (including insurance carried by an absent parent) such as:

1. Private health
2. Group health
3. Liability
4. Automobile, including casualty, medical payment, uninsured motorist, bodily injury coverage and underinsured benefits except benefits payable for or limited under the terms of the policy to property damage or wrongful death
5. A Managed Care Organization
6. A Pharmacy Benefit Manager
7. Indemnity

D. Worker's Compensation

E. Veteran's Administration

F. TRICARE (formerly known as CHAMPUS)

G. Social Security Disability Determination

H. Self-insured plans

l. Other parties that are, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service

Medicaid regulations concerning dual Medicare/Medicaid eligibility (including QMB) and coverage differ from the rules regarding other third-party payers and coverage. See Sections 133.300, 302.100 and 332.000 for additional information.

Arkansas Rehabilitation Services (ARS) is not a third-party source. If ARS and Medicaid pay for the same service, refund ARS.

Indian Health Services is not a third-party resource.

332.000 Patients With Joint Medicare-Medicaid Coverage 11-1-17

The following provider types accept Medicare-Medicaid Crossovers: Ambulatory Surgical Center, Chiropractic, Clinics, Dental, Domiciliary Care, Family Planning, Federally Qualified Health Center, Health Department, Hearing Services, Hemodialysis, Home Health, Hospital, Hyperalimentation, Independent Laboratory, Independent Radiology, Inpatient Psychiatric Services for Under Age 21, Nurse Practitioner, Nursing Home, Occupational, Physical and Speech Therapy Services, Physician, Podiatrist, Prosthetics, Rehabilitation Center, Rehabilitative Services for Persons with Mental Illness, Rural Health Clinic Services, Transportation, Ventilator Equipment and Visual Care.

Claim filing procedures for these provider types are in Sections 332.100 through 332.300.

332.100 Medicare-Medicaid Crossover Claim Filing Procedures 11-1-17

If medical services are provided to a patient who is entitled to and is enrolled with coverage within the original Medicare plan under the Social Security Act and also to Medicaid benefits, it is necessary to file a claim only with the original Medicare plan. The claim must be filed according to Medicare's instructions and sent to the Medicare intermediary. The claim should automatically cross to Medicaid if the provider is properly enrolled with Arkansas Medicaid and indicates the beneficiary's dual eligibility on the Medicare claim form. According to the terms of the Medicaid provider contract, a provider must "accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any appropriate deductible or coinsurance which may be due and payable under Title XIX (Medicaid)." See Section 142.700 for further information regarding Medicare/Medicaid mandatory acceptance of assignment for providers.

When the original Medicare plan intermediary completes the processing of the claim, the payment information is automatically crossed to Medicare's Coordination of Benefits Agreement (COBA) process and from there crossed to Arkansas Medicaid and the claim is processed in the next weekend cycle for Medicaid payment of applicable coinsurance and deductible. The transaction will usually appear on the provider's Medicaid RA within four (4) to six (6) weeks of payment by Medicare. If it does not appear within that time, payment should be requested according to the instructions below.

Claims for Medicare beneficiaries entitled under the Railroad Retirement Act **do not** cross to Medicaid. The provider of services must request payment of co-insurance and deductible amounts through Medicaid according to the instructions below, after Railroad Retirement Act Medicare pays the claim.

Medicare Advantage/Medigap Plans (like HMOs and PPOs) are health plan options that are available to beneficiaries, approved by Medicare, but run by private companies. These companies bill Medicare and pay directly through the private company for benefits that are a part of the Medicare Program, as well as offering enhanced coverage provisions to enrollees. Since these claims are paid through private companies and not through the original Medicare plan directly, these claims **do not** automatically cross to Medicaid; and the provider must request

payment of Medicare covered services co-insurance and deductible amounts through Medicaid according to the below instructions after the Medicare Advantage/Medigap plan pays the claim.

When a provider learns of a patient's Medicaid eligibility only after filing a claim to Medicare, the instructions below should be followed after Medicare pays the claim.

Instructions: The Arkansas Medicaid fiscal agent provides software and web-based technology with which to electronically bill Medicaid for crossover claims that do not cross to Medicaid. Additional information regarding electronic billing can be located in this Sections 301.000 through 301.200. Providers are strongly encouraged to submit claims electronically or through the Arkansas Medicaid website. Front-end processing of electronically and web-based submitted claims ensures prompt adjudication and facilitates reimbursement.

Providers without electronic billing capability must mail the appropriate National Standard Claim Form (CMS-1500 or CMS-1450) to DXC Technology, PO Box 34440, Little Rock, AR 72203. (See Section V of this manual for examples of CMS-1500 and CMS-1450).). Along with the National Standard Claim Form, providers must submit attachment DMS-600. (**View or print attachment DMS-600.**) Providers must also submit the Medicare Explanation of Benefits (EOMB). Claims must be submitted in the following order:

A. National Standard Claim Form

B. DMS-600

C. Medicare Explanation of Benefits (EOMB)

D. Other supporting or applicable documentation

Paper claims will be returned to the provider if not submitted in the above order.

332.200 Denial of Claim by Medicare

11-1-17

Any charges denied by the original Medicare plan, a Medicare Advantage/Medigap plan, or Railroad Retirement will not be automatically forwarded to Medicaid for reimbursement. An appropriate Medicaid claim form must be completed and a copy of the Medicare denial statement attached. Claims under these circumstances must be forwarded to the Provider Assistance Center (PAC) for processing. **View or print PAC contact information.**

332.300 Adjustments by Medicare

11-1-17

Any adjustment made by the original Medicare plan, a Medicare Advantage/Medigap plan, or Medicare Railroad Retirement, **will not** be automatically forwarded to Medicaid. If any Medicare payment source makes an adjustment that results in an overpayment or underpayment by Medicaid, the provider must submit in the following order:

A. Adjustment Request Form – Medicaid XIX AR 004 (**View or print Adjustment Request Form-Medicaid XIX AR-004**), available in Section V of this manual

B. National Standard Claim Form (CMS-1500 or CMS-1450)

C. Copy of the Medicare Explanation of Benefits (EOMB) reflecting Medicare's adjustment and other supporting documentation

Enter the provider identification number and the patient's Medicaid identification number on the face of the Medicare EOMB and mail all documents to the address located on the Adjustment Request Form (AR-004).

340.000 OTHER PAYMENT SOURCES

341.000 General Information 11-1-17

Many persons eligible for Arkansas Medicaid are covered by private insurance or may sustain injuries for which a third party could be liable. The following is an explanation of the patient's and the provider's roles in the detection of third-party sources and in the reimbursement of the third-party payments to the Medicaid Program for services that have been reimbursed by Medicaid.

The Arkansas Medicaid fiscal agent has a full-time staff of trained professionals available to assist with any questions or problems regarding third party liability, including payment of claims involving third party liability and requests for insurance information. Providers should contact the Provider Assistance Center (PAC) for any questions regarding third party liability. **View or print PAC contact information.**

342.000 Patient's Responsibility 11-1-17

It is the responsibility of the beneficiary to report the name and policy number of any other payment source to the provider of medical services at the time services are provided. The beneficiary must also authorize the insurance payment to be made directly to the provider.

343.000 Provider's Responsibility 11-1-17

It is the provider's responsibility to be alert to the possibility of third-party sources and to make every effort to obtain third-party insurance information. The provider should also inquire about liability coverage in accident cases and pursue this or notify Medicaid. It is the responsibility of the provider to file a claim with the third-party source and to report the third-party payment to the Medicaid Program. If a provider is aware that a Medicaid beneficiary has other insurance that is not reflected by the system, the insurance information should be faxed to the DMS Third Party Liability Unit. **View or print Third Party Liability Unit contact information.**

All Medicaid claims, including claims that involve third party liability, are filed on an assignment basis. In no case may the beneficiary be billed for charges above the Medicaid allowable on paid claims. A claim is considered paid even though the actual Medicaid payment has been reduced to zero by the amount of third party liability. This applies whether the third-party payment was reported on the original claim or was refunded by way of an adjustment or by personal check. All paid services that are limited by the Medicaid Program count toward the patient's benefit limits even when the amount of Medicaid payment is reduced to zero by the amount of third party liability, except for Medicare crossover claims with no secondary payer other than Medicaid.

The system provides fields to capture any third party liability (TPL) information the provider may obtain. The provider is required to record TPL for each claim submitted.

When a provider enters an electronic claim for services to a beneficiary who has other insurance coverage for the service and enters a TPL paid amount of $0.00, the software prompts the user to enter the date of the denial HIPAA Explanation of Benefits (HEOB) or the date of the HEOB showing that the allowed amount was applied to the insurance deductible.

350.000 REFERENCE BOOKS

351.000 ICD Diagnosis and Procedure Code Reference 11-1-17

The Arkansas Medicaid Program uses the current version of the *International Classification of Diseases (ICD)* as a reference for coding primary and secondary diagnoses for all providers required to file claims with diagnosis codes completed. ICD procedure codes are also required

for billing institutional inpatient hospital claims. Providers can order the ICD reference from various suppliers.

352.000 HCPCS and CPT Procedure Code References 11-1-17

The State of Arkansas uses the HCFA Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of Level I-CPT codes, Level II-HCPCS national codes and Level III-HCPCS local codes. If applicable, the state-assigned codes are listed in the Billing Procedures section of this manual.

The *Current Procedural Terminology (CPT)* is the professional component of the Healthcare Common Procedure Coding System (HCPCS). CPT is a systematic listing of medical terms and identifying codes for reporting medical services provided by physicians. Each procedure or service is identified with a 5-digit code. The use of CPT codes simplifies the reporting of services.

The CPT book and the HCPCS-Level II book also include modifiers, which are used in conjunction with some procedure codes. Providers can order the CPT and HCPCS books from various suppliers.

353.000 CMS-1450 (UB-04) Data Specifications Manual 11-1-17

Revenue codes and other data, which are used for institutional claims, can be found in the CMS-1450 (UB-04) Data Specifications Manual. Providers can order this manual by subscription.