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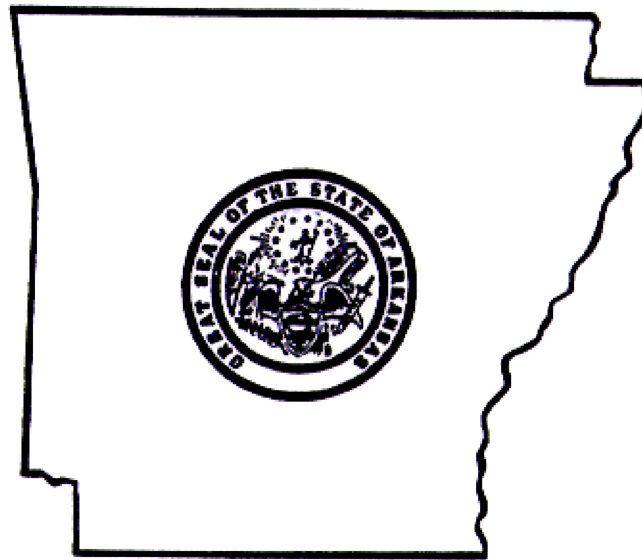

CHILDREN'S MEDICAL SERVICES (CMS)
TARGETED CASE MANAGEMENT
PROVIDER MANUAL

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EDS

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200.000 CMS TARGETED CASE MANAGEMENT GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Children's Medical Services (CMS) Targeted Case Management Program

The provider of targeted case management for CMS services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

A. The CMS targeted case management (TCM) provider must complete a provider application (DMS-652) and a Medicaid contract (DMS-653) with the Arkansas Medicaid Program. (See Section I of this manual.)

B. The provider application (DMS-652) and Medicaid contract (DMS-653) must be approved by the Arkansas Medicaid Program.

C. The CMS targeted case management staff must be licensed or certified in accordance with the requirements in section 201.100 to serve their respective target population.

201.100 Qualifications of Children's Medical Services (CMS) TCM Provider

Providers of CMS targeted case management services must be certified and have a demonstrated capacity to provide all core elements of case management, which includes:

A. Assessment
B. Care or service plan
C. Development
D. Linking or coordination of services
E. Reassessment
F. Follow-up of services

The case management staff for targeted case management for Children's Medical Services may include registered nurses, licensed social workers, pediatricians, registered dieticians, parent aides and clerical support staff who are credentialed or who are under the direct supervision of an appropriately credentialed case manager.

201.100 Qualifications of Children's Medical Services (CMS) TCM Provider (continued)

The qualifications for credentialed case manager include:

A. Registered Nurse

This individual must be licensed as a registered nurse by the Arkansas Board of Nursing and have satisfactorily completed a one-month (four-week) case management orientation provided by CMS.

B. Social Worker

This individual must be a licensed social worker in the state of Arkansas or be qualified through education, training or experience to work in a social work role and have satisfactorily completed a one-month (four-week) case management orientation provided by CMS.

C. Pediatrician

This individual must be a licensed M.D. in the state of Arkansas and have satisfactorily completed a one-month (four-week) case management orientation provided by CMS.

D. Parent Aide

This individual must be employed by CMS for the purpose of assisting families to access services and be a parent of a child with special health care needs. The parent aid must have satisfactorily completed the one-month (four-week) orientation provided by CMS. A parent aide cannot be a case manager of his or her own child.

E. Clerical Support Staff

This individual must have two years of experience with a program for children with special health care needs, in assisting families to obtain needed medical, social and educational services and must have demonstrated the ability to assist families appropriately to access needed services. The individual must have satisfactorily completed a two-week orientation training class with CMS.

202.000 CMS Targeted Case Management Providers in Bordering and Non-Bordering States

The Arkansas Medicaid CMS Targeted Case Management Program is limited to in-state providers only.

210.000 PROGRAM COVERAGE

210.100 Introduction

Children's Medical Services (CMS) serves as the Title V (Children with Special Health Care Needs) Agency within the single state agency, the Department of Human Services.

211.000 Scope

Medicaid covered CMS targeted case management services are services that assist recipients in accessing needed medical, social, and other support services appropriate to the recipient's needs.

CMS targeted case management services are covered when they are:

A. Medically necessary;

B. Provided to outpatients only;

C. Provided at the option of the recipient and by the provider chosen by the recipient;

D. Provided to recipients who have no reliable or available supports to assist them in gaining access to needed care and services; and they are

E. Services that directly affect the recipient but may not require the recipient's active participation (e.g., housing assistance).

F. Furnished in accordance with a service plan.

212.000 Target Population Covered by Children's Medical Services (CMS)

CMS targeted case managers enrolled as providers for this target population are restricted to serving recipients who are not receiving case management services under an approved waiver program, are not placed in an institution and are:

A. Aged 0 to 21 years and meet the medical eligibility criteria of Children's Medical Services (CMS)

B. Recipients in the state's Title V Children with Special Health Care Needs Agency

or are

C. SSI/TEFRA Disabled Children Program recipients, aged 0 to 16 years with any diagnosis(es).

213.000 Description of Service Activities

Children's Medical Services must provide the following targeted case management activities.

A. Needs Assessment

1. A written comprehensive assessment by CMS of the child's needs, including analysis of recommendations (e.g. medical records) regarding the service needs of the child.

2. Review of records of medical/psychological evaluations in order to assess the child's needs.

3. Development of a service plan with the family.

4. Assisting the recipient in accessing needed services.

B. Service Plan

Monitoring the child's progress by making referrals to service providers through telephone, written or personal contacts, tracking the child's appointments, performing follow-up on services rendered and performing periodic reassessments of the child's changing needs (including reviews of the child's medical records).

C. Preparing and maintaining case records, and documenting contacts, needed services, reports, the child's progress, etc. These activities may apply to either the needs assessment or the service plan.

214.000 Exclusions

Services that are not appropriate for CMS targeted case management and are not covered under the Arkansas Medicaid Program include, but are not limited to:

A. Targeted case management for recipients who are receiving case management services through the DDS Alternative Community Services Waiver program.

B. The actual provision of services or treatment. Examples include, but are not limited to:

1. Training in daily living skills
2. Training in work skills, social skills and/or exercise
3. Training in housekeeping, laundry, cooking
4. Transportation services
5. Counseling or crisis intervention services

C. Services that go beyond assisting individuals in gaining access to needed services. Examples include, but are not limited to:

1. Supervisory activities
2. Paying bills and/or balancing the recipient's checkbook
3. Observing a recipient receiving a service, e.g., physical therapy, speech therapy, classroom instruction
4. Travel and/or waiting time

D. Case management services that duplicate services provided by public agencies or private entities under another program authorized for the same purpose. For example, Targeted Case Management services provided to foster children duplicate payments made to a public agency and are therefore, not reimbursable.

E. Case management services that duplicate integral and inseparable parts of other Medicaid or Medicare services, (e.g., home health services), when provided on the same date of service.

F. Case management services provided to inpatients. Discharge planning is a required service of inpatient facilities. These facilities include, but are not limited to acute care hospitals, rehabilitative hospitals, inpatient psychiatric facilities, nursing homes and residential treatment facilities.

G. Case management services provided while transporting a recipient.

H. Time spent billing for targeted case management services

I. Time spent determining medical and financial eligibility for CMS.

J. Any activity relating to CMS authorization and payment of services.

215.000 Documentation Requirements

The targeted case management providers must keep and properly maintain written records. At a minimum, the following records must be included in the provider's files.

215.100 General Records

General records that must be available for review include:

A. A copy of the Arkansas Medicaid provider contract (form DMS-652) for participation in the Arkansas Medicaid Program.

B. Copies of the CMS TCM staff's licensures and/or certifications.

215.200 Documentation in Recipient Files

The CMS targeted case manager must develop and maintain sufficient written documentation to support each service for which billing is made. All entries in a recipient's file must be signed and dated by the CMS targeted case manager who provided the service, along with the individual's title. The documentation must be kept in the recipient's case file.

Documentation should consist of, at a minimum, material that includes:

A. When applicable, a copy of the original and all updates of the recipient's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).

B. The specific program services provided.

C. The date services are provided.

D. Updated progress notes describing the nature and extent of specific services provided. Progress notes are signed electronically.

E. The recipient's name and Medicaid identification number.

F. The name and title of the CMS targeted case manager providing the service.

G. A copy of the original, and all updates, of the CMS recipient's service plan.

215.300 Record Keeping Requirements

All records must be completed promptly, filed and retained 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 is longer.

All documentation must be made available, upon request, to authorized representatives of the Arkansas Division of Medical Services, the state Medicaid Fraud Control Unit, representatives of the Department of Health and Human Services and its authorized agents or officials.

At the time of an audit by the Division of Medical Services Medicaid Field Audit Unit, all documentation must be available at the provider's place of business during normal business hours. In the case of recoupment, there will be no more than thirty days allowed after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the thirty day period.

Failure to furnish records upon request may result in sanctions being imposed.

240.000 PRIOR AUTHORIZATION

Prior authorization is not required for CMS targeted case management services.

250.000 REIMBURSEMENT

250.100 Method of Reimbursement

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the recipient and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying the recipient is eligible for Medicaid prior to rendering services.

CMS targeted case management services must be billed on a per unit basis. One case management unit is the sum of CMS targeted case management activities that occur within a day.

251.000 Rate Appeal Process

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 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.

When the provider disagrees with the decision made by the Assistant Director, Division of Medical Services, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The Rate Review Panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff who will serve as chairperson.

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 panel will hear the question(s) and will submit a recommendation to the Director of the Division of Medical Services.

300.000 GENERAL INFORMATION

301.000 Introduction

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

Three 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. Billing Procedures: This section contains information on submitting claims via AEVCS options or paper. This section also contains information on procedure codes and other program-specific data elements.

C. Financial Information: This section contains information on the Remittance and Status report or Remittance Advice (RA) adjustments, refunds, and additional payment sources.

301.100 Automated Eligibility Verification and Claims Submission (AEVCS) System

The Automated Eligibility Verification and Claims Submission (AEVCS) System is the method of submitting Medicaid claims electronically. Medicaid requires AEVCS submission of the following claim types: UB-92, HCFA-1500, Visual Care, Dental, EPSDT, Pharmacy and Hospice/INH.

Providers have several choices of AEVCS submission methods: PES software, point of sale (POS) devices, or vendor systems.

301.200 PES Software

Provider Electronic Solution (PES) Application software is available for any provider who submits Medicaid claims. The minimum system requirements include, a minimum, 486/66 processor with 16 MB RAM, 30 MB free space, CD-ROM drive, and Windows 95 or higher. Claims can be transmitted for processing by almost any Hayes-compatible modem, with the exception of the US Robotics Voice Modem and Hewlett-Packard's HP "Pavillion". The software allows for eligibility verification and supports all claim types: HCFA-1500, UB-92, Dental, EPSDT, Hospice/INH, Pharmacy and Visual Care. The software also supports all Medicare/Medicaid crossover claim types: Inpatient Crossover, Outpatient Crossover, Professional Crossover and Long Term Care Crossover.

301.300 Other AEVCS Solutions

A. Vendor Systems - Providers who have an office management system can opt to have their vendors upgrade their system to support AEVCS on-line transactions. EDS provides vendor specifications to interested vendors. The cost of upgrading the provider's system to support AEVCS is the responsibility of the provider.

B. Batch Solution - Providers who want to transmit a large volume of claims using their existing office management system may request the vendor specifications, which contain the batch specifications, from EDS. The batch solution allows providers to call into a bulletin board system at EDS and upload a batch of claims (transactions). EDS processes the claims, then creates response files on the bulletin board for providers to download.

C. Emerald - This is a stand-alone POS device with a keyboard, printer and card-swipe. The Emerald is designed for use in offices with no other computer-based communication. The Emerald can be used to verify a patient's eligibility for Medicaid on the date of service, to key a claim for processing on-line or to reverse a claim submitted in error. (Reversals can only be processed on the same day the claim was accepted.)

D. Omni 380 - This is a stand-alone POS device with a keypad, printer and card swipe that allows the providers to verify a recipient's eligibility. Omnis can only check eligibility. The Omni can be beneficial in Admissions, Emergency Rooms and busy reception/check-in areas.

EDS maintains a Provider Assistance Center to assist Medicaid providers during regular business hours from 8:00 a.m. to 4:30 p.m. Central Time. See Section I of this manual for EDS holiday closings. Should you have any questions concerning claims payment, 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.

EDS has a staff of representatives available during regular business hours from 8:00 a.m. to 4:30 p.m. (see Section I of this manual for EDS holiday closings) to assist with any needs concerning POS devices. Please call the AEVCS Help Desk at 1-800-457-4275 (Toll Free) within Arkansas or locally and out-of-state at (501) 375-1025 for help with questions regarding software or POS devices.

EDS has a full time staff of Provider Representatives available for consultation regarding billing problems that cannot be resolved through the Provider Assistance Center. Provider Representatives are available to visit your office to provide training on billing.

302.000 Timely Filing

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 recipients 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 below will permit some flexibility for those who adhere closely to them.

302.100 Medicare/Medicaid Crossover Claims

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 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 6 months after the Medicaid "agency or the provider receives notice of the disposition of the Medicare claim."

Providers may not electronically transmit to EDS any claims for dates of service over 12 months in the past. To submit a Medicare/Medicaid crossover claim meeting the timely filing conditions in the first paragraph above, please refer to *Patients with Joint Medicare/Medicaid Coverage*, section 342.000, of this manual. In addition to following the billing procedures explained in section 342.000, enclose a signed cover memo or Claim Inquiry Form requesting payment for the Medicaid portion of a Medicare claim which was filed to Medicare within 12 months of the date of service, and which Medicare adjudicated more than 12 months after the date of service.

302.200 Clean Claims and New Claims

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

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. For Medicaid to consider that the submission is not a new claim and, therefore, is 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; *and*

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

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 denies for recipient 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.

302.400 Claims With Retroactive Eligibility (Continued)

To submit a claim for services rendered to a patient who is not yet eligible for Medicaid, enter, on the claim form or on the electronic format, a pseudo Medicaid recipient 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.

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 rendered to an ineligible individual, and 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 recipient 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 claim as a clean claim, denied by processing error, we may allow the provider to refile the claim when the government agency completes the eligibility determination. The provider must submit with the claim, 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.

302.500 Submitting Adjustments and Resubmitting Claims

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

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 (Form EDS-AR-004, section 330.000 of this manual) must be submitted to the address specified on the form. Attach the documentation necessary to explain why the error has prevented re-filing the claim until more than 12 months have passed after the beginning date of service.

302.520 Claims Denied Incorrectly

Submit a paper claim to the address below, attaching:

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

B. A copy of the error response to an AEVCS transmission, **computer-dated** within twelve (12) months after the beginning date of service; and

C. Attach 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:

EDS
Provider Assistance Center
P.O. Box 8036
Little Rock, AR 72203-8036

302.530 Claims Involving Retroactive Eligibility

Submit a paper claim to the address below, attaching:

A. A copy of the Remittance and Status Report or Remittance Advice (RA) page documenting a denial of the claim with 9999999999 as the Medicaid recipient identification number, dated within 12 months after the beginning date of service, *or*

B. A copy of the error response to an AEVCS transmission of the claim with 9999999999 as the Medicaid recipient identification number; the error response **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 a year has passed after the beginning date of service.

Send these materials to:

EDS
Provider Assistance Center
P.O. Box 8036
Little Rock, AR 72203-8036

302.600 ClaimCheck® Enhancement

To solve some of the billing problems associated with differing interpretations of procedure code descriptions, EDS implemented the ClaimCheck® enhancement to the Arkansas Medicaid Management Information System (MMIS) system. 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 330.000 for information about how to use the Adjustment Request Form. If you think your claim was denied incorrectly, contact the Provider Assistance Center (PAC) at the numbers listed below.

ClaimCheck® 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 ClaimCheck® implementation does not affect Medicaid policy.

If there are other questions regarding the function of ClaimCheck® edits, call the Provider Assistance Center (PAC) at (501) 376-2211 (local and out-of-state) or 1-800-457-4454 (in-state WATS).

303.000 Claim Inquiries

The Arkansas Medicaid Program distributes a weekly Remittance and Status Report or Remittance Advice (RA) to each provider with claims paid, denied or pending, as of the previous weekend processing cycle. (Sections 320.000 through 324.800 of this manual contain a complete explanation of the RA). Use the RA to verify claim receipt and to track claims through the system. Claims transmitted through the Automated Eligibility Verification and Claims Submission (AEVCS) system will appear on the RA within 2 weeks of transmission. Paper claims and adjustments may take as long as six weeks to appear on the RA.

If a claim does not appear on the RA within the amount of time appropriate for its method of submission, contact the EDS Provider Assistance Center. A Provider Assistance Center Representative can explain what system activity, if any, regarding the submission, has occurred since EDS 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.

303.100 Claim Inquiry Form

When a written response to a claim inquiry is preferred, use the Medicaid Claim Inquiry Form, EDS-CI-003, provided by EDS. The form in this manual may be copied, or a supply may be requested from EDS. A separate form for each claim in question must be used. EDS 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 330.000 of this manual for the Adjustment Request Form and information regarding adjustments.

303.200 Completion of the Claim Inquiry Form

To inquire about a claim, the following items on the Medicaid Claim Inquiry Form must be completed. A copy of this form follows these instructions. In order to answer your inquiry as quickly and accurately as possible, please follow these instructions:

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

B. Include supporting documents for your inquiry. (Use claim copies, AEVCS 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.

	Field Name and Number	**Instructions for Completion**
1.	Provider Number	Enter the 9-digit Arkansas Medicaid provider number assigned. If requesting information regarding a clinic billing, indicate the clinic provider number.
2.	Provider Name and Address	Enter the name and address of the provider as shown on the claim in question.
3.	Recipient Name (First, Last)	Enter the patient's name as shown on the claim in question.
4.	Recipient ID	Enter the 10-digit Medicaid identification number assigned to the patient.
5.	Billed Amount	Enter the amount the Medicaid Program was billed for the service.
6.	Remittance Advice Date	Enter the date of the Medicaid RA on which the claim most recently appeared.
7.	Date(s) of Service	Enter the month, day and year of the earliest date of service or the date range.

303.200 Completion of the Claim Inquiry Form (Continued)

	Field Name and Number	Instructions for Completion
8.	ICN (Claim Number)	Enter the 13-digit claim control number assigned to the claim by Medicaid. If the claim in question is shown on a Medicaid RA, this number will appear under the heading “Claim Number.”
9.	Provider Message/Reason for Inquiry	State the specific description of the problem and any remarks that may be helpful to the person answering the inquiry.
10.	Signature, Phone and Date	The provider of service or designated authorized individual inquiring must sign and date the form.

NOTE: The lower section of the form is reserved for the response to your inquiry.

MEDICAID CLAIM INQUIRY FORM

SUBMIT ONE CLAIM INQUIRY FORM PER CLAIM INQUIRY

EDS
P.O. Box 8036
Little Rock, Arkansas 72203

1. Provider Number ____________________
2. Provider Name and Address:

____

____

____

3. Recipient Name (first, last) ____________________
4. Recipient ID ____________________
5. Billed Amount __________ 6. RA Date__________
7. Date(s) of Service ____________________
8. ICN (Claim Number) ____________________

THE ABOVE INFORMATION IS USED FOR MAILING PURPOSES, PLEASE COMPLETE

9. Provider Message/Reason for Inquiry:____

____

____

____

____

____

10. Provider Signature______________________________ Phone__________Date ______________

RESERVED FOR EDS RESPONSE

Dear Provider:

- O This claim has been resubmitted for possible payment.
- O EDS can find no record of receipt of this claim as indicated above. Please resubmit.
- O This claim paid on ____________ in the amount of $ ____________.
- O This claim was denied on _____________ with EOB code ____________.
- O This claim denied on ________ with EOB code 952, "Service requires primary care physician referral."
- O This claim denied on ________ with EOB code 900, "Pricing of this procedure includes related services."
- O This claim denied on ________ with EOB code 280, "Recipient has other medical coverage, bill other insurance first."
- O This claim was received for payment after the 12 month filing deadline.

OTHER:____

____

____

____

EDS REPRESENTATIVE SIGNATURE ______________________________ DATE __________

304.000 Supply Procedures

304.100 Ordering Forms from EDS

To order EDS-supplied forms, please use the Medicaid Form Request, Form EDS-MFR-001. An example of the form appears in this section of the manual. EDS supplies the following forms:

Form	Number
Acknowledgement of Hysterectomy Information	(DMS-2606)
Adjustment Request Form - Medicaid XIX	(EDS-AR-004)
Certification Statement for Abortion	(DMS-2698)
Consent for Release of Information	(DMS-619)
DDTCS Transportation Survey	(DMS-632)
DDTCS Transportation Log	(DMS-638)
EPSDT	(DMS-694)
Explanation of Check Refund	(EDS-CR-002)
Hospice/INH Claim Form	(DHS-754)
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	(DCO-645)
Inpatient Services Medicare-Medicaid Crossover Invoice	(EDS-MC-001)
Long Term Care Services Medicare-Medicaid Crossover Invoice	(EDS-MC-002)
Medicaid Claim Inquiry Form	(EDS-CI-003)
Medicaid Form Request	(EDS-MFR-001)
Medicaid Prior Authorization and Extension of Benefits Request	(DMS-2694)
Medical Equipment Request for Prior Authorization & Prescription	(DMS-679)
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	(DMS-633)
Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral	(DMS-640)
Outpatient Services Medicare-Medicaid Crossover Invoice	(EDS-MC-003)
Personal Care Assessment and Service Plan	(DMS-618)
Primary Care Physician Selection and Change Form	(DMS-2609)
Professional Services Medicare-Medicaid Crossover Invoice	(EDS-MC-004)
Referral for Medical Assistance	(DMS-630)
Request for Extension of Benefits	(DMS-699)
Request for Extension of Benefits for Medical Supplies for Medicaid Recipients Under Age 21	(DMS-602)
Request for Prior Authorization and Prescription for Hyperalimentation	(DMS-2615)
Request for Private Duty Nursing Services Prior Authorization and Prescription - Initial Request or Recertification	(DMS-2692)
Request for Targeted Case Management Prior Authorization for Recipients Under Age 21	(DMS-601)
Sterilization Consent Form	(DMS-615)
Sterilization Consent Form - Information for Men	(PUB-020)
Sterilization Consent Form - Information for Women	(PUB-019)
Visual Care	(DMS-26-V)

304.100 Ordering Forms from EDS (Continued)

Complete the Medicaid Form Request, and indicate the quantity needed for each form.

Mail your request to:

EDS
Provider Assistance Center
P. O. Box 8036
Little Rock, AR 72203-8036

The Medicaid Program does not provide copies of the HCFA-1500 claim form. The provider may request a supply of this claim form from any available vendor. 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. The contact information is given below:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

Phone: (Toll Free) (866) 512-1800, between 7:30 a.m. and 4:30 p.m.
Fax: (202) 512 2250
Website: http://bookstore.gpo.gov
E-Mail: orders@gpo.gov

EDS requires the use of red-ink (censor coded) HCFA-1500 claim originals instead of copies. A new processing system uses scanners to distinguish between red ink of the form fields and blue or black ink claim data (provider number, Recipient Identification Number (RID), procedure codes, etc.).

MEDICAID FORM REQUEST

Provider #: ______________________________ Name: ____

Address: ____

City: ___________________________________ State/ZIP: _____________________________________

Please indicate the quantity of forms below:

_____ DCO-645 (Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage)

_____ DHS-754 (Hospice/INH Claim Form)

_____ DMS-26-V (Visual Care)

_____ DMS-601 (Request for Targeted Case Management Prior Authorization for Recipients Under Age 21)

_____ DMS-602 (Request for Extension of Benefits for Medical Supplies for Medicaid Recipients Under Age 21)

_____ DMS-615 (Sterilization Consent Form)

_____ DMS-618 (Personal Care Assessment and Service Plan)

_____ DMS-619 (Consent for Release of Information)

_____ DMS-630 (Referral for Medical Assistance)

_____ DMS-632 (DDTCS Transportation Survey)

_____ DMS-633 (Mental Health Services Provider Qualification form for LCSW, LMFT and LPC)

_____ DMS-638 (DDTCS Transportation Log)

_____ DMS-640 (Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral)

_____ DMS-679 (Medical Equipment Request for Prior Authorization & Prescription)

_____ DMS-694 (EPSDT)

_____ DMS-699 (Request for Extension of Benefits)

_____ DMS-2606 (Acknowledgement of Hysterectomy Information)

_____ DMS-2609 (Primary Care Physician Selection and Change Form)

_____ DMS-2615 (Request for Prior Authorization and Prescription for Hyperalimentation)

_____ DMS-2692 (Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification)

_____ DMS-2694 (Medicaid Prior Authorization & Extension of Benefits Request)

_____ DMS-2698 (Certification Statement for Abortion)

_____ EDS-AR-004 (Adjustment Request Form - Medicaid XIX)

_____ EDS-CI-003 (Medicaid Claim Inquiry Form)

_____ EDS-CR-002 (Explanation of Check Refund)

_____ EDS-MFR-001 (Medicaid Form Request)

_____ EDS-MC-001 (Inpatient Services Medicare-Medicaid Crossover Invoice)

_____ EDS-MC-002 (Long Term Care Services Medicare-Medicaid Crossover Invoice)

_____ EDS-MC-003 (Outpatient Services Medicare-Medicaid Crossover Invoice)

_____ EDS-MC-004 (Professional Services Medicare-Medicaid Crossover Invoice)

_____ PUB-019 (Sterilization Consent Form Information for Women)

_____ PUB-020 (Sterilization Consent Form Information for Men)

Received	Mailed
Date ______________________	Date ______________________
By ______________________	Qty ______________________

EDS-MFR-001 (Revised 10/02)

310.000 BILLING PROCEDURES

311.000 Introduction

CMS Targeted Case Management providers use the HCFA-1500 format to bill the Arkansas Medicaid Program for services provided to eligible Medicaid recipients. Providers using the Provider Electronic Solution (PES) software use the Professional claim form. Each claim may contain charges for only one recipient.

Providers submitting claims electronically, must maintain a daily electronic claim transaction summary, signed by an authorized individual. Refer to the Provider Contract (form DMS-653).

311.100 Billing Instructions - AEVCS

The Automated Eligibility Verification and Claims Submission (AEVCS) system is the electronic method for verifying a recipient's eligibility and filing claims for payment. A provider may file a claim immediately after providing a service. AEVCS will edit the claim for billing errors and advise of the claim's acceptance into the processing system for adjudication. If AEVCS rejects the claim, it will list up to 9 reasons for the rejection and permit the claim to be corrected and resubmitted.

EDS processes each week's accumulation of claims during the weekend cycle. The deadline for each weekend cycle is 12:00 midnight Friday.

Section 301.000 of this manual contains information on available AEVCS options.

311.110 PES Professional Claim Field Descriptions

The following table lists the values/comments for each of the fields associated with a Provider Electronic Solution (PES) Professional claim transaction. The last column provides a cross-reference to section 311.400 of this manual for specific field requirements and instructions.

Field Name	Values/Comments	Refer to Section 311.400
Header 1 Information		
Provider ID	Required field for all claim types. The 9-digit identification number of the provider who is to receive payment for the service. If the number you enter on the claim is not on file or not eligible on the dates of service you enter, the claim will not be accepted.	Field 33
Recipient – ID	The 10–digit, assigned identification number of the individual receiving services.	Field 1A
Recipient First Name	At least the first character of the recipient's first name.	Field 2
Recipient Last Name	At least the first two letters of the recipient's last name.	Field 2
Patient Account #	Unique number assigned by the provider's facility for the recipient. Optional field.	Field 26
Prior Authorization #	Not applicable to CMS Targeted Case Management.	Field 23
Referring Phys ID	Not applicable to CMS Targeted Case Management.	Field 17A

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
Header 2 Information		
Diagnosis Code	The identity of a condition or disease for which the service is being billed. Diagnosis codes are listed in the ICD-9-CM code book and are 3 to 5 characters. Each code identifies the condition or disease that makes the service medically necessary.	Field 21
Employment Related?	Not applicable to CMS Targeted Case Management.	Field 10A
Incident Date	Not applicable to CMS Targeted Case Management.	Field 14
Accident Related?	Not applicable to CMS Targeted Case Management.	Field 10B or 10C
Hospital Admit Date	Not applicable to CMS Targeted Case Management.	Field 18
Facility Name	If the services were rendered somewhere other than an office or home, enter the name of the facility.	Field 32
Facility Address	If the services were rendered somewhere other than an office or home, enter the address of the facility.	Field 32
Outside Lab Work?	Not applicable to CMS Targeted Case Management.	Field 20
Therapy Services Code	Not applicable to CMS Targeted Case Management.	Field 19
School District Code	Not applicable to CMS Targeted Case Management.	Field 19
Other Insurance?	If recipient has other insurance coverage, type Y. If not, type N.	N/A
TPL Paid Amount	The amount paid by the other insurance company. If *Other Insurance* is Y and *TPL Denial Date* is blank, this field is required.	Field 29
TPL Denial Date	The date on which the other insurance company denied payment for services billed.	N/A

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
TPL Information		
Carrier Code	Code assigned by the state to identify Third Party Liability (TPL) or other insurance carrier name and address. When you verify eligibility, the response includes the TPL Carrier Code along with other TPL information for the recipient. If you enter this code on a claim, you do not have to type the TPL Company name and address.	N/A
Policy Number	The recipient's third party insurance company policy number.	Field 11
Company Name	The name of the third party insurance company.	Field 11C
Address	The address of the third party insurance company.	N/A
Second TPL	Indicates whether the recipient has a second third party insurance. Response required if primary insurance is entered; "Y" = Yes "N" = No.	Field 11D
Carrier Code	Code assigned by the state to identify the second Third Party Liability (TPL) resource or other insurance carrier name and address.	N/A
Policy Number	The recipient's additional third party insurance company policy number.	Field 9A
Company Name	The name of the second third party insurance company.	Field 9D
Address	The address of the second third party insurance company.	N/A
Insured/Other Than Recipient – First Name	If the recipient is not the insured person, type the first name of the insured person.	Field 4

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
TPL Information (con't)		
Insured/Other Than Recipient – Last Name	If the recipient is not the insured person, type the last name of the insured person.	Field 4
Insured/Other Than Recipient – Address	If the recipient is not the insured person, type the address of the insured person.	N/A
Employer or School Name	Name of insured's employer or school.	Field 9C
Detail Information		
From DOS	Beginning date of service. For spanning dates of service, do not include any date on which no service was rendered. Units of service must be the same for each of the dates included in the span.	Field 24A
To DOS	Ending date of service. For spanning dates of service, do not include any date on which no service was rendered.	Field 24A
POS	Place of service code. Enter 0.	Field 24B
TOS	Type of service code. Enter 9.	Field 24C
Procedure	Enter Z1934.	Field 24D
Modifier	Not applicable to CMS Targeted Case Management.	Field 24D
Hours	Not applicable to CMS Targeted Case Management.	Field 24D
Minutes	Not applicable to CMS Targeted Case Management.	Field 24D
Extreme Age	Not applicable to CMS Targeted Case Management.	N/A
Surgical Avoid	Not applicable to CMS Targeted Case Management.	N/A

311.110 PES Professional Claim Field Descriptions (Continued)

Field Name	Values/Comments	Refer to Section 311.400
Detail Information (con't)		
Hypothermia	Not applicable to CMS Targeted Case Management.	N/A
Hypotension	Not applicable to CMS Targeted Case Management.	N/A
Pressure	Not applicable to CMS Targeted Case Management.	N/A
Circulation	Not applicable to CMS Targeted Case Management.	N/A
Units	Required field for all claim types. Number of units of a service that were supplied for the claim detail.	Field 24G
Diagnosis	The identity of a condition or disease for which the service is being billed for this detail. Diagnosis codes are listed in the ICD-9-CM code book and are 3 to 5 characters.	Field 24E
Charges	Required for all claim types. Provide the amount billed for a service performed for this detail. If you bill more than one unit of service on a detail, type the total charge for all units billed for that detail.	Field 24F
Fund Code	Not applicable to Medicaid claims.	N/A
EPSDT/Family Planning	If the service was rendered as the result of an EPSDT screening, type E.	Field 24H
Performing Provider ID	Not applicable to CMS Targeted Case Management.	Field 24K

311.120 PES Professional Claim Response

Field Name	Values/Comments
Recipient ID	Displays the 10 digit assigned identification number of the individual receiving services.
Recipient Name	Displays the recipient's first and last name.
Patient Acct	Displays the unique number assigned by the provider's facility for the recipient.
Transaction Type	Displays the transaction type. This response will read "HCFA-1500".
Date	Displays the date the claim was submitted.
Time	Displays the time the claim was submitted.
Pay to Provider Number	Displays the provider number of the provider that is to receive payment.
Primary TPL - TPL Indicator	Displays "Y" for yes or "N" for no, depending on the information that was submitted.
Secondary TPL – TPL Indicator	Displays "Y" for yes or "N" for no, depending on the information that was submitted.
Employment Related	Not applicable to CMS Targeted Case Management.
Accident Related	Not applicable to CMS Targeted Case Management.
Outside Lab Work	Not applicable to CMS Targeted Case Management.
Diagnosis	Displays up to four diagnosis codes and related descriptions.
Detail Number	Displays the number of the detail that was submitted, up to six. Each detail and detail criteria will be listed separately.

311.120 PES Professional Claim Response (Continued)

Field Name	Values/Comments
From Date of Service	Displays the beginning date of service for the detail submitted.
To Date of Service	Displays the ending date of service for the detail submitted.
Place of Service	Displays the place of service for the detail submitted.
Type of Service	Displays the type of service for the detail submitted.
Procedure Code	Displays the procedure code for the detail submitted.
Diagnosis	Displays the diagnosis code the detail is referring to.
Charge	Displays the dollar amount billed for the detail submitted.
Number of Units	Displays the number of units for the detail submitted.
Modifier	Not applicable to CMS Targeted Case Management.
Performing Provider	Not applicable to CMS Targeted Case Management.
Total Amount Billed	Displays the total amount billed for the submitted claim.
TPL Amount	Displays the total amount from other insurances on the claim submitted.
Net Amount Billed	Displays the amount billed minus the TPL amount on the submitted claim.
Claim Submission Accepted - Net Amount Billed	Displays the net billed amount for the claim submitted.
ICN	Displays the unique 13-digit internal control number assigned by EDS to an accepted or adjudicated claim.

311.130 PES Claim Reversal

Field Name	Values/Comments
Provider ID	Enter the 9-digit identification number of the provider who filed the claim being reversed.
Patient ID	Enter the 10-digit Medicaid recipient identification number of the individual receiving services.
ICN	Enter the unique 13-digit internal control number assigned by EDS to an accepted or adjudicated claim.

311.140 PES Claim Reversal Response

Field Name	Values/Comments
Transaction Type	Displays the transaction type. This response will read “Claim Reversal”.
Date	The date of the claim reversal.
Time	The time of the claim reversal.
Provider ID	Displays the 9-digit identification number of the provider who filed the reversed claim.
Patient ID	Displays the 10-digit Medicaid recipient identification number of the individual that received the services.
ICN	Displays the unique 13-digit internal control number assigned by EDS to an accepted claim. When a claim is reversed the ICN is no longer valid.

311.150 PES Rejected Claims and Claim Reversals

If a claim or claim reversal is rejected, PES will display error codes and the meaning of the codes.

311.200 Place of Service and Type of Service Codes

Place of Service	Type of Service
0 – Other locations	9 – Other Medical Service

311.300 Billing Instructions - Paper Claims Only

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 CMS Targeted Case Management, use the HCFA-1500. The numbered items correspond to numbered fields on the claim form. (A sample HCFA-1500 follows these billing instructions.)

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:

EDS
Claims
P.O. Box 8034
Little Rock, AR 72203

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.**

311.400 Completion of HCFA-1500 Claim Form

	Field Name and Number	Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
1a.	Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number as it appears on the AEVCS eligibility verification transaction response.
2.	Patient's Name	Enter the patient's last name and first name as it appears on the AEVCS eligibility verification transaction response.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number	Instructions for Completion
5. Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name, (post office box or RFD), city name, state name and zip code.
6. Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7. Insured's Address	Required if insured's address is different from the patient's address.
8. Patient Status	This field is not required for Medicaid.
9. Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
b. Other Insured's Date of Birth	This field is not required for Medicaid.
Sex	This field is not required for Medicaid.
c. Employer's Name or School Name	Enter the insured's employer's name or school name.
d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10. Is Patient's Condition Related to	
a. Employment	Not applicable to CMS Targeted Case Management.
b. Auto Accident	Not applicable to CMS Targeted Case Management.

311.400 Completion of HCFA-1500 Claim Form (Continued)

	Field Name and Number	Instructions for Completion
	c. Other Accident	Not applicable to CMS Targeted Case Management.
10d.	Reserved for Local Use	This field is not required for Medicaid.
11.	Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
	a. Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer's Name or School Name	Enter the insured's employer's name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13.	Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14.	Date of current: Illness Injury Pregnancy	Not applicable to CMS Targeted Case Management.
15.	If Patient Has Had Same or Similar Illness, Give First Date.	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.

311.400 Completion of HCFA-1500 Claim Form (Continued)

	Field Name and Number	Instructions for Completion
17.	Name of Referring Physician or Other Source	Not applicable to CMS Targeted Case Management.
17a.	I.D. Number of Referring Physician	Not applicable to CMS Targeted Case Management.
18.	Hospitalization Dates Related to Current Services	Not applicable to CMS Targeted Case Management.
19.	Reserved for Local Use	Not applicable to CMS Targeted Case Management.
20.	Outside Lab?	Not applicable to CMS Targeted Case Management.
21.	Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with Centers for Medicare and Medicaid Services (CMS) diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22.	Medicaid Resubmission Code	Reserved for future use.
	Original Ref. No.	Reserved for future use.
23.	Prior Authorization Number	Not applicable to CMS Targeted Case Management.
24.	A. Dates of Service	Enter the “from” and “to” dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number	Instructions for Completion
B. Place of Service	See section 311.200 for place of service (POS) codes.
C. Type of Service	See section 311.200 for type of service (TOS) codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	See section 312.000 for the procedure code.
Modifier	Not applicable to CMS Targeted Case Management.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only one diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD- 9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private-pay clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.

311.400 Completion of HCFA-1500 Claim Form (Continued)

	Field Name and Number	Instructions for Completion
	I. EMG	This field is not required for Medicaid.
	J. COB	This field is not required for Medicaid.
	K. Reserved for Local Use	Enter the provider number in Field 33 after “GRP#.”
25.	Federal Tax I.D. Number	This field is not required for Medicaid.
26.	Patient’s Account #	This is an optional entry that may be used for accounting purposes. Enter the patient’s (recipient’s) account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid.
28.	Total Charge	Enter the total of Column 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the recipient, unless the recipient has an insurer that requires copay. In such a case, enter the sum of the insurer’s payment and the recipient’s copay. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE:** For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.

311.400 Completion of HCFA-1500 Claim Form (Continued)

	Field Name and Number	Instructions for Completion
31.	Signature of Physician or Supplier Including Degrees or Credentials	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. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and zip code of the facility where services were performed.
33.	Physician's Suppliers, Billing Name, Address and Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
	PIN #	Not Required for Medicaid.
	GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."

RESERVED

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE(State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. ______ 3. ______

2. ______ 4. ______

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A		B	C	D	E	F	G	H	I	J	K
DATES OF SERVICE FROM MM DD YY	TO MM DD YY	Place Of Service	Type Of Service	PROCEDURES. SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I Certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

SAMPLE
DO NOT USE

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90) FORM AAD-1500

FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS. SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS, and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 US 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as other necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed. Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988" permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: 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, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this

SAMPLE DO NOT USE

burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

SAMPLE
DO NOT USE

312.000 SPECIAL BILLING PROCEDURES

312.100 CMS Targeted Case Management Procedure Codes

The CMS targeted case management (TCM) code is listed below. Providers must use this code when billing for CMS TCM services.

Procedure Code	Description	Benefit Limit
Z1934	CMS targeted case management.	One (1) unit per client per day.

RESERVED

320.000 REMITTANCE AND STATUS REPORT

321.000 Introduction of Remittance and Status Report

The Remittance and Status Report, or Remittance Advice (RA), is a computer generated document that reports the status and payment breakdown of claims submitted to Medicaid for processing. It is designed to simplify provider accounting by allowing accurate reconciliation of claim and payment records.

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 when payments 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.

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 RAs.

321.100 Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT) allows providers to have their Medicaid payments automatically deposited instead of receiving a check. See Section I of the provider manual for an enrollment form and additional information.

322.000 Purpose of the RA

The 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 become necessary to contact the EDS Provider Assistance Center (PAC). PAC will need the claim number from the RA to research the question.

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

323.000 Segments of the RA

There are eight main segments of an RA:

Report Heading
Paid Claims
Denied Claims
Adjusted Claims
Claims In Process
Financial Items
AEVCS Transactions
Claims Payment Summary

Refer to the explanation and example of the RA in the following sections. The printed column headings at the top of each page and the numbered field headings are described to help in reading the RA. The X characters represent monetary amounts.

324.000 Explanation of the Remittance and Status Report

324.100 Report Heading

	Report Heading	**Description**
1.	PROVIDER NAME AND ADDRESS	The name and address of the Medicaid provider to whom the Medicaid payment will be made.
2.	RA NUMBER	A unique identification number assigned to each RA.
3.	PROVIDER NUMBER	The unique 9-digit number to which this RA pertains. The payment associated with each RA is reported to the IRS on the federal tax ID linked to each provider number.
4.	CONTROL NUMBER	Internal page number for all RAs produced on each cycle date.
5.	REPORT SEQUENCE	Assigned sequentially for the provider's convenience in identifying the RA. The first RA received from EDS for the calendar year is numbered "1," the second "2," etc. Filing your RAs in numerical order by this number ensures that none are missing.
6.	DATE	The date the RA was produced. This is also the "checkwrite" date, or the date on the check associated with this RA.
7.	PAGE	The number assigned to each page comprising the RA. Numbering begins with "1" and increases sequentially.

324.100 Report Heading (Continued)

	Report Heading	Description
8.	NAME AND RECIPIENT ID	The recipient's last name, first name, middle initial and 10-digit Medicaid identification number. Claims are sorted alphabetically, by patient last name.
9.	SERVICE DATES	Format MM/DD/YY (Month, Day, Year) in "From" and "To" dates of service. For each detail, "From" indicates the beginning date of service and "To" indicates the ending date of service.
10.	DAYS OR UNITS	The number of times a particular service is billed within the given service dates.
11.	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	The CPT or HCPCS Procedure code – Billed on the claim. The type of service code directly precedes the 5-digit procedure code.
12.	TOTAL BILLED	The amount the provider bills per detail.
13.	NON-ALLOWED	The amount of the billed charge that is non-allowed per detail.
14.	TOTAL ALLOWED	The total amount Medicaid allows for that detail. (Total Allowed = Total Billed - Non-Allowed)
15.	SPEND DOWN	Not applicable to CMS Targeted Case Management.
16.	PATIENT LIABILITY	Not applicable.
17.	OTHER DEDUCTED CHARGES	The total amount paid by other resources (other insurance or co-pay if either exist).
18.	PAID AMOUNT	The amount Medicaid pays (Paid Amount = Total Allowed - Other Deducted Charges).
19.	EXPLANATION OF BENEFIT CODE(S)	A number corresponding to a message that explains the action taken on claims. The messages for the explanation codes are listed on the final page of the RA.
20.	COVER PAGE MESSAGES	Messages written for provider information.

324.200 Paid Claims

This section shows the claims that have been paid, or partially paid, since the previous checkwrite.

	Field Name	**Description**
1.	CO	County Code - A unique 2-digit number assigned to each recipient's county of residence.
2.	RCC	Reimbursement Cost Containment - The reimbursement rate on file for a hospital. This item doesn't apply to claims filed on HCFA-1500.
3.	COST SHARE, PA/LEA, TPL	"COST SHARE=" displays Medicaid and ARKids First-B copay amounts. "PA/LEA=" displays applicable prior authorization or LEA numbers. Third Party Liability (TPL) will show the amount paid from insurance or other sources.
4.	CLAIM NUMBER	A unique 13-digit control number assigned to each claim by EDS for internal control purposes. Please use this internal control number (ICN) when corresponding with EDS about a claim. Example: 0599033067530 (ICN) Format: RRYYDDDBBBSSS a. RR-05 - The first and second digits indicate the media the claim was submitted on to EDS (e.g., "05" - AEVCS, "10" - magnetic tape, "98" - paper, "50" - adjusted claims). b. YY-99 - The third and fourth digits indicate the year the claim was received.

324.200 Paid Claims (Continued)

	Field Name	Description
		c. DDD-033 - The fifth, sixth and seventh digits indicate the day of the year, or Julian date, the claim was received (e.g., 033 = February 2). d. The remaining digits are used for internal record-keeping purposes.
5.	MRN	Medical Record Number – The “patient control number” entered in electronic claim format, or “patient account number” (field 26) entered on the HCFA-1500 paper claim.
6.	DIAG	Diagnosis - The primary (first) diagnosis code used on the claim.
7.	SERV PHYS	Not applicable to CMS Targeted Case Management.
8.	ADMIT	Not applicable to CMS Targeted Case Management.
9.	COINS, DED, MCR PD, TPL	Coinsurance, deductible, the Medicare paid amount and will be listed for crossover claims. Third Party Liability (TPL) will show the amount paid from insurance or other sources.

324.300 Denied Claims

This section 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 recipient’s last name, thereby facilitating reconciliation with provider records. Up to three code numbers will appear in the column entitled EOB (Explanation of Benefit) codes. Definitions of EOB codes are on the last page of the RA. The EOB messages regarding denied claims specify the reason EDS is unable to process the claims further.

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.

324.400 Adjusted Claims

Payment errors - 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. Most adjustment transactions appear in the *Adjusted Claims* 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. EDS subtracts from today's check total the full amount paid on a claim that contained at least one payment error.

B. EDS reprocesses the claim - or processes the corrected claim - and pays the correct amount.

C. EDS adds the difference to the remittance (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 EDS additional funds) adjustments, adjustments involving withholding of previously paid amounts, adjustments submitted with check payments and denied adjustments. The following subsections thoroughly explain adjustments, how they appear on the RA, and the meaning, from a bookkeeping perspective, of each significant element.

324.410 The Adjustment Transaction

The *Adjusted Claims* section has two parts. Each part is divided into two segments. The first part is the adjustment transaction. The adjustment transaction is divided into a "Credit To" segment and a "Debit To" segment.

324.411 The "Credit To" Segment

The first segment of the adjustment transaction is the "Credit To" segment. In this section, EDS identifies the adjustment transaction, the adjusted claim, and the previously paid amount EDS will withhold from today's check as a result of this adjustment. The adjustment transaction is identified by an internal control number (ICN) that follows the field heading, "Claim Number." Adjustment ICNs are formatted in the same way as claim numbers; the first two digits of an adjustment ICN are "50." Immediately to the right of the adjustment ICN are the words "Credit To," followed by the claim number and paid date of the original claim that paid in error.

324.411 The "Credit To" Segment (Continued)

Underneath the "Credit To" line are displayed the recipient's Medicaid ID number, the claim beginning and ending dates of service and the provider's medical record number (or the patient account number) from the original claim, followed by the original billed amount. Keep in mind that EDS 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. At the right end of this line, in the "Paid Amount" column, is the amount originally paid on the claim, which is the amount EDS will withhold from today's remittance.

The actual withholding of the original paid amount does not occur in the *Adjusted Claims* section; it occurs in the *Financial Items* section of the RA. Adjustments are listed in *Financial Items*, with the appropriate amounts displayed under the field headings "Original Amount," "Beginning Balance," "Applied Amount" and "New Balance." (Please see the discussion of *Financial Items* in section 324.600.) Finally, the total of all amounts withheld from the remittance is displayed under "Withheld Amount," in the *Claims Payment Summary* section of the RA.

324.412 The "Debit To" Segment

A. The second segment of the adjustment transaction is the "Debit To" segment. In this segment, EDS displays the adjudication of the reprocessed claim and, for informational purposes, the net adjustment amount. The net adjustment amount is the additional amount to be paid in this remittance as a result of the adjustment, **or** it is the amount by which the remittance will be less than the total of all paid claims minus AEVCS fees and other withheld amounts.

B. The "Net Adjustment" amount - the amount due to EDS when adjusting an overpayment, or the amount due to the provider when adjusting an underpayment - is on the second line of the "Debit To" segment.

1. In the case of an adjustment of an underpayment, the "Net Adjustment" amount will be added to the total paid claims amount on today's remittance.

2. If EDS is due the amount shown as the net adjustment, the letters "CR" will immediately follow the amount. "CR" means that the claim's original paid amount is greater than the new paid amount (as when the original payment is an overpayment), and the amount denoted by "CR" must be deducted from the total paid claims amount on today's remittance.

C. Adjudication:

Immediately following the "Net Adjustment" line is the complete adjudication of the reprocessed claim, cross-referenced to the original claim number. The last line displays the new paid amount. The difference between the paid amount in the "Credit To" segment and the paid amount in the "Debit To" segment is the amount shown in "Net Adjustment." (See subpart B, above.)

324.420 Adjusted Claims Totals

At the end of the adjustment transactions is the total number of adjusted claims in today's RA, the total of all billed amounts, the total non-allowed amounts and the total of all paid amounts, the last being the total "Debit To" amount, as well.

For information purposes, the last segment is the total of all "Net Adjustment" amounts in today's RA. Net adjustment amounts displayed with "CR" are treated as negative numbers in the calculation of the net adjustment total.

324.430 Adjustment Submitted with Check Payment

Some providers prefer to send a check for the overpayment amount with their adjustment request. In such a case, the original paid amount displayed in the "Credit To" segment is listed in the *Financial Items* section of the RA with an EOB code indicating that EDS has received a check for that amount. Also, since EDS does not withhold that amount from the remittance, it appears in the *Claims Payment Summary* section under "Credit Amount" (instead of appearing under "Withheld Amount"). If EDS 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.

324.440 Denied Adjustments

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 *Adjusted Claims* section. Denied adjustments do not have "Credit To" segments. Denied adjustments do not reflect a cross-reference to the original claim. Denied adjustments appear at the end of the *Denied Claims* section. Their adjudication is displayed by detail, in the same manner as an adjustment "Debit To" segment. The original paid amount of the claim intended to be adjusted is withheld from the remittance and it is so indicated in the *Financial Items* section, listed under the adjustment ICN.

324.500 Claims In Process

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.

Summary totals follow this section.

	Field Name	Description
1.	RECIPIENT ID	The recipient's 10-digit Medicaid identification number.
2.	PATIENT NAME	The recipient's last name, first name and middle initial.
3.	SERVICE DATES: FROM	The beginning date of service for this claim.
4.	SERVICE DATES: TO	The ending date of service for this claim.
5.	ICN	Claim Number – The unique 13-digit number assigned to each claim for control purposes.
6.	TOTAL BILLED	The total amount billed by the provider. (The sum of the detail lines.)
7.	MEDICAL RECORD	The "patient control number" entered in electronic claim format, or "patient account number" (field 26) entered on the HCFA-1500 paper claim.
8.	EOB CODE(S)	Numeric representation of messages which explain what research is being done to the claim before payment can occur. Detailed descriptions of these messages will be listed on the last page of the RA.

324.600 Financial Items

This section contains a listing of the payments refunded by the provider, amounts recouped since the previous checkwrite, payouts and other transactions. It also includes any other recoupment activities being applied that will reflect negatively to the provider's total earnings for the year. The Explanation of Benefit codes beside each item indicate the action taken.

The "Credit To" entries from the *Adjusted Claims* section that are being recouped are listed in the *Financial Items* section. The "Credit To" portion of all adjusted claims appears in the *Adjusted Claims* section as information only and is actually applied in the *Financial Items* section.

	Field Name	Description
1.	RECIP ID	Recipient ID – The recipient's 10-digit Medicaid identification number.
2.	FROM DOS	The from date of service.
3.	TXN DATES	Transaction Dates – The date on which this transaction was entered into the system.
4.	CONTROL NUMBER	The unique number assigned to this transaction by EDS.
5.	REFERENCE	Information that may be of help in identifying the transaction (For example, claim number or AEVCS transaction fees).
6.	ORIGINAL AMOUNT	The original amount of the transaction. This amount will be the same on each RA for a particular transaction until it has been completed.
7.	BEGINNING BALANCE	The amount remaining for this transaction before this RA. (For example, if a recoupment had been initiated for $1,000.00, but only $200.90 was deducted, then the next RA would show a beginning balance of $799.10 to be recouped.)

324.600 Financial Items (Continued)

	Field Name	Description
8.	APPLIED AMOUNT	The amount applied on this RA to the beginning balance. (If the provider sent a refund check for two different recipients or if the monies were recouped from two different recipients, then the amounts applicable to each recipient would be displayed in the applied amount column individually.)
9.	NEW BALANCE	The amount left for this transaction after this RA.
10.	EOB	Explanation of Benefit Code(s) - The last page of the RA will give detailed descriptions.

324.700 AEVCS Transactions

This section contains a listing of all AEVCS transactions by the transaction category and transaction type submitted by the provider. It also contains separate totals for claim transactions, reversal transactions and total transactions for this provider.

	Field Name	Description
1.	TRANSACTION CATEGORY	This field indicates the type of transaction submitted by the provider.
2.	TRANSACTION TYPES	The type of claim transmitted by the provider.
3.	TRANSACTION COUNT	The total number of transactions for the transaction type.
4.	TRANSACTION AMOUNT	The total charges for transactions transmitted for the transaction type.
5.	TOTAL CLAIM TRANSACTION	The total number of claims transmitted and the total charges for the transaction category.
6.	TOTAL REVERSAL TRANSACTION	The total number of reversals submitted by the provider. This is informational only as there are no transaction fees for reversals.
7.	TOTAL TRANSACTIONS FOR THIS PROVIDER	The total number of AEVCS transactions, including claims transmitted, reversals, eligibility verifications and total charges.

324.800 Claims Payment Summary

This section summarizes Medicaid payments and credits made to the provider for the specific RA pay period under "Current Processed" and for the year under "Year to Date Total."

	Field Name	**Description**
1.	DAYS OR UNITS	The total units paid, denied and adjusted. Includes details added to indicate ARKids First-B copays. Does not included crossovers.
2.	CLAIMS PAID	Total number of claims paid, denied and adjusted by the Medicaid Program, including crossovers.
3.	CLAIMS AMOUNT	Total paid amount from *Paid Claims* section plus any supplemental payouts (e.g., a positive adjustment listed in the *Adjusted Claims* section).
4.	WITHHELD AMOUNT	Total amount withheld from RA (e.g., resulting from negative adjustments). This amount is the sum of the "Applied Amount" fields of the *Financial Items* section. This does not include the withheld AEVCS transaction amount.
5.	NET PAY AMOUNT	Claims amount less withheld amount(s) including AEVCS transaction fees. This is the amount of the provider's payment.
6.	CREDIT AMOUNT	Total amount refunded to the Medicaid Program by the provider. EDS posts check refunds here. See section 330.000.
7.	NET 1099 AMOUNT	The provider's income reported to Federal and State governments for tax purposes. This amount is the "Net Pay Amount" plus the "AEVCS Transaction Recoupment Amount". AEVCS transaction fees are paid with taxable revenue, so they are added back to the "Net Pay Amount" for tax reporting purposes.
8.	TAX AMOUNT	The amount of tax withheld on this RA. (Not currently used.)

324.800 Claims Payment Summary (Continued)

	Field Name	**Description**
9.	QTR TAX AMOUNT	Quarterly Tax Amount – The cumulative amount of tax withheld for this financial quarter. Not currently used.
10.	AEVCS TXN FEES	AEVCS Transaction Fees – Total amount of AEVCS transaction fees charged to the provider.
11.	AEVCS TXN RECOUP AMT	AEVCS Transaction Recoupment Amount – Total amount of AEVCS transaction fees withheld from the payment. This amount is obtained from the "Transfer Amount" corresponding to the "Total Transactions For This Provider" field of the AEVCS transaction section.
12.	DEF COMP RECOUP AMT	Deferred Compensation Recoup Amount – Amount withheld from the payment and deposited in the provider's designated account for deferred compensation.
13.	ARKIDS 1ST/CHIP/MEDICAID SUMMARY	A summary count and total amount paid for ARKids First, CHIP and Medicaid claims.
14.	DESCRIPTION OF EOB CODE(S)	The descriptions of all explanation of benefit codes used in the RA.
15.	FEDERAL TAX ID	The provider's social security number or federal Employer Identification Number (EIN). All monies paid to the provider will be reported to the IRS under this number. If the number listed is incorrect, contact the provider enrollment unit to update the file.

CMS Targeted Case Management sample RA

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

[1] PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

[2] R/A NUMBER 12345

[3] **STATE OF ARKANSAS**
PROVIDER NUMBER 123456176

[4] CNTRL NUM 1

[5] REPORT SEQ NUMBER 3

[6] DATE 12/01/01 PAGE 1 [7]

NAME RECIPIENT ID	SERVICE DATES FROM MM	DD	DD	TO MM	DD	YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
8			9				10	11	12	13	14	15	16	17	18	19

[20] TO ALL PROVIDERS

THE PURPOSE OF THE "RA MESSAE" IS TO KEEP YOU INFORMED. PLEASE READ EACH ONE AND CONTACT EDS IF YOU HAVE ANY QUESTIONS CONCERNING THE RA MESSAGE.

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

REMITTANCE ADVICES CANNOT BE FORWARDED. THEREFORE, THE ARKANSAS MEDICAID PROGRAM MUST BE NOTIFIED OF AN ADDRESS CHANGE WITH THE PROVIDER'S ORIGINAL SIGNATURE (NO FACSIMILE). PLEASE INDICATE ALL PROVIDER NUMBERS AFFECTED BY THE CHANGE.

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456176 | CNTRL NUM 2 | REPORT SEQ NUMBER 3 | DATE 11/01/01 PAGE 2

NAME RECIPIENT ID	SERVICE DATES FROM MM	DD	YY	TO MM	DD	YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
PAID CLAIMS MEDICAL	1			2				4	5	6		7		8		
DUNN, JOHN	CO = 60			RCC =				CLAIM NUMBER = 0501294123456	MRN =	DIAG = 29620	SERV PHYS = 123456176		ADMIT =			
0123456789	10	21	01	10	22	01	2 9	Z1934 CMS CASE MANAGEMENT	XX XX	XX XX	XX XX	00	00		XX XX	61
3	COST SHARE = 00						PA/LEA =	TPL = 00	XX XX	XX XX	XX XX	00	00		XX XX	TAX = 00
SMITH, BOB	CO = 26			RCC =				CLAIM NUMBER = 0501297123456	MRN =	DIAG = 29620	SERV PHYS = 123456176		ADMIT =			
0123654789	10	24	01	10	24	01	1 9	Z1934 CMS CASE MANAGEMENT	XX XX	XX XX	XX XX	00	00		XX XX	61
	COST SHARE = 00						PA/LEA =	TPL = 00	XX XX	XX XX	XX XX	00	00		XX XX	TAX = 00
2 CLAIMS						3	MEDICAL	****************	XX XX	XX XX	XX XX	00	00		XX XX TAX=00	
********* TOTAL PAID CLAIMS							2 CLAIMS		XX XX	XX XX	XX XX	00	00		XX XX TAX=00	

CMS Targeted Case Management sample RA (Continued)

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456176 CNTRL NUM 3 REPORT SEQ NUMBER 3 DATE 11/01/01 PAGE 3

NAME RECIPIENT ID	SERVICE DATES FROM MM	DD	DD	TO MM	DD	YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
DENIED CLAIMS MEDICAL																
SMITH, MARY	CO = 37			RCC =				CLAIM NUMBER = 9801292123456	MRN =	DIAG = 29620		SERV PHYS = 123456176	ADMIT =			
0112233456	10	19	01	10	19	01	1 9	Z1934 CMS CASE MANAGEMENT	XX XX	XX XX	00	00	00	00	00	470
	COST SHARE = 00						PA/LEA =	TPL = 00	XX XX	XX XX	00	00	00	00	00	TAX = 00
1 CLAIMS							1 MEDICAL	****************	XX XX	XX XX	00	00	00	00	00 TAX=00	
******* TOTAL DENIED CLAIMS							1 CLAIMS		XX XX	XX XX	00	00	00	00	00 TAX=00	

CMS Targeted Case Management sample RA (Continued)

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456176 | CNTRL NUM 4 | REPORT SEQ NUMBER 3 | DATE 11/01/01 PAGE 4

NAME / RECIPIENT ID	SERVICE DATES FROM (MM DD DD) / TO (MM DD YY)	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
ADJUSTED CLAIMS PROFESSIONAL ADJUSTMENT											
SMITH, MARY	CO = 37 CLAIM NUMBER = 5001289925450			** ADJUSTMENT	** CREDIT TO 9801289123456		PAID DATE 102801				
0112233456	10 16 01 10 16 01	1 9	MED REC =	XX XX						XX XX	
SMITH, MARY	CO = 37 CLAIM NUMBER = 5101289123456			** ADJUSTMENT	** DEBIT TO 9801289123456	NET ADJUSTMENT	PAID DATE 102801		SERV PHYS = 123456176 TAX= 00	XX XXCR	
0112233456	10 16 01 10 16 01	1 9	Z1934 CMS CASE MANAGEMENT	XX XX	XX XX	XX XX	00	00	00	XX XX TAX=00	61
	COST SHARE = 00	PA/LEA =	TPL = 00								
1 CLAIMS		1 PROFESSIONAL ADJUSTMENT *****									
*** TOTAL ADJUSTED CLAIMS		1 CLAIMS									
TOTAL NET ADJUSTMENT				XX XX	XX XX TOTAL NET TAX = 00	XX XX	00	00	00	XX XX XX XXCR	TAX=00

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456176 | CNTRL NUM 5 | REPORT SEQ NUMBER 3 | DATE 11/01/01 PAGE 5

NAME / RECIPIENT ID	SERVICE DATES FROM (MM DD DD) / TO (MM DD YY)	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
CLAIMS IN PROCESS MEDICAL	THESE CLAIMS ARE BEING PROCESSED AS LISTED										
[1] SMITH, FRANKLIN 5544332211 [2]	10 12 [3] 01 10 12 [4] 01		ICN 9801285123456 [5]	XX XX [6]	MEDICAL RECORD=430001001 [7]						14 [8]
1 CLAIMS			MEDICAL	********	XX XX						
** TOTAL PENDING CLAIMS			1 CLAIMS		XX XX						

CMS Targeted Case Management sample RA (Continued)

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456176 CNTRL NUM 6 REPORT SEQ NUMBER 3 DATE 11/01/01 PAGE 6

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	DD	TO MM	TO DD	YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
FINANCIAL ITEMS																
[1] RECIP ID	[2] FROM DOS			[3] TXN DATES			[4] CONTROL NUMBER	[5] REFERENCE			[6] ORIGINAL AMOUNT	[7] BEGINNING BALANCE	[8] APPLIED AMOUNT		[9] NEW BALANCE	[10] EOB
5544332211	10	16	01	10	27	01	9801285123564	SMITH, FRANKLIN			XX XX	XX XX	XX XX		XX XX	112
				10	29	01	5542421	AEVCS TRANSACTION FEES			XX XX	XX XX	XX XX		XX XX	112
								TOTAL FINANCIAL ITEMS 2								

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456176 CNTRL NUM 7 REPORT SEQ NUMBER 3 DATE 11/01/01 PAGE 7

NAME / RECIPIENT ID	SERVICE DATES FROM MM	FROM DD	DD	TO MM	TO DD	YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
AEVCS TRANSACTIONS																
[1] TRANSACTION CATEGORY							[2]	[3]	TRANSACTION COUNT		[4]	TRANSACTION AMOUNT				
CLAIM								HCFA		1			XX XX			
							[5]	TOTAL CLAIM TRASACTIONS		1			XX XX			
REVERSAL							[6]	TOTAL REVERSAL TRASACTIONS		1			XX XX			
ELIGIBILITY VERIFICATION										10			XX XX			
							[7]	TOTAL TRANSACTIONS FOR THIS PROVIDER		12			XX XX			

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456176 | CNTRL NUM 8 | REPORT SEQ NUMBER 3 | DATE 12/01/01 PAGE 8

NAME / RECIPIENT ID	SERVICE DATES FROM (MM DD DD) TO (MM DD YY)	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES

CLAIMS PAYMENT SUMMARY

	[1] DAYS OR UNITS	[2] CLAIMS PAID	[3] CLAIMS AMOUNT	[4] WITHHELD AMOUNT	[5] NET PAY AMOUNT	[6] CREDIT AMOUNT	[7] NET 1099 AMOUNT	[8] TAX AMOUNT	[9] QTR TAX AMOUNT
CURRENT PROCESSED	5	4	XX.XX	XX XX	XX XX	00	XX XX	00	00
YEAR-TO-DATE TOTAL	11	10	XX.XX	XX XX	XX XX	00	XX XX	00	00

	[10] AEVCS TXN FEES	[11] AEVCS TXN RECOUP AMT	[12] DEF COMP RECOUP AMT
CURRENT PROCESSED	XX.XX	XX.XX	.00
YEAR-TO-DATE TOTAL	XX.XX	XX.XX	.00

****
PROVIDER PAID BY EFT
****

[13] ARKIDS 1ST/CHIP/MEDICAID SUMMARY

	ARKIDS 1ST CLAIMS	ARKIDS 1ST TOTAL PAID	CHIP CLAIMS	CHIP TOTAL PAID	MEDICAID CLAIMS	MEDICAID TOTAL PAID
DRUG	0	0.00	0	0.00	0	0.00
DRUG ADJUSTMENT	0	0.00	0	0.00	0	0.00
MEDICAL	0	0.00	0	0.00	2	XX.XX
DENTAL	0	0.00	0	0.00	0	0.00
SCREEN	0	0.00	0	0.00	0	0.00
PROFESSIONAL CROSSOVER	0	0.00	0	0.00	0	0.00
VISION	0	0.00	0	0.00	0	0.00
PROFESSIONAL ADJUSTMENT	0	0.00	0	0.00	0	0.00
INPATIENT HOSPITAL	0	0.00	0	0.00	0	0.00
INPATIENT NURSING HOME	0	0.00	0	0.00	0	0.00
INPATIENT CROSSOVER	0	0.00	0	0.00	0	0.00
NURSING HOME CROSSOVER	0	0.00	0	0.00	0	0.00
NURSING HOME ADJUSTMENT	0	0.00	0	0.00	0	0.00
INPATIENT ADJUSTMENT	0	0.00	0	0.00	0	0.00
OUTPATIENT	0	0.00	0	0.00	0	0.00
OUTPATIENT CROSSOVER	0	0.00	0	0.00	0	0.00
OUTPATIENT ADJUSTMENT	0	0.00	0	0.00	0	0.00

[14] IF AN * APPEARS TO THE LEFT OF A DETAIL, PAID DETAIL HAS BEEN ADDED SYSTEMATICALLY.
IF ** APPEARS TO THE LEFT OF A DETAIL, A DENIED DETAIL WAS ADDED SYSTEMATICALLY. RECOMMENDED BILLING INDICATED ON DETAIL.

THE FOLLOWING IS A DESCRIPTION OF THE EOB CODES UTILIZED THROUGHOUT THE REPORT.

[15] **** FEDERAL TAX ID EIN 222334455

470 DUPLICATE OF CLAIM PAID.
14 CLAIM IN PROCESS. PLEASE DO NOT REBILL.
61 PAID IN FULL BY MEDICAID.
112 EOB CODE EXPLANATION

330.000 ADJUSTMENT REQUEST FORM

Use the Adjustment Request Form 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, the proper redlined crossover form must be attached. If a provider submits an Adjustment Request Form that is not valid, the EDS Adjustment Unit will notify the provider.

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

The following instructions explain how to complete the form. A copy of the form is included following these instructions. Read the instructions carefully and be sure to complete all Adjustment Request Forms thoroughly and accurately so that they may be handled efficiently.

331.000 Instructions for Completing the Adjustment Request Form

	Field Name and Number	**Instructions for Completion**
1.	Provider Number	Enter the 9-digit Arkansas Medicaid provider number under which payment is to be made.
2.	Provider Name and Address	Complete this field with the same information with which you bill Medicaid.
3.	Overpayment (Credit)	If duplicate payments, incorrect payments or overpayments are made, submit an adjustment request and check the box labeled overpayment. EDS will withhold (recoup) the overpayment amount from future claims payments.
4.	Underpayment (Debit)	If a claim is underpaid, check the box labeled underpayment to have the correct amount added to future claims payments.

331.000 Instructions for Completing the Adjustment Request Form (Continued)

	Field Name and Number	Instructions for Completion
5.	Informational Corrections	Check this box if the claim paid the correct amount using incorrect information, such as the wrong dates of service. This box should be checked only if it will not affect the amount paid.
6.	Claim Number (ICN - Internal Control Number)	Enter the 13-digit claim number exactly as it is printed on your RA.
7.	Patient Name	Enter the patient's last name, first name and middle initial.
8.	Recipient ID Number	Enter the entire 10-digit Medicaid recipient identification number as it appears on the RA.
9.	Remittance Advice Date	Enter the date of the RA, which is found at the top right corner of the RA.
10.	Date(s) of Service	Enter the beginning and ending month, day and year of the services rendered.
11.	Billed Amount	Enter the amount the Medicaid Program was actually billed for the service(s).
12.	Paid Amount	Enter the amount actually paid by Medicaid for the service(s) in question.
13.	Description of the Problem	Indicate a specific reason for the adjustment request and the nature of the incorrect payment.
14.	Signature and Date	Enter the signature of the requester and the date the adjustment request was prepared.

ADJUSTMENT REQUEST FORM - MEDICAID XIX

MAIL TO: EDS; Adjustments; P.O. Box 8036; Little Rock, AR 72203
IMPORTANT: If all required information is not complete, the form will be returned to provider.

Provider Number: ______________

Provider Name: ______________________

Address: ____________________________

____

☐ Overpayment: Please process to correct the overpayment.

☐ Underpayment: Please process to correct the underpayment.

☐ Informational Corrections: Please process to reflect the correct information.

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

Claim Number: ____________________ Patient Name: ____________________________

Recipient I.D. Number: ______________________ Remittance Advice Date: _____________

Date(s) of Service: __________________________

Billed Amount: ____________________________ Paid Amount: _______________________

Description of the Problem:

____

____

____

____

Signature: ___________________________________ Date: ______________________________

EDS USE ONLY

_____________ Date of Adjustment Reviewer: ______________________

Adjustment Action:

_________ Pay

_________ Deny

_________ Recoup

EDS-AR-004
Revised 6/02

332.000 Explanation of Check Refund Form

The Arkansas Medicaid Program generates RAs each week for providers who have claims paid, denied or in process. If an overpayment occurs, the provider is responsible for refunding the Medicaid Program.

Providers may refund to 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 EDS. Submit a completed Explanation of Check Refund Form with the refund.

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 EDS posts the refund, the amount of the refund appears in the *Claims Payment Summary* section of the RA. The provider may then resubmit the original or corrected claim for correct adjudication and payment.

Provide the following information in the appropriate fields on an Arkansas Medicaid Explanation of Check Refund Form for each refund you send to EDS:

1. Provider Name and Medicaid Provider Number
2. Refund Check Number, Check Date and Check Amount
3. 13 digit Claim Number (from RA)
4. Recipient ID Number and Name (as it appears on the RA)
5. Dates of Service
6. Date of Medicaid Payment
7. Date of Service Being Refunded
8. Services Being Refunded (enter procedure and type of service codes)
9. Amount of Refund
10. Amount of Insurance Received
11. Insurance Name, Address and Policy Number
12. Reason for Return (from codes listed on form)
13. Signature, Date and Telephone

This information will allow the refund to be processed accurately and efficiently.

Explanation of Check Refund

Mail To: Arkansas Medicaid
Refunds
PO Box 8104
Little Rock, AR 72203

Provider Name ______________________ Medicaid Provider Number ____________

Refund Check Number ________ Refund Check Date ________ Refund Check Amount ________

Information needed on each claim being refunded	**Claim 1**	**Claim 2**	**Claim 3**
13 digit Claim Number (from RA)			
Recipient's ID Number (from RA)			
Recipient's Name (Last, First)			
Date(s) of service on claim			
Date of Medicaid payment			
Date(s) of service being refunded			
Services being refunded			
Amount of refund			
Amount of insurance received, if applicable			
Insurance Co. name, address, and policy number, if applicable			
Reason for return (see codes listed below)			

1. BILL: An incorrect billing or keying error was made.
2. DUP: A payment was made by Arkansas Medicaid more than once for the same service(s).
3. INS: A payment was received from a third party source other than Medicare.
4. MC ADJ: An over application of deductible or coinsurance by Medicare has occurred.
5. PNO: A payment was made on a recipient who is not a client in this office.
6. OTHER: (Please explain)

____

____

Signature ______________________ Date ____________ Telephone ____________

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340.000 ADDITIONAL PAYMENT SOURCES

341.000 Introduction

The Medicaid Program is required by federal regulations to utilize all third party sources and to seek reimbursement for services that have also been paid by Medicaid. "Third party" means an individual, institution, corporation or public or private agency that is liable to pay all or part of the medical cost of injury, disease or disability of a Medicaid recipient. Examples of third party resources are:

A. Medicare (Title XVIII)

B. Railroad Retirement Act

C. Insurance Policies
   1. private health
   2. group health
   3. liability
   4. automobile/medical insurance
   5. family health insurance carried by an absent parent

D. Worker's Compensation

E. Veteran's Administration

F. CHAMPUS

The Medicaid policies concerning the handling of cases involving dual Medicare/Medicaid eligibility coverage differ from the policies concerning other third party coverage.

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

350.000 OTHER PAYMENT SOURCES

351.000 General Information

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 role in the detection of third party sources and in the reimbursement of the third party payment to the Medicaid Program for services that have been paid by Medicaid.

EDS has a full time staff of trained professionals 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 EDS Provider Assistance Center (PAC) for any questions regarding third party liability. PAC may be contacted at (501) 376-2211 (local and out-of-state) or 1-800-457-4454 (in-state WATS).

352.000 Patient's Responsibility

It is the responsibility of the recipient 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 recipient must also authorize the insurance payment to be made directly to the provider.

353.000 Provider's Responsibility

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 recipient has other insurance that is not reflected by AEVCS, the insurance information should be faxed to the DMS Third-Party Liability unit at (501) 682-1644.

All Medicaid claims, including claims that involve third party liability, are filed on an assignment basis. In no case may the recipient 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 whether it was refunded by way of an adjustment or by personal check. All paid 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 AEVCS 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 an AEVCS user enters a claim for services to a recipient 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 Explanation of Benefits (EOB) or the date of the EOB showing that the allowed amount was applied to the insurance deductible.

360.000 REFERENCE BOOKS

361.000 Diagnosis Code Reference

The Arkansas Medicaid Program uses the *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM) as a reference for coding primary and secondary diagnoses for all providers that are required to file claims with diagnosis codes completed.

You can order the ICD-9-CM online at http://www.ingenixonline.com/, or contact Ingenix using the information provided below.

Ingenix
P.O. Box 27116
Salt Lake City, UT 84127-0116

Fax: 1-800-982-4033
Telephone: 1-877-464-3649

362.000 HCPCS Procedure Code Reference

The State of Arkansas uses the HCFA Common Procedure Coding System (HCPCS). HCPCS is composed of unique state assigned codes and CPT codes. If applicable, the state-assigned codes are listed in the Billing Procedures section of this manual. *The Physician's Current Procedural Terminology* (CPT) is the basic component of the HCFA Common Procedure Coding System (HCPCS).

You can order the CPT online at http://www.ingenixonline.com/, or contact Ingenix using the information provided below.

Ingenix
P.O. Box 27116
Salt Lake City, UT 84127-0116

Fax: 1-800-982-4033
Telephone: 1-877-464-3649

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.