TOC not required

220.200 Central Clinical Records 6-1-25

A hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The Department of Human Services requires retention of all records for five (5) years or until all audits are completed, whichever is later. Each record must contain:

A. Primary care physician (PCP) referral (written referral from the PCP or oral referral noted in the clinical record) if the patient is not exempt from PCP referral requirements.

B. Physician statements certifying the patient's terminal illness.

C. Pertinent medical history.

D. Plan of care, including:

1. Plan of care revisions,
2. Initial and subsequent assessments and
3. Dates and pertinent notes of IDG meetings regarding the patients' care, including the names and signatures or initials of IDG members present and participating.

E. Election-of-hospice statement.

F. Acknowledgment of informed consent.

G. Revocation of Hospice and Change of Hospice statements when applicable.

H. Complete documentation of all services and events, including evaluations, treatments, service and progress notes, and service-time logs corresponding to continuous home care days billed to Medicaid.

I. Other correspondence, including any documented telephone conversations, between the patient (or the patient's authorized representative) and the hospice staff or administration, relevant to the patient's hospice services.

J. Correspondence, memoranda, notes, and observations regarding the performance of, and quality of service delivery by, other entities providing services or direct patient care under contract or other arrangement with the hospice.

K. Form DMS-9939 – Providers should use this form when a Medicaid beneficiary is being admitted to or discharged from Hospice services. This form should be completed and submitted to DMS UR (Utilization Review). **View or print the Arkansas Division of Medical Services, Utilization Review Section contact information**.

L. See Section 142.300 for additional details regarding conditions related to record keeping.

250.230 Completing a CMS-1450 (UB-04) Paper Claim for Hospice Care 6-1-25

Field #	Field name	Description

Field #	Field name	Description
01.	(blank)	**Required:** Enter the Hospice provider's name, (physical address – service location) city, state, ZIP code and telephone number.
02.	(blank)	The address that the provider submitting the bill intends payment to be sent if different from FL 01. (Use this address for provider's return address for returned mail.)
03a.	PAT CNTL #	**Required:** This field is for accounting purposes. Enter the patient's financial account number; the number the Hospice uses to retrieve individual patients' financial account information. The account ("PAT CNTL") number appears on the RA, labeled "**MRN**." This number ensures correct identification when reconciling the Medicaid remittance with patients' accounts. The Arkansas Medicaid fiscal agent accepts up to 16 alphanumeric characters in this field.
03b.	MED REC #	**Required:** Enter the patient's medical record number; the number the Hospice uses to file and retrieve individual patients' medical records. The Arkansas Medicaid fiscal agent accepts up to 15 alphanumeric characters in this field.
04.	TYPE OF BILL	**Required:** The first two digits must be **81** (Special Facility/Hospice, non-hospital based) or **82** (Special Facility/Hospice, hospital based). Use the applicable code from the UB-04 Manual for the third (i.e., frequency) digit.
05.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
06.	STATEMENT COVERS PERIOD—**FROM** and **THROUGH**	**Required:** Enter the first and last service dates on this claim. In the Hospice Program, these dates must be within the same calendar month. The format is **MMDDYY**.
07.	Not used	Reserved for assignment by the NUBC.
08a.	PATIENT NAME	**Required:** Enter the patient's last name, first name and middle initial.
08b.	(blank)	Not required.
09.	PATIENT ADDRESS	Optional.
10.	BIRTH DATE	**Required:** Enter the patient's date of birth. The format is **MMDDCCYY**.
11.	SEX	**Required:** Enter M for male, F for female, or U for unknown.

Field #	Field name	Description
12.	ADMISSION DATE	Enter the date that hospice services began or the date that the hospice plan of care was approved, whichever date is more recent. If the beneficiary has elected, then revoked hospice in the past, and then later re-elected hospice, enter the date services began under the most recent re-election or the date that the most recent new plan of care was authorized, whichever is more recent. The format is **MMDDYY.**
13.	ADMISSION HR	Not applicable to Hospice
14.	ADMISSION TYPE	Not applicable to Hospice
15.	ADMISSION SRC	Not applicable to Hospice
16.	DHR	Not applicable to Hospice
17.	STAT	**Required:** From the UB-04 manual, enter the code indicating the patient's disposition or discharge status on the Statement Covers Period THROUGH date (field 6).
18.-28.	CONDITION CODES	Enter when applicable. See the UB-04 Manual for requirements and for the codes used to identify conditions or events relating to this bill.
29.	ACDT STATE	Not required.
30.	(blank)	Unassigned data field.
31.-34.	OCCURRENCE CODES AND DATES	Enter when applicable. See the UB-04 Manual.
35.-36.	OCCURRENCE SPAN CODES AND DATES	Not applicable to Hospice
37.	Not used	Reserved for assignment by the NUBC.
38.	Responsible Party Name and Address	Not applicable to Hospice
39.	VALUE CODES	**Required** when the claim is for only one consecutive period (within the same calendar month) of one Hospice care category (**except Continuous Home Care**) and that consecutive period is identical to the period identified by the Statement Covers Period (field 6) FROM and THROUGH dates. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeroes (00) to the right of the vertical dotted line. Not applicable to Continuous Home Care.
a.	CODE	When applicable, as determined by the VALUE CODES requirement rule, enter 80.
b.	AMOUNT	When applicable, as determined by the VALUE CODES requirement rule, enter the number of days between the Statement Covers Period FROM date and THROUGH date (field 6), inclusive. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeroes (00) to the right of the vertical dotted line.

Field #	Field name	Description
40.	VALUE CODES	Not required.
41.	VALUE CODES	Not required.
42.	REV CD	**Required:** Enter the applicable Hospice Program revenue code. When the claim is for Continuous Home Care, enter revenue code **0652** once for each date of service
43.	DESCRIPTION	**Required:** From the UB-04 Manual, enter the Hospice revenue code's Standard Abbreviation. Required only on paper claims
44.	HCPCS/RATE/HIPPS CODE	Not applicable to Hospice
45.	SERV DATE	**Required on claims for Continuous Home Care.** Enter the applicable date of service for each entry of revenue code **0652**. Every service date must be within the Statement Covers Period FROM and THROUGH dates (field 6), inclusive. **Required** when the claim is for non-sequential service dates for one Hospice care category (excluding Continuous Home Care, which has its own billing rules) or for more than one Hospice care category. When required, enter a service date for each entry of each Hospice revenue code. Service dates must be within the Statement Covers Period FROM and THROUGH dates (field 6), inclusive.
46.	SERV UNITS	When service dates are required in field 45, service units are required in field 46. For Continuous Home Care, enter total hours of service for each service date. For the other three categories of Hospice care, enter "1" for each service date when service dates are required.
47.	TOTAL CHARGES	**Required**: Enter the total charge for the revenue code on each line (Units times the charge for one unit of service).
48.	NON-COVERED CHARGES	Not applicable to Hospice
49.	Not used	Reserved for assignment by the NUBC.
50.	PAYER NAME	**Required:** Enter "Medicaid"
51.	HEALTH PLAN ID	Report the HIPAA National Plan Identifier; otherwise report the legacy/proprietary number.
52.	REL INFO	**Required: One of two alternative entries** 1) "**I**" ("Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes") when the Hospice provider has not collected a Release of Information Certification Signature from the patient or the patient's representative, or 2) "**Y**" ("Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim"). **This is a HIPAA Privacy Rule requirement.**
53.	ASG BEN	Not applicable to Hospice

Field #	Field name	Description
54.	PRIOR PAYMENTS	**Required when applicable**. Enter all payments made by any other parties toward this bill. See the UB-04 Manual
55.	EST AMOUNT DUE	Not applicable to Medicaid
56.	NPI	**Either NPI or Medicaid Provider ID Required**: Enter NPI of the billing provider or if submitting with the 9 digit Medicaid Provider ID enter the number in field 57.
57.	OTHER PRV ID	**Required:** Enter the 9-digit Arkansas Medicaid provider ID number of the billing Hospice provider.
58. A, B, C	INSURED'S NAME	Not applicable to Medicaid.
59. A, B, C	P REL	Not applicable to Medicaid.
60. A, B, C	INSURED'S UNIQUE ID	**Required;** Enter the patient's Medicaid identification number.
61. A, B, C	GROUP NAME	**Required** when the patient is insured by another payer or other payers. Refer to the UB-04 manual.
62. A, B, C	INSURANCE GROUP NO	**Required** when applicable. See the UB-04 Manual.
63. A, B, C	TREATMENT AUTHORIZATION CODES	**Required** only when a benefit extension was required for an Inpatient Respite Care stay. When required, enter the benefit extension control number.
64. A, B, C	DOCUMENT CONTROL NUMBER	Field used internally by Arkansas Medicaid. No provider input.
65. A, B, C	EMPLOYER NAME	**Required** when a beneficiary is covered by other insurance through an employer. Enter the employer's name.
66.	DX	Diagnosis Version Qualifier. See the UB-04 Manual. Qualifier Code "9" designating ICD-9-CM diagnosis required on claims. Qualifier Code "0" designating ICD-10-CM diagnosis required on claims. Comply with the UB-04 Manual's instructions on claims processing requirements.
67.	(blank)	**Required** when applicable. Enter any ICD-9-CM or ICD-10-CM diagnosis codes for other conditions that coexist with the terminal condition.
68.	Not used	Reserved for assignment by the NUBC.
69.	ADMIT DX	**Required.** Enter the most specific ICD-9-CM or ICD-10-CM diagnosis code that corresponds to the beneficiary's terminal condition.
70.	PATIENT REASON DX	Not applicable to Hospice
71.	PPS CODE	Not required.
72	ECI	Not applicable to Hospice.

Field #	Field name	Description
73.	Not used	Reserved for assignment by the NUBC.
74.	PRINCIPAL PROCEDURE CODE AND DATE and OTHER PROCEDURE CODES AND DATES	Not applicable to Hospice.
75.	Not used	Reserved for assignment by the NUBC.
76.	ATTENDING NPI	Enter NPI for primary attending physician.
	QUAL	Enter the 9-digit Arkansas Medicaid provider ID number of the primary attending physician.
	LAST	**Required:** Enter the last name of the primary attending physician during this episode of care.
	FIRST	**Required:** Enter the primary attending physician's first name.
		Note: Either the NPI or the 9-digit Arkansas Medicaid provider ID number is required in field 76.
77.	OPERATING NPI	Not applicable to Hospice
	QUAL	Not applicable to Hospice
	LAST	Not applicable to Hospice
	FIRST	Not applicable to Hospice
78.	OTHER NPI	**NPI only required for referring provider:** Enter NPI of the referring provider.
	QUAL	**Not Required.**
	LAST	**Required:** Enter the referring physician's last name.
	FIRST	**Required:** Enter the referring physician's first name.
		NOTE: When there is no referring physician, enter the same information entered in field 76.
79.	OTHER NPI	**Required for Inpatient Respite Care and General Inpatient Care claims**. Enter NPI of the Inpatient Facility.
	QUAL	Enter the 9-digit Arkansas Medicaid provider ID number of the inpatient facility.
		Note: Either the NPI or the 9-digit Arkansas Medicaid provider ID number is required in field 79.
	LAST	Not applicable
	FIRST	Not applicable.
80.	REMARKS	For provider's use. Providers may enter the inpatient facility's name and/or other notes here.
81.	Not used	Reserved for assignment by the NUBC.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION _____
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Hospice Provider Manual

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

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

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

   If no, please explain:

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

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

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

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

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

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

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

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

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

Current Fiscal Year	**Next Fiscal Year**
$	$

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

Current Fiscal Year	**Next Fiscal Year**
$ 0.00	$ 0.00

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

Yes ☐ No ☑

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

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

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

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

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

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

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

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.