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TO: **Arkansas Medicaid Health Care Providers – Visual Care**

DATE: **July 1, 2005**

SUBJECT: **Provider Manual Update Transmittal #62**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000 – 201.100	10-13-03	201.000 – 201.100	7-1-05
242.110	4-15-05	242.110	7-1-05
243.300 – 243.310	10-13-03	243.300 – 243.310	7-1-05

Explanation of Updates

Sections 201.000 and 201.100 are included to add language pertaining to the Arkansas Medicaid Participation Requirements.

Section 242.110 is included to indicate two new modifiers being used. Effective for claims for dates of service on or after July 1, 2005, modifier **UB** replaces modifier 52 and modifier **UA** replaces modifier 22.

Sections 243.300 and 243.310 are included to delete obsolete information. In section 243.310, obsolete information has been removed from field number 29 of the CMS-1500 claim form instructions regarding recipient co-payments imposed by private insurance. The recipient is no longer responsible for insurance co-payments.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

201.000 Arkansas Medicaid Participation Requirements for Visual Care Providers 7-1-05

Visual Care Program providers meeting the following criteria are eligible for participation in the Arkansas Medicaid Program:

A. Provider must be licensed by the State Board of Optometry to practice in his or her state. A current copy of the optometrist's license must be submitted with the provider application for participation. Subsequent licensure must be provided when issued.

B. Provider must be enrolled in the Title XVIII (Medicare) Program.

C. Provider must complete a provider application (Form DMS-652), a Medicaid contract (Form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print the provider application (Form DMS-652), the Medicaid contract (Form DMS-653) and the Request for Taxpayer Identification Number and Certification (Form W-9).**

D. The Arkansas Medicaid Program must approve the provider application and the Medicaid contract as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

Visual Care Providers in Arkansas and Bordering States

Visual Care Program providers in Arkansas and the bordering states of Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas will be enrolled as routine services providers.

Routine Services Providers

A. Provider will be enrolled in the program as a regular provider of routine services.

B. Reimbursement will be available for all visual care services covered in the Arkansas Medicaid Program.

C. Claims must be filed according to section 240.000 of this manual. This includes assignment of ICD-9-CM and HCPCS codes for all services rendered.

Visual Care Providers in Non-Bordering States

All Visual Care Program providers in non-bordering states may be enrolled only as limited services providers.

Limited Services Providers

A. Providers will be enrolled in the program to provide prior authorized or emergency services only.

"Emergency services" are defined as inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.
Source: 42 U.S. Code of Federal Regulations §422.2 and §424.101.

"Prior authorized services" are those that are medically necessary and not available in Arkansas. Each request for these services must be made in writing, forwarded to the Utilization Review Section and approved before the service is provided. An Arkansas Medicaid Provider Contract must be signed before reimbursement can be made. A provider number will be assigned upon receipt and approval of the provider application and

Medicaid contract. **View or print the Division of Medical Services, Utilization Review Section contact information**.

B. Limited Services provider claims will be manually reviewed prior to processing to ensure that only emergency or prior authorized services are approved for payment. These claims should be mailed to the Arkansas Division of Medical Services, Program Communications Unit. **View or print the Division of Medical Services, Program Communications Unit contact information.**

201.100 Group Providers of Visual Care Services 7-1-05

Group providers of visual care services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

In situations where an optometrist is a member of a group, each individual optometrist and the group must both enroll according to the following criteria:

A. Each individual optometrist in the group must enroll following the criteria established in section 201.000.

B. The group must complete a provider application and Medicaid contract as an Arkansas Medicaid provider of visual care services. See Section I of this manual. The Arkansas Medicaid Program must approve the provider application and the Medicaid contract as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

All group providers are “pay to” providers only. The service must be performed and billed by a licensed and enrolled optometrist with the group.

242.110 Visual Procedure Codes 7-1-05

The following services are covered under the Arkansas Medicaid Program.

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
DIAGNOSTIC AND ANCILLARY SERVICES				
S0620 S0621	—	VISION ANALYSIS AND DIAGNOSIS (SINGLE VISION) This service must include the following: case history, general health observation, external exam of the eye and adnexa, ophthalmoscopic examination, determination of refractive state, basic sensorimotor and binocularity examination. It may also include initiation of diagnostic and treatment programs or referral.	yes	yes
92340	—	PRESCRIPTION SERVICES This service includes determination of prescription, sizing, ordering, verification, dispensing of spectacles and follow-up services for the life of the prescription.	yes	yes
99173	UB	PRELIMINARY EVALUATION (MODIFIED SCREENING) This procedure must include at minimum three of the services listed under procedure code V0100. This code may not be billed in conjunction with procedure code V0100.	yes	yes
CONTACT LENS SERVICES				
S0592	—	VISION ANALYSIS AND CONTACT LENS EXAM This service must include the following: biomicroscopy, multiple ophthalmometry, case history, tear flow, measurement of ocular adnexa, initial tolerance evaluation, and may include other tests. This procedure does not include contact lens and should be billed in conjunction with other contact lens procedure codes. If billing this code, **DO NOT** bill V0100. Contacts and glasses may be ordered using this code.	yes W/PA	yes W/PA
S0512	—	SUPPLYING AND FITTING OF CONTACT LENS (HARD) Spherical, aphakic, lenticular, toric, prism ballast (per lens)	yes W/PA	yes W/PA

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
S0512	—	SUPPLYING AND FITTING OF CONTACT LENS (SOFT) Spherical, aphakic, lenticular, toric, hydrophilic (per lens)	yes W/PA	yes W/PA
S0512	—	SUPPLYING AND FITTING OF CONTACT LENS (GAS PERMEABLE) Spherical, aphakic, lenticular, toric, prism ballast (per lens)	yes W/PA	yes W/PA
V2501	UA	SUPPLYING AND FITTING OF KERATOCONUS LENS (HARD OR GAS PERMEABLE) - per lens	yes W/PA	yes W/PA
S0512	—	SUPPLYING AND FITTING OF MONOCULAR LENS (HARD OR GAS PERMEABLE) - per lens	yes W/PA	yes W/PA
V2501	U1	SUPPLYING AND FITTING OF MONOCULAR LENS (SOFT LENS) - per lens	yes W/PA	yes W/PA
LOW VISION SERVICES				
92002	UB	LOW VISION EVALUATION	yes W/PA	yes W/PA
SUPPLEMENTAL PROCEDURES				
92081	U1	VISUAL FIELD - Electronic or Goldmann	yes	yes
92081	U1	VISUAL FIELD - Confrontation Perimetry	yes	yes
MISCELLANEOUS SERVICES				
92100	UB	TONOMETRY This procedure will only be covered when medically necessary. These conditions include, but are not limited to, diabetes, hypertension and age of the patient.	yes	yes
92393	—	OCULAR PROSTHESIS This procedure must include fitting, prescriptions and supplying of stock artificial eyes with medical supervision of adaptation.	yes W/PA	no
V2624	—	CLEANING OF PROSTHESIS	yes W/PA	no
REPAIRS AND MATERIAL SERVICES				
V2025	—	FRAME REPLACEMENT This procedure is for professional services only when replacing the whole frame. This procedure may be billed in conjunction with procedure code 92390 (Z0146) for material cost or the material may be ordered through the current optical contractor.	yes	no

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
PROFESSIONAL SERVICES FOR LENS REPLACEMENT				
S0504	RP	LENS REPLACEMENT - SINGLE VISION This procedure is for professional services only. It may be billed in conjunction with procedure code 92390 (Z0146) or through the current optical contractor.	yes	yes W/PA
S0506	RP	LENS REPLACEMENT - BIFOCAL This procedure is for professional services only. It may be billed in conjunction with procedure code 92390 (Z0146) or through the current optical contractor.	yes	yes W/PA
CONTACT LENS REPLACEMENT				
92326	—	HARD LENS (PER LENS) This procedure code does not include a professional fee.	yes W/PA	no
92326	—	SOFT LENS (PER LENS) This procedure code does not include a professional fee.	yes W/PA	no
92326	—	GAS PERMEABLE (PER LENS) This procedure code does not include a professional fee.	yes W/PA	no
92396	—	APHAKIC LENS Post-operative cataract.	yes	yes W/PA
92390	—	SPECTACLE MATERIAL Cost of material for replacing frame, front, temple. This procedure code may be billed in conjunction with V2025 (Z0124), S0504 (Z0134) and S0506 (Z0136). This price may not exceed our maximum rates established with our current optical contractor. When this code is used, an invoice must be attached.	yes	no
V2799	—	UNSPECIFIED PROCEDURE	yes	yes

W/PA = Coverage with prior authorization.

243.300 Billing Instructions – CMS-1500 – Paper Only 7-1-05

To bill for office medical services, the CMS-1500 claim form must be completed. **View a CMS-1500 sample form**.

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.

243.310 Completion of CMS-1500 Claim Form 7-1-05

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.
2.	Patient's Name	Enter the patient's last name and first name.
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.
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 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	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."

Field Name and Number	Instructions for Completion
b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter state postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
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	Required only if medical care being billed is related to an accident. Enter the date of the accident.
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.
17. Name of Referring Physician or Other Source	Primary Care Physician (PCP) referral is not required for visual care services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18. Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.
19. Reserved for Local Use	Not applicable to Visual Care.
20. Outside Lab?	This field is not required for Medicaid
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 CMS diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.

Field Name and Number	Instructions for Completion
22. Medicaid Resubmission Code	Reserved for future use.
Original Ref No.	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number, if applicable.
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.
B. Place of Service	Enter the appropriate place of service code. See Section 243.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 243.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 243.100 through 243.150.
Modifier	Enter the applicable modifier.
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 <u>one</u> 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 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.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.

Field Name and Number	Instructions for Completion
K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25. Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient'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. Assignment is automatically accepted by the provider when billing Medicaid.
28. Total Charge	Enter the total of Field 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. (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.**
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/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.

Field Name and Number	Instructions for Completion
PIN #	This field is 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#.”