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TO: **Arkansas Medicaid Health Care Providers – Nurse Practitioner**

DATE: **July 1, 2005**

SUBJECT: **Provider Manual Update Transmittal No. 52**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
203.100	10-13-03	203.100	7-1-05
214.620*	10-13-03	214.620 – 214.630	7-1-05
252.300 – 252.310	10-13-03	252.300 – 252.310	7-1-05
252.430 – 252.431	10-13-03	252.430 – 252.431	7-1-05
252.450	10-13-03	252.450	7-1-05

* Remove both sections numbered 214.620

Explanation of Updates

Section 203.100 has been revised to include current policy for prescriptions that require prior authorization for long-term care patients.

Section 214.620 has been revised to add maximum number of units for risk management services for pregnancy. The second section number 214.620 has been renumbered 214.630.

Sections 252.300 and 252.310 have been revised to make minor wording changes. Instructions for fields 17, 29 and 30 of the CMS-1500 have been revised to delete information that is not applicable to this program and to change wording for clarification.

Sections 252.430 and 252.431 have been revised to include all currently payable family planning procedure codes. Modifier changes are effective for dates of service on and after July 1, 2005. Minor wording changes have been made for clarity.

Section 242.450 has been revised to include changes in modifiers. Modifier changes are effective for dates of service on and after July 1, 2005.

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

SECTION II – NURSE PRACTITIONER

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203.100 The Nurse Practitioner's Role in the Pharmacy Program 7-1-05

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) which was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

An advanced nurse practitioner with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

A. Prescribers must refer to the Arkansas Medicaid Web site at **http://www.medicaid.state.ar.us/** to obtain the following information:

1. Multisource Drugs Listing/Generic Upper Limits.
2. Covered cough and cold preparations (see part C, number 7 of this section).
3. Covered over-the-counter (OTC) products (see part C, number 8 of this section).
4. Drugs requiring prior authorization (PA), the forms to be completed for PA requests and the procedures required of the prescriber to request prior authorization.
5. List of alternative drugs that do not require PA.
6. Information on MedWatch, the Food and Drug Administration (FDA) Safety Information and Adverse Event Reporting Program.

As additions or deletions by labelers are submitted to the state by Centers for Medicare and Medicaid Services (CMS), the Web site is updated.

B. The following procedures are to be followed when prescribing drugs for Medicaid recipients:

1. In addition to the prescriber's normal procedure for prescribing drugs, the prescriber must include his or her Medicaid provider number on all prescriptions for Medicaid recipients whether or not the drug prescribed is a controlled substance. The prescriber's Medicaid provider number is essential for tracking and utilization review purposes.

   The requirement to include the prescriber's Medicaid provider number is a condition of participation in the Arkansas Medicaid Program. Administrative sanctions will be imposed for noncompliance. If prescription pads are not preprinted with the prescriber's name, it is essential that the physician's signature be legible.

2. When the prescriber determines that a particular brand is medically necessary, the prescriber must write "This Brand Medically Necessary" in his or her own handwriting on the face of the prescription. A rubber stamp is not acceptable. The statements "Do not substitute" or "Dispense as written" are not sufficient. For prescriptions ordered by telephone, a written prescription that includes the required statement must also be provided to the pharmacist.

C. Coverage Limitations

1. Medicaid-eligible recipients aged 21 and older are limited to three prescriptions per month, each filled for a maximum of one month's supply. Extensions of an

individual's drug benefit up to six prescriptions per month may be considered for reasons of medical necessity. The prescribing provider must request an extension.

2. A prescription may be filled for a maximum of one month's supply. A thirty-one day supply is allowed.
3. Up to five refills within six months of the date the prescription is issued are covered if specified by the prescriber. Renewals or continuations of drug therapy beyond six months require another prescription.
4. Prescriptions for any family planning item will not be counted toward the recipient's monthly three-prescription limit.
5. Medicaid recipients under age 21 are not subject to the prescription benefit limit.
6. Long-term care (LTC) certified Medicaid beneficiaries are not subject to the prescription benefit limit.

   LTC patients must receive prescribed drugs within a specific period of time after the prescriber's order. For prescribed drugs that require PA and are administered in oral dosage forms for which a 5-day supply may be calculated and dispensed, one 5-day supply of the drug may be provided to the LTC recipient upon receipt of the prescription and reimbursed by Arkansas Medicaid without receipt of PA.

   Within 5 days of the prescription of a PA drug for which no PA has been obtained, the pharmacist and the physician shall consult to determine if there is a therapeutically equivalent drug that does not require PA. The results of the consultation shall be documented in writing.

   If a non-PA, therapeutically equivalent drug exists, the physician will immediately write a substitute prescription for the non-PA drug
7. Cough and cold preparations are not covered except for those listed on the Web site at **http://www.medicaid.state.ar.us/** in the covered cough and cold products list. Coverage is restricted to Medicaid-eligible recipients under age 21 and for certified long-term care recipients. Any OTC cough and cold products listed at the Web site are not covered for certified long term care recipients.
8. OTC products are not covered except for those listed on the Web site at **http://www.medicaid.state.ar.us/** in the covered over-the-counter products list. OTC products are not covered for certified long term care recipients.
9. When prescribing pharmaceuticals to Medicaid recipients who are excluded from the recipient cost-sharing coinsurance/copayment policy, the prescribing provider must write "Excluded from copay" on the face of the prescription. (Refer to Section I of this manual for more information.)

214.620 Risk Management Services for High Risk Pregnancy 7-1-05

A nurse practitioner may provide risk management services if he or she employs the professional staff indicated in service descriptions below. If a nurse practitioner does not choose to provide high-risk pregnancy services but believes the patient would benefit from such services, he or she may refer the patient to a clinic that offers the services.

Covered risk management services described in parts A through E below are considered as one service with a benefit limit of 32 cumulative units. The early discharge home visit described in part F is considered as a separate service.

A. Risk Assessment

Risk assessment is defined as a medical, nutritional and psychosocial assessment by a nurse practitioner or a registered nurse on the nurse practitioner's staff, to designate patients as high or low risk.

1. Medical assessment using the Hollister Maternal and/or Newborn Record System or equivalent form includes:
   a. Medical history
   b. Menstrual history
   c. Pregnancy history
2. Nutritional assessment includes:
   a. 24 hour diet recall
   b. Screening for anemia
   c. Weight history
3. Psychosocial assessment includes criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: 2 units per pregnancy

B. Case Management Services

Case management services are provided by a nurse practitioner, a licensed social worker or registered nurse to assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational and other services (e.g., locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver a newborn, following up to verify that the patient kept her appointment, rescheduling the appointment).

Maximum: 1 unit per month. A minimum of two contacts per month must be provided. A case management contact may be with the patient, other professionals, family and/or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (physician, public health nurse, nutritionist or health educator) include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health
4. Postpartum care
5. Nutrition in pregnancy

Maximum: 6 classes (units) per pregnancy

D. Nutrition Consultation — Individual

Nutrition consultation services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration must include at least one of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan
2. Nutritional care plan follow-up and reassessment as indicated

Maximum: 9 units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker must include at least one of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan
2. Social work plan follow-up, appropriate intervention and referrals

Maximum: 6 units per pregnancy

F. Early Discharge Home Visit

If a physician or certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours after delivery), the physician or certified nurse-midwife may provide a home visit to the mother and baby within 72 hours of the hospital discharge. The physician or certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by the physician or certified nurse-midwife's order (includes a hospital discharge order).

A home visit may be ordered for the mother and/or infant discharged later than 24 hours if there is specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in section 252.450.

214.630 Fetal Non-Stress Test 7-1-05

The fetal non-stress test is *limited to 2 per pregnancy per recipient*. If it is necessary to exceed this limit, the nurse practitioner must request an extension of benefits and submit documentation that establishes medical necessity. Refer to section 214.900 of this manual for procedures to request extension of benefits. Refer to section 252.451 of this manual for billing instructions and the procedure code.

The post-procedural visits are covered within the 10-day period following the fetal non-stress test.

252.300 Billing Instructions – Paper Claims Only 7-1-05

EDS offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once per month. The only claims exempt from this process are those that require attachments or manual pricing.

To bill for nurse practitioner services, use form CMS-1500. The numbered items correspond to numbered fields on the claim form. **View a CMS-1500 sample form.**

The following instructions must be read and carefully followed 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 the EDS Claims Department. **View or print the EDS Claims Department contact information.**

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.

252.310 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."
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 required for most Medicaid covered services. Enter the referring physician's 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 Nurse Practitioner services.
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.
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 252.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See section 252.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from sections 252.100 through 252.130.
Modifier	Use applicable modifiers.
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.
	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 the 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. (See the NOTE below Field 30.)
30.	Balance Due	Enter the total amount of funds. 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 beneficiary. **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.
	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#."

252.430 Family Planning Services Program Procedure Codes 7-1-05

The following table contains Family Planning Services Program procedure codes payable to nurse practitioners. When filing on paper, type of service (TOS) code **"A"** is required with these procedure codes. All of the following procedure codes require a family planning diagnosis code in each claim detail.

Procedure Code	Required Modifiers	Description
A4260	FP	Norplant System (Complete Kit)
J1055	FP	Medrozyprogesterone acetate for contraceptive use
J7300	FP	Supply of Intrauterine Device
J7302	FP	Levonorgestrel-releasing intrauterine contraceptive system
J7303	FP	Contraceptive supply, hormone containing vaginal ring
S0612*	FP, SA, 52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52	Annual Post-Sterilization Visit*
11975	FP, SA	Implantation of Contraceptive Capsules
11976	FP, SA	Removal of Contraceptive Capsules
11977	FP, SA	Removal and Reinsertion of Contraceptive Capsules
36415	FP	Routine venipuncture for blood collection
58300	FP,SA	Insertion of Intrauterine Device
58301	FP,SA	Removal of Intrauterine Device
99402	FP, SA	Basic Family Planning Visit
99401	FP, SA, 22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22.	Periodic Family Planning Visit

Procedure code **S0612*** is unique to the Family Planning Services Demonstration Waiver. Annual post-sterilization visit as a family planning service is covered for Aid Category 69, FP-W, only. Women in the FP-W category who have undergone sterilization are eligible for only this annual follow-up visit.

252.431 Family Planning Services Program Laboratory Procedure Codes 7-1-05

A. Nurse practitioners performing any of these tests in connection with family planning services must use type of service (TOS) code **"A"** when filing paper.

B. Use TOS (paper only) code **"N"** when the service diagnosis is not related to family planning.

1. Each claim detail for a procedure covered by the Family Planning Services Program and billed with TOS (paper only) code "**A"** must include a family planning diagnosis code.
2. Medicaid will deny any claim detail that includes TOS (paper only) code **"N"** and a family-planning-related diagnosis code.

C. When filing electronic claims or paper claims, modifier FP must be used with the procedure code.

Q0111	81001	81002	81003	81025	83020
81000	83896	84703	85014	85018	85660
83520	86593	86687	86701	87075	87081
86592	87210	87390	87470	87490	87590
87088					

252.450 Obstetrical Care and Risk Management Services for High Risk Pregnancy 7-1-05

Covered nurse practitioner obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A nurse practitioner may provide risk management services listed below if he or she receives a referral from the patient's physician or certified nurse-midwife and if the nurse practitioner employs the professional staff required. Complete service descriptions and coverage information may be found in section 214.620 of this manual. The services in the list below are considered as one service and are limited to 32 cumulative units.

National Code	Required Modifiers	Description
99402	SA, U1,22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22	Risk Assessment
99402	SA, U4, 22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22	Case Management Services, low-risk case
99402	SA, U5, 22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22	Case Management Services, high-risk case
99402	SA, 22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22	Perinatal Education
99402	SA, U3, 22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22	Social Work Consultation
99402	SA, U2, 22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22	Nutrition Consultation – Individual

For early discharge home visit, use one of the applicable CPT procedure codes **99341, 99343, 99347, 99348** and **99349**.