Arkansas Department of Human Services
Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – Licensed Mental Health Practitioners (LMHP)**

DATE: **July 1, 2005**

SUBJECT: **Provider Manual Update Transmittal No. 44**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	10-13-03	201.000	7-1-05
211.200	10-13-03	211.200	7-1-05
240.000	10-13-03	240.000	7-1-05
251.200	10-13-03		
262.100	10-13-03	262.100	7-1-05
262.310	10-13-03	262.310	7-1-05

Explanation of Updates

Section 201.000 is included to add to subpart D a statement regarding applications for enrollment from persons or entities who are excluded or debarred under any state or federal law, regulation or rule.

Section 211.200 is included to explain that a PCP may give a retroactive referral for service but the referral must be received within 45 days of the service.

Section 240.000 is included to add information regarding the process for prior authorization requests, to delete the local procedure codes that are no longer in use and the note that applies to them and to delete information related to types of service that do not apply to this program.

Section 251.200 is deleted.

Section 262.100 is included to delete local codes that are no longer in use and the note that applies to them, change modifier 52 to UB for procedure code 96100, add types of service to H0046 and delete types of service from procedure code 90847 that do not apply to this program.

Section 262.310 is included to correct field 17. PCP referrals are required for LMHP services and to delete from field 29 reference to co-payments to private insurers. Medicaid recipients are not responsible for co-payments to other insurers

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.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

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.

201.000 Arkansas Medicaid Participation Requirements for Licensed Mental Health Practitioners - Licensed Certified Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor (LPC) and Psychologist 7-1-05

In order to ensure quality and continuity of care, all mental health providers approved to receive Medicaid reimbursement for services provided to the under age 21 Medicaid population must meet specific qualifications for their services and staff.

In order to be enrolled as a Medicaid Licensed Mental Health Practitioner provider, the following must occur:

A. A provider application (Form DMS-652) and a contract (Form DMS-653) with the Arkansas Medicaid Program must be completed and submitted. **View or print a provider application (Form DMS-652), Medicaid contract (Form DMS-653) and Request for Taxpayer Identification Number and Certification (W-9).**

B. For the LCSW, LMFT and LPC, a copy of the certification letter from the Division of Mental Health Services (DMHS) must accompany the provider application. Any changes or subsequent certifications must be furnished to Arkansas Medicaid when received. See Sections 201.100 through 201.130 for the DMHS certification requirements.

C. In order to be enrolled as a Medicaid provider, the psychologist must:

1. Be licensed as a psychologist by the Arkansas Board of Examiners in Psychology.
2. Provide a copy of the current license to the Arkansas Medicaid Program with the psychologist's provider application and Medicaid contract. Subsequent licensure must be provided when issued.

D. The provider application and Medicaid contract must be approved by the Arkansas 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.

Providers of Licensed Mental Health Practitioner services have the option of enrolling in the Title XVIII (Medicare) Program. When a recipient is dually eligible for Medicare and Medicaid and is provided services that are reimbursable under both programs, the Medicare Program must be billed first. Medicaid will not reimburse for services that have not been submitted to Medicare prior to being billed to Medicaid. The recipient may not be billed for the charges.

Providers who have agreements with Medicaid to provide other services to Medicaid recipients must submit a separate provider application and Medicaid contract to provide Licensed Mental Health Practitioner services. A separate provider number is assigned.

An LCSW may not be enrolled in both the Targeted Case Management (TCM) and the Licensed Mental Health Practitioner Medicaid Programs. He or she must choose the program in which he or she wishes to enroll.

211.200 Primary Care Physician (PCP) Referral 7-1-05

A primary care physician (PCP) referral is required for each Medicaid recipient under age twenty-one for outpatient mental health services. See section 180 of this manual for the PCP procedures. A PCP referral is generally obtained **prior** to providing service to Medicaid eligible children. However, a PCP is given the option of providing a referral after a service is provided. If a PCP chooses to make a referral after a service has been provided, the referral must be received by the LMHP provider no later 45 calendar days after the date of service. The PCP has no obligation to give a retroactive referral.

The LMHP provider may not file a claim and will not be reimbursed for any services provided that require a PCP referral unless the referral is received.

240.000 PRIOR AUTHORIZATION 7-1-05

Prior Authorization is required for certain services provided to Medicaid-eligible individuals under age 21. Prior authorization requests must be sent to APS Healthcare. **View or print APS Healthcare contact information.**

Prior authorization is required for the following procedure codes:

Procedure Code	Required Modifier	Type of Service Code	Description
H0004	—		Individual Outpatient—Therapy Session
90847 90847	U1 U2	F 1	Marital/Family Therapy Psychologist
90847	U1		Marital/Family Therapy LCSW, LMFT, LPC
90853 90857	U1 —		Group Outpatient—Group Therapy

262.100 Licensed Mental Health Practitioner Procedure Codes 10-13-03

The following services are billed on a per unit basis. Unless otherwise specified in the appropriate CPT or HCPCS book, one unit equals 15 minutes. Services less than 15 minutes in duration are not reimbursable. Services billed on a per hour basis according to CPT or HCPCS must be billed for a full hour of service. Services less than 1 hour are not reimbursable. See section 251.000 for instructions for billing more than full units.

Procedure Code	Required Modifier	Type of Service Code	Description	Length of Service
90801	U1		Diagnosis Direct clinical service provided by a licensed mental health practitioner for the purpose of determining the existence, type, nature and most appropriate treatment of a mental illness or related disorder as described in the DSM-IV. This psychodiagnostic process may include but is not limited to a psychosocial and medical history, diagnostic findings and recommendations.	8 unit maximum per day.
96100	—		Diagnosis—Psychological Test/Evaluation Payable only to psychologists. A single diagnostic test administered to a client by a licensed psychologist. This procedure should reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the client.	8 unit maximum per day.
96100	HA, UB	9	Diagnosis—Psychological Testing-Battery Payable only to psychologists. Two (2) or more diagnostic tests administered to a client by a psychologist. This battery should assess the mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics of the client.	8 unit maximum per day.

90887	—		Interpretation of Diagnosis A direct service provided by a licensed mental health practitioner for the purpose of interpreting the results of diagnostic activities to the patient and/or significant others. If significant others are involved, appropriate consent forms may need to be obtained.	4 unit maximum per day.
H2011 (Psycholo-gist) H0046 (LCSW, LMFT, LPC)			Crisis Management Visit An unscheduled direct service contact between an identified patient and a licensed mental health practitioner for the purpose of preventing an inappropriate or more restrictive placement.	4 unit maximum per day.
H0004	—		Individual Outpatient—Therapy Session Scheduled individual outpatient care provided by a licensed mental health practitioner to a patient for the purposes of treatment and remediation of a condition described in DSM-IV and subsequent revisions.	4 unit maximum per day.
90847 90847	U1 U2	F 1	Marital/Family Therapy Family therapy shall be treatment provided to two or more family members and conducted by a licensed mental health practitioner for the purpose of alleviating conflict and promoting harmony.	6 unit maximum per day.
H0046 (Psycholo-gist) H0046 (LCSW, LMFT, LPC)	U2 U1	1 F	Individual Outpatient—Collateral Services A face-to-face contact by a licensed mental health practitioner with other professionals, caregivers or other parties on behalf of an identified patient to obtain relevant information necessary to the patient's assessment, evaluation and treatment.	4 unit maximum per day.
90853 90857	—		Group Outpatient—Group Therapy A direct-service contact between a group of patients and a LCSW, LMFT or LPC for the purposes of treatment and remediation of a psychiatric condition.	6 unit maximum per day.

90853 90857	U1 U1	Group Outpatient—Group Therapy A direct-service contact between a group of patients and a psychologist for the purposes of treatment and remediation of a psychiatric condition.	6 unit maximum per day

262.310 Completion of CMS-1500 Claim Form 10-13-03

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 LMHP 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 LMHP 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 HCFA 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 262.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 262.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 262.100.
Modifier	Use 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.
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. Do not enter any payment by the recipient. (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 28 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#."