Arkansas Department of Human Services
Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers - School-Based Mental Health**

DATE: **July 1, 2005**

SUBJECT: **Provider Manual Update Transmittal No. 17**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
211.300 – 211.310	10-13-03	211.300 – 211.310	7-1-05
272.100	10-13-03	272.100	7-1-05
272.310	10-13-03	272.310	7-1-05

Explanation of Updates

Sections 211.300 and 211.310 are included to explain that a PCP may issue a retroactive referral.

Section 272.100 is included to change modifier 52 to UB and delete the note that contains information that no longer applies.

272.310 is included to delete information from field 29 regarding co-payments to private insurers. Medicaid recipients are not responsible for paying these 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.

Roy Jeffus, Director

211.300 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 I 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 SBMH provider no later 45 calendar days after the date of service. The PCP has no obligation to give a retroactive referral.

The SBMH 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.

211.310 When a Child is Ineligible for Medicaid at Time of Service 7-1-05

A. When a child who is not eligible for Medicaid receives an outpatient mental health service, an application for Medicaid eligibility may be filed by the child or his or her representative.

B. If the application for Medicaid coverage is approved, a PCP referral is not required for the period prior to the Medicaid authorization date. This period is considered **retroactive** eligibility and does not require a referral.

C. A PCP referral is required no later than forty-five calendar days after the authorization date. If the PCP referral is not obtained within forty-five calendar days of the Medicaid authorization date, reimbursement will begin, if all other requirements are met, the date the PCP referral is received. To verify the authorization date, a provider may call EDS or the local DHS Office.

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 SBMH provider no later 45 calendar days after the date of authorization. The PCP has no obligation to give a retroactive referral.

The SBMH 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.

View or print EDS PAC contact information. **View or print DHS contact information.**

272.100 School-Based Mental Health Services Procedure Codes 7-1-05

The following is a list of covered services available in the School-Based Mental Health Services Program. Practitioners enrolled as school-based mental health services provider personnel may provide the services on this list according to their scope of practice as identified by the licensure requirements.

The services are billed on a per unit basis. One unit equals 15 minutes. Services less than 15 minutes in duration are not reimbursable. The unit maximum shown below each procedure code description is a daily maximum.

Procedure Code	Required Modifier	Description and Definition	Length of Service
90801	—	Diagnosis Direct clinical service provided by school-based mental health services provider personnel 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 psycho-diagnostic process may include, but not be limited to, a psychosocial and medical history, diagnostic findings and recommendations.	8-unit maximum
96100	—	Diagnosis - Psychological Test/Evaluation A single diagnostic test administered to a client by school-based mental health services provider personnel. This procedure should reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the client.	8-unit maximum
96100	UB	Diagnosis - Psychological Testing-Battery Two (2) or more diagnostic tests administered to a client by school-based mental health services provider personnel. This battery should assess the mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics of the client.	8-unit maximum
90887	—	Interpretation of Diagnosis A direct service provided by school-based mental health services provider personnel 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
H0046	—	Crisis Management Visit An unscheduled direct service contact between an identified patient and school-based mental health services provider personnel for the purpose of preventing an inappropriate or more restrictive placement.	4-unit maximum
H0004	—	Individual Outpatient - Therapy Session Scheduled individual outpatient care provided by school-based mental health services provider personnel to a patient for the purposes of treatment and remediation of a condition described in DSM-IV and subsequent revisions.	4-unit maximum

90847	U6	Marital/Family Therapy Family therapy shall be treatment provided to two or more family members and conducted by school-based mental health services provider personnel for the purpose of alleviating conflict and promoting harmony.	6-unit maximum
H0046	—	Individual Outpatient - Collateral Services A face-to-face contact by school-based mental health services provider personnel 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
90853	—	Group Outpatient - Group Therapy A direct service contact between a group of patients and school-based mental health services provider personnel for the purposes of treatment and remediation of a psychiatric condition	6-unit maximum

272.310 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	Enter the name of the referring physician. 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 SBMH.
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 272.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 272.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code.
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. (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.
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#."