



Arkansas Department of Health and Human Services

Division of Medical Services



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TO: Arkansas Medicaid Health Care Providers – Certified Nurse-Midwife

DATE: July 1, 2006

SUBJECT: Provider Manual Update Transmittal #60

REMOVE Section	Date	INSERT Section	Date
201.000 – 202.000	Dates Vary	201.000 – 202.000	7-1-06
202.200 – 202.210	10-13-03	202.200	7-1-06
202.300 – 202.310	10-13-03	202.300	7-1-06
203.000 – 204.500	10-13-03	202.310 – 204.500	7-1-06
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272.502	10-13-03	272.502	7-1-06
272.530	10-13-03	272.530	7-1-06

Explanation of Updates

The agency name Arkansas Department of Human Services has been changed to Arkansas Department of Health and Human Services throughout the update. This update includes deletion of obsolete information, correction of grammatical errors and change in format. Only sections that have policy revisions are cited below with explanation of the policy change.

Section 201.000 has been revised by deleting unnecessary information and to add applicable information regarding requirements for participation in the Medicaid program.

Section 202.000 has been revised to inform the provider of the requirement that renewals of licenses issued by the Arkansas State Board of Nursing must be received within 30 days of issuance. If the renewal document(s) have not been received within this time period, the provider will have an additional, and final, 30 days to comply.

Section 202.200 has been revised to clarify the requirements for routine services providers. Section 202.210 has been deleted.

Section 202.300 has been revised to include new policy for participation of providers in states not bordering Arkansas. Section 202.310 has been deleted.

Section 203.000 has been revised to clarify the provider's responsibility for maintaining records. Requirements for providing records that are stored off premises to the Medicaid Field Audit Unit have been included.

Section 204.200 has been revised to include current policy regarding the Prescription Drug Program.

Section 204.300 has been revised to delete some unnecessary information about the Child Health Services (EPSDT) Program and to add information about the ARKids First-B Program.

Section 213.510 has been revised to correct diagnosis ICD-9-CM codes that are automatically extended for pregnancy services in the outpatient hospital.

Section 214.130 has been revised to include current policy for administrative reconsideration of extension of benefits denial.

Section 214.140 is a new section to direct providers to Section I of the manual for information regarding administrative appeals.

Section 215.260 has been revised to include policy that covers unborn children of alien pregnant women who meet eligibility requirements.

Section 272.100 has been revised to include procedure codes payable to the certified nurse-midwife that have not been included in the policy manual previously. Effective for dates of service on and after March 1, 2006, procedure codes **A4260, J1564, J1750, 90780 and 90799** are no longer payable and have been deleted. Procedure codes **J1751, J1752, J2916, J7306, T1502, 56820, 57456, 90656, 90765, 90766, 90767, 90768, 90774, and 90779** have been added to this section as payable procedures effective for dates of service on and after March 1, 2006.

Sections 272.110 and 272.120 have been deleted. Relevant information in these sections is now included in section 272.100.

Section 272.310 has been revised. Some unnecessary wording has been deleted from the instructions for completion of form CMS-1500. Fields 24 and 30 have new wording in the instructions column for the purpose of clarity.

Section 272.430 has been revised to include current procedure codes for family planning services. Effective for dates of service on and after March 1, 2006, procedure code **A4260** is no longer

payable. It has been replaced with procedure code **J7306**. Procedure code **J7303** has been included in this section as a payable code for family planning services.

Section 272.441 has been revised to delete two procedure codes. Effective for dates of service on and after March 1, 2006, procedure code **J1564** is no longer payable and has been deleted. Procedure code **J2000** is not a valid code and has been deleted.

Section 272.442 has been revised to include descriptions of injections and to add injections that are payable to certified nurse-midwife providers but have not previously been included in the manual. Procedure code **J1564** has been deleted from this section. Effective for dates of service on and after March 1, 2006, procedure code **J1750** is non-payable and has been deleted from this section. Procedure codes **J1751** and **J1752** have been added as replacement codes for **J1750**. Procedure code **T1502**, with modifier **U1**, is included as a replacement for procedure code **90799**.

Section 272.493 has been revised to include procedure code **59426** for 7 or more visits of antepartum care without delivery.

Section 272.530 has been revised to inform providers that modifier 11 has been replaced with modifier **Q5** for a reciprocal billing arrangement. Modifier 12 has been replaced with modifier **Q6** for *locum tenens* billing arrangements.

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 (TDD only).

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

SECTION II – CERTIFIED NURSE-MIDWIFE

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To participate in the Arkansas Medicaid Program, providers must adhere to all applicable professional standards of care and conduct.

202.000	Arkansas Medicaid Participation Requirements for Certified Nurse-Midwife Providers	7-1-06
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All providers of certified nurse-midwife services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

- A. The 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 a provider application \(form DMS-652\), a Medicaid contract \(form DMS-653\) and a Request for Taxpayer Identification Number and Certification \(Form W-9\).](#)
- B. A current copy of the certified nurse-midwife license from the Arkansas State Board of Nursing must accompany the provider application and Medicaid contract.
 1. Subsequent renewals of license must be forwarded to Provider Enrollment within 30 days of issuance.
 2. If the renewal document(s) have not been received within this time period, the provider will have an additional, and final, 30 days to comply.
- C. The certified nurse-midwife who provides intrapartum care must have a consulting agreement with a Medicaid-enrolled physician and must furnish the name of the consulting physician with the provider application and the Medicaid contract.
 1. The consulting physician must be available within thirty (30) minutes of the hospital admitting the certified nurse-midwife's laboring patients or within thirty (30) minutes of the alternative birth site if the patient is not transported to the hospital.
 2. A licensed certified nurse-midwife will not be deemed an agent or employee of the physician solely on the basis of a collaborative or consulting physician agreement and will be enrolled as an independent provider with the Arkansas Medicaid Program in the category of Certified Nurse-Midwife.

- D. Subsequent changes in the name of the consulting physician must be immediately provided to Arkansas Medicaid.
- E. The certified nurse-midwife who has prescriptive authority must furnish the Certificate of Prescriptive Authority Number issued by the Arkansas State Board of Nursing with the provider application and Medicaid contract. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.
- F. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Agreement.
- G. 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.

202.200 Providers in Arkansas and Bordering States

7-1-06

- A. Providers in Arkansas and the six bordering states may be enrolled in the Medicaid Program as routine services providers if they meet all Arkansas Medicaid participation requirements outlined in section 202.000.
- B. Reimbursement may be available for all covered certified nurse-midwife services in the Arkansas Medicaid Program. Claims must be filed according to billing procedures provided in this manual.

202.300 Certified Nurse-Midwives in States Not Bordering Arkansas

7-1-06

- A. Providers in states not bordering Arkansas are called limited services providers because they may enroll in Arkansas Medicaid only after they have treated an Arkansas Medicaid beneficiary and have a claim to file, and because their enrollment automatically expires.
 - 1. A non-bordering state provider may send a claim to Provider Enrollment and Provider Enrollment will forward by return mail a provider manual and a provider application and contract. [View or print Medicaid Provider Enrollment Unit contact information.](#)
 - 2. Alternatively, a non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, www.medicaid.state.ar.us, and then submit the application and claim to the Medicaid Provider Enrollment Unit.
- B. Limited services providers remain enrolled for one year.
 - 1. If a limited services provider treats another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
 - 2. During the enrollment period the provider may file any subsequent claims directly to EDS.
 - 3. Limited services providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

203.000 Required Medical Records

7-1-06

- A. Providers must contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with its delivery of medical assistance to any Medicaid beneficiary.

- B. Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the prescription, care plan or order within five (5) business days of the date it is written. Providers also must maintain a copy of each prescription, care plan or order in the beneficiary's medical record and follow all prescriptions, care plans, and orders as required by law, by Medicaid rule, or both.
- C. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary. When records are stored off-premise or are in active use, the provider may certify, in writing that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.
- D. All records must be kept for a period of five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish medical records upon request may result in sanctions being imposed. (See Section I of this manual.)
- E. Certified nurse-midwives are required to keep the following patient records:
 1. History and physical examinations.
 2. Appropriate diagnosis or chief complaint, when applicable, on each visit.
 3. Tests and results.
 4. Diagnoses.
 5. Treatment, including prescriptions.
 6. Signature or initials of the certified nurse-midwife after each visit.
 7. Copies of records pertinent to services delivered by the certified nurse-midwife and billed to Medicaid.
 8. Records must contain service dates of any services billed to Medicaid, including service dates for all components of global services billed.
 9. Record of physician referral or consultation, if applicable.

204.000 Certified Nurse-Midwife's Role in the Medicaid Program 7-1-06

204.100 Ambulance Services 7-1-06

Ambulance service for Medicaid beneficiaries is covered by Medicaid when the ambulance transportation is medically necessary, as determined by the certified nurse-midwife.

It is the responsibility of the transportation provider to maintain documentation that will verify the medical necessity of transportation provided.

204.200 Certified Nurse-Midwife's Role in the Prescription Drug Program 7-1-06

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) that 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.

The certified nurse-midwife's prescriptive authority (when applicable) only extends to legend drugs in Schedule III through Schedule V. 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:

Multisource Drugs Listing/Generic Upper Limits.

1. Covered cough and cold preparations (see part C, 7 of this section).
2. Covered over-the-counter (OTC) products (see part C, 8 of this section).
3. Drugs requiring prior authorization (PA), the forms to be completed for PA requests and the procedures required of the prescriber to request prior authorization.
4. List of alternative drugs that do not require PA.
5. 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 the Centers for Medicare and Medicaid Services (CMS), the Web site is updated.

- B. Providers must follow the procedures below** when prescribing drugs for Medicaid beneficiaries.

1. In addition to **following** the prescriber's normal procedure for prescribing drugs, the prescriber must include his or her Medicaid provider number on all prescriptions for Medicaid **beneficiaries**, whether or not the drug prescribed is a controlled substance. The prescriber's Medicaid provider number is essential for tracking and utilization review purposes.
2. 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.
3. 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 **beneficiaries** aged **21** and older are limited to three (3) prescriptions per month, each filled for a maximum of one month's supply. Extensions of an individual's drug benefit up to six (6) 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 (31) 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 **beneficiary's** monthly three-prescription limit.
 5. Medicaid **beneficiaries** 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 prior authorization (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 drug requiring PA and for which no PA has been obtained, the pharmacist and the physician must consult to determine if there is a therapeutically equivalent drug that does not require PA. The results of the consultation must be documented in writing.

If a non-PA, therapeutically equivalent drug exists, the physician must 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 **beneficiaries** under age 21 and for certified long-term care **beneficiaries**. Any over-the-counter cough and cold products listed at the Web site are not covered for certified long-term care **beneficiaries**.
8. Over-the-counter (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 **beneficiaries**.
9. When prescribing pharmaceuticals to Medicaid **beneficiaries** who are excluded from the 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.)

204.300 Certified Nurse-Midwife's Role in the Child Health Services (EPSDT) Program and ARKids First-B Program

7-1-06

The Arkansas Medical Assistance Program includes a Child Health Services (EPSDT) Program for eligible individuals under **age 21**. The purpose of this program is to detect and treat health problems in their early stages and to provide well child health care such as immunizations.

Similar services are also covered through the ARKids First-B Program. This program covers children age 18 years and younger.

Certified nurse-midwives may provide routine newborn care that includes the physical examination of the baby and conference(s) with the newborn's parents. These services are considered to be the initial Child Health Services (EPSDT) screen and may be covered as the initial preventive health screen for those eligible for the ARKids First-B Program.

Certified nurse-midwives interested in enrolling in the Child Health Services (EPSDT) Program **or** the ARKids First-B Program should contact the Central Child Health Services Office. [View or print the Central Child Health Services Office contact information.](#)

204.400 Certified Nurse-Midwife's Role in Hospital Services

7-1-06

- A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to sections 213.200 through 213.220.)
- B. The care and treatment of a patient must be under the direction of a licensed physician, a certified nurse-midwife or dentist with hospital staff affiliation.
- C. Arkansas Foundation for Medical Care, Inc., (AFMC) is the Medicaid agency's quality improvement organization (QIO).

1. AFMC reviews for the Medicaid Utilization Management Program (MUMP), all inpatient hospital transfers and all inpatient stays longer than four days.
 2. The QIO also performs post-payment reviews of hospital claims for medical necessity determinations.
- D. Hospital claims are also subject to review by the Medical Director for the Medicaid Program.
1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to certified nurse-midwives for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
 2. Certified nurse-midwives and hospitals may not bill a Medicaid **beneficiary** for a service Medicaid has declared not medically necessary.
 3. Certified nurse-midwives and hospitals may not bill as outpatient services **any inpatient services** previously denied for lack of medical necessity **as inpatient services**.

204.500**Certified Nurse-Midwife's Role in Preventing Program Abuse****7-1-06**

The Arkansas Medicaid Program has the responsibility for assuring quality medical care for its **beneficiaries** along with protecting the integrity of the funds supporting the program. The Division of Medical Services is committed to **these goals, provides** staff and resources to the prevention, detection and correction of known abuse. **These tasks** can only be accomplished through the cooperation and support of the provider community.

A certified nurse-midwife who has reason to suspect either **beneficiary** or provider abuse or unacceptable quality of care should contact the Utilization Review Section of Arkansas Division of Medical Services. An investigation will then be made. [View or print the Arkansas Division of Medical Services, Utilization Review Section contact information.](#)

Examples of the types of abuse you may detect include:

- A. **Beneficiary** over-utilization of services
- B. **Beneficiary misuse** or inappropriate utilization of services
- C. **Beneficiary** misuse of I.D. card
- D. Poor quality of service
- E. Provider over-utilization or abuse

210.000**PROGRAM COVERAGE****7-1-06****211.000****Introduction****7-1-06**

The Medical Assistance Program is designed to assist Medicaid **beneficiaries obtain** medical care within the guidelines specified in Section I of this manual. Certified nurse-midwives **who** are licensed by the Arkansas State Board of Nursing and certified by the American College of Nurse-Midwives (ACNM) and **who are** enrolled in the Arkansas Medicaid Program may be reimbursed for their services within the Arkansas Medicaid Program's limitations.

212.000**Scope****7-1-06**

Licensed certified nurse-midwives **may** be reimbursed for their services to Medicaid **beneficiaries**. (See Section I of this manual for an explanation of the Medicaid ID card.)

Services may be provided in a variety of settings, including an office, a birthing center or clinic, a **beneficiary's** home or a hospital.

Services performed by a certified nurse-midwife require a **primary care physician (PCP) referral, except those services with **family planning**, obstetrical or gynecological diagnosis codes.**

In **accordance** with Act 409 of 1995: "Nurse-Midwifery means the performance, for compensation, of nursing skills relevant to the management of women's health care, focusing on pregnancy, childbirth, the postpartum period, care of the newborn, family planning and gynecological needs of women, within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client."

213.000 Benefit Limits

7-1-06

Medicaid **beneficiaries** are responsible for payment for services beyond the established benefit limits unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit. If a **beneficiary** elects to receive a service for which DMS has denied a benefit extension, or for which DMS subsequently denies a benefit extension, the patient is responsible for payment.

NOTE: When serving ARKids First-B beneficiaries, Aid Category 01, use the ARKids First-B provider manual for benefit limits that are specific to that category.

213.100 Family Planning Services

7-1-06

- A. Medicaid covers one **basic family planning examination** and three **periodic family planning visits** per client, per state fiscal year (July 1 through June 30). Refer to sections 215.200 through 215.260 of this manual for service descriptions and coverage information.
- B. Family planning prescriptions are unlimited and do not count toward the benefit limit.
- C. Norplant
 - 1. The benefit limit for **contraceptive implants** and insertion of **implants** is two each per five-year period per **beneficiary**.
 - 2. The benefit limit for removal of the **implant** is only once per 5-year period, with or without reinsertion.
- D. Extension of benefits is not available for family planning services.
- E. Refer to sections 215.200 through 215.260 for a full explanation of family planning services coverage.
- F. Special billing instructions for all family planning services are in section 272.430 of this manual.

213.200 Inpatient Hospital Services

7-1-06

213.210 Medicaid Utilization Management Program (MUMP)

7-1-06

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care/general hospitals, in-state and out-of-state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), Arkansas Foundation for Medical Care, Inc. (AFMC), under contract to the Arkansas Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except **individuals** under age one (1), are subject to this policy. Medicaid **beneficiaries** under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday. Refer to item “D” below for the procedure to follow when a child's first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

- A. Medicaid will reimburse hospitals for up to four (4) days of inpatient service with no precertification requirement, except for admissions by transfer from another hospital.
 - B. If the attending certified nurse-midwife determines **that** the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact AFMC and request an extension of inpatient days. The following information is required:
 1. Patient name and address (including zip code)
 2. Patient birth date
 3. Patient Medicaid number
 4. Admission date
 5. Hospital name
 6. Hospital Medicaid provider number
 7. Attending certified nurse-midwife Medicaid provider number
 8. Principal diagnosis and other diagnoses influencing this stay
 9. Surgical procedures performed or planned
 10. The number of days being requested for continued inpatient care
 11. All available medical information justifying or supporting the necessity of continued stay in the hospital.
 - C. Contact AFMC for procedure precertification or length of stay review. [View or print AFMC contact information.](#) AFMC will base the number of days allowed for an extension on their medical judgment utilizing Medicaid guidelines.
 - D. When a Medicaid **beneficiary** reaches age one (1) during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four days not requiring MUMP certification. If the stay continues beyond the fourth day (inclusive) of the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.
 - E. Additional extensions may be requested as needed.
 - F. AFMC assigns an authorization number to an approved extension request and sends written notification to the hospital.
 - G. Reconsideration reviews of denied extensions may be requested by sending the medical record to AFMC through regular mail, or expedited by overnight express. The hospital will be notified by the next working day of the decision. [View or print AFMC contact information.](#)
 - H. Calls for extension of days may be made at any point from the fourth day of the stay through discharge. However, the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay calling for extension verification and the services are denied based on medical necessity, the **beneficiary** may not be held liable. All calls will be limited to 10 minutes to allow equal access to all providers.
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- I. If the fifth day of an admission falls on a Saturday, Sunday or holiday, it is recommended that the hospital provider call for an extension prior to the fifth day if the certified nurse-midwife has recommended a continued stay.
- J. Inpatient stays for bone marrow, liver, heart, lung, skin and pancreas/kidney transplant procedures are excluded from this review program.
- K. The retrospective or post payment random sample review will be continued for all admissions, including inpatient stays of four days or less, to ensure that medical necessity for the services is substantiated.
- L. Admissions of **retroactively** eligible **beneficiaries**: If eligibility is identified while the patient is still an inpatient, the hospital may call for retrospective review of those days already used past the original four for a determination of post authorization and concurrent evaluation of future extended days.

If the **retroactive eligibility** is not identified until after discharge and the hospital bills and receives a denial for any days past the original four allowed, then the hospital may call for post-extension evaluation approval of the denied days, which, if granted, may be rebilled. If the length of stay is more than 30 days, the provider may submit the entire medical record to AFMC to review.

- M. Out-of-state claims are subject to the determination of medical necessity for out-of-state treatment. In addition, the claim and records will be reviewed retrospectively for lengths of stay beyond the four days allowed. "Out-of-state" refers to **states not bordering Arkansas**.
- N. **Medicaid will automatically deny claims submitted for any days billed beyond the fourth day if the provider has not called for an extension request.** There will be no exceptions granted except for claims reflecting third party liability.
- O. If a patient is transferred from one facility to another, the receiving facility must contact AFMC within 24 hours of admitting the patient to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider **must** contact AFMC on the first working day following the **admission**.
- P. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure in order to be reimbursed.
- Q. If a provider fails to contact AFMC for an extension of inpatient days due to the patient's having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, etc., post certification of days past the original four days may be obtained by the following procedures:

Send a copy of the denial notice received from the third party payer to AFMC. [View or print AFMC contact information.](#) Include a note requesting post certification and the full name of the requester and a phone number where the requester may be reached. Upon receipt of the denial copy and the provider request, an AFMC coordinator will call the provider and obtain certification information.

- R. If a third party insurer pays for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

213.220 Benefit Limit – Inpatient Hospital Services

7-1-06

- A. There is an annual benefit limit of 24 medically necessary days per state fiscal year (July 1 through June 30) for Medicaid **beneficiaries** ages 21 and older.

- B. There is no inpatient hospital benefit limit for **individuals** under age 21 in the Child Health Services (EPSDT) Program.
- C. **Inpatient hospital services for ARKids First-B beneficiaries aged 1 year and older are limited to 4 days. Additional days of services must be prior authorized.**

213.410 Laboratory and X-Ray Services Benefit Limits**7-1-06**

Medicaid has established a maximum paid amount (benefit limitation) of \$500 per state fiscal year (July 1 through June 30) for **beneficiaries aged** 21 and older, for outpatient laboratory and machine tests and outpatient radiology.

- A. There is no lab and X-ray benefit limit for **beneficiaries** under age 21.
- B. There is no benefit limit on professional components of laboratory, X-ray and machine tests for hospital inpatients.
- C. There is no benefit limit on laboratory services related to family planning. See section 272.431 for the family planning-related clinical laboratory procedures.
- D. There is no benefit limit on laboratory, X-ray and machine-test services performed **in conjunction with** emergency services **in an emergency department of a hospital.**

213.420 Laboratory and X-Ray Services Referral Requirements**7-1-06**

- A. A certified nurse-midwife, referring a Medicaid **beneficiary** for laboratory, radiology or machine testing services, must specify a diagnosis code (ICD-9-CM coding) for each test ordered and include in the order, pertinent supplemental diagnoses supporting the need for the test(s).
 - 1. Reference diagnostic facilities and hospital labs and outpatient departments performing reference diagnostics rely on the referring physicians/certified nurse-midwives to establish medical necessity.
 - 2. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities performing the tests.
 - 3. Certified nurse-midwives must follow Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.
 - 4. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD-9-CM volume concurrent with the referral dates and the claim dates of service.
 - 5. ICD-9-CM diagnosis codes V72.5 and V72.6 may not be **used** for billing.

213.500 Outpatient Hospital Certified Nurse-Midwife Services**7-1-06**

For the purpose of coverage and reimbursement determination, outpatient hospital certified nurse-midwife services are divided into the following two types of service:

- A. Emergency Services

Special Coverage Requirements - Certified nurse-midwives may bill a hospital outpatient visit as an emergency when the **patient's** medical condition constitutes an emergency medical condition, in compliance with Section 1867 of the Social Security Act.

- B. Non-Emergency Services

Special Coverage Requirements - Non-emergency certified nurse-midwife services in an outpatient hospital setting are covered as a visit and the professional component for machine tests, radiology and anatomical laboratory procedures.

213.510 Outpatient Hospital Benefit Limit

7-1-06

Beneficiaries aged 21 and older are limited to a total of 12 outpatient hospital visits a year. This benefit limit includes outpatient hospital services provided in an acute care/general hospital or a rehabilitative hospital. This yearly limit is based on the state fiscal year (July 1 through June 30). Outpatient hospital services include the following:

- A. Non-emergency outpatient hospital and related certified nurse-midwife services.
- B. Outpatient hospital therapy and treatment services related to certified nurse-midwife services.

Refer to section 272.120 for the procedure code subject to the non-emergency outpatient hospital benefit limit.

Generally outpatient hospital services for beneficiaries under age 21 are not benefit limited.

The Arkansas Medicaid Program exempts the following ICD-9-CM diagnoses from the extension of benefit requirements.

1. Malignant Neoplasm	Diagnosis code range 140.0 through 208.91
2. HIV or AIDS	Diagnosis code 042
3. Renal failure	Diagnosis code range 584 through 586
4. Pregnancy	Diagnosis code range 630 through 677, with applicable 4th and 5th digits, diagnosis codes V22.0, V22.1 and V28 through V29, with applicable 4th digits.

When a Medicaid beneficiary has exhausted the Medicaid established benefit limit for certified nurse-midwife outpatient hospital services, benefits are automatically extended for these diagnoses.

213.600 Certified Nurse-Midwife Services Benefit Limit

7-1-06

Beneficiaries age 21 and older are limited to twelve (12) visits per state fiscal year (July 1 through June 30) for services. For services provided by a certified nurse-midwife, physician's services, rural health clinic services, medical services furnished by a dentist or office medical services by an optometrist or a combination of the five.

For example: a beneficiary who has had two office medical visits to the dentist, one office medical visit to an optometrist and two visits to a physician has used five of the limit of twelve visits per state fiscal year.

The following services are counted toward the 12 visits per state fiscal year limit established for the Certified Nurse-Midwife Program:

- A. Certified nurse-midwife services
- B. Physician services in the office, patient's home or nursing facility
- C. Rural health clinic (RHC) core services
- D. Medical services provided by a dentist

E. Medical services furnished by an optometrist

Global obstetric fees are not counted against the 12-visit limit. Itemized obstetric office visits are counted in the limit.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to section 214.000 of this manual for procedures for obtaining extension of benefits.

Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

214.130 **Administrative Reconsideration of Extension of Benefits Denial** 7-1-06

A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation as detailed in section 214.120. The deadline request will be enforced as indicated in sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days gives rise to a rebuttable presumption that it is not timely.

214.140 **Appealing an Adverse Action** 7-1-06

Please see section 190.000 for information regarding administrative appeals

215.000 **Coverage Limitations** 7-1-06

215.100 **New Patient Visit** 7-1-06

One new patient visit is covered every three (3) years per beneficiary per attending provider.

215.200 **Family Planning Services** 7-1-06

- A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, certified nurse-midwives, clinics and hospitals for a comprehensive range of family planning services.
 - 1. Family planning services do not require a PCP referral.
 - 2. Medicaid **beneficiaries'** family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
 - 3. Abortion is not a family planning service in the Arkansas Medicaid Program.
- B. Certified nurse-midwives desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in sections 215.210 through 215.260, to Medicaid **beneficiaries** of childbearing age.
- C. Certified nurse-midwives preferring not to provide family planning services may refer their patients to other providers. **DHHS** County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:
 - 1. **DHHS Division** of Health local health units,
 - 2. Obstetricians and gynecologists,
 - 3. Nurse practitioners,
 - 4. Rural Health Clinics,

5. Federally Qualified Health Centers,
6. Family planning clinics,
7. Physicians and
8. Certified nurse-midwives.

215.210 Women's Health Demonstration Waiver Aid Category 69 (FP-W)**7-1-06**

- A. The **Women's Health** Demonstration Waiver extends Medicaid coverage of family planning services to women throughout Arkansas who:
 1. Have a family income at or below **200%** of the Federal poverty guidelines and
 2. Are of childbearing age. The target population is women age 14 to age 44, but all women at risk of unintended pregnancy may apply for **Women's Health** Waiver eligibility.
- B. The women **receiving services through the Women's Health Demonstration Waiver** will be eligible for Medicaid coverage of family planning services only. The AEVCS eligibility transaction response and other available electronic options will identify them as eligible in Aid Category 69 (FP-W).
- C. Adult (**aged** 21 or older) women in the **Women's Health** Waiver category, Aid Category 69, who are mentally competent, are eligible for sterilization procedures. For women in this aid category, Medicaid also covers an annual post-sterilization follow-up visit for each year they remain eligible in the FP-W category.
- D. Medicaid does not require women certified in the **Women's Health** Demonstration Waiver to choose a PCP. No family planning services require PCP referral.

215.230 Basic Family Planning Visit**7-1-06**

Medicaid pays for one **basic family planning visit** per **beneficiary** per Arkansas state fiscal year (July 1 through June 30). This basic visit comprises the following:

- A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight and blood pressure.
- B. Counseling and education regarding:
 1. Breast self-exam,
 2. The full range of contraceptive methods available and
 3. HIV/STD prevention.
- C. Prescription for any contraceptives selected by the recipient.
- D. Laboratory services, including, as necessary:
 1. Pregnancy test.
 2. Hemoglobin and Hematocrit.
 3. Sickle cell screening.
 4. Urinalysis testing for albumin and glucose.
 5. Papanicolaou smear for cervical cancer.
 6. Testing for sexually transmitted diseases.

215.240 Periodic Family Planning Visit**7-1-06**

Medicaid covers three periodic family planning visits per **beneficiary** per state fiscal year (July 1 through June 30). The periodic visit includes follow-up medical history, weight and blood pressure and counseling regarding contraceptives and possible complications of contraceptives. The purpose of the periodic visits is to evaluate the patient's contraceptive program, renew or change the contraceptive prescription and provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

215.260 Expansion of Medicaid Eligibility for Pregnant Women**7-1-06**

- A. Arkansas Medicaid provides expanded coverage for pregnant women. Women in Aid Category 61 may receive only the services listed below. Service settings may be both outpatient and inpatient, as appropriate.

1. Prenatal services
2. Delivery
3. Postpartum services for 60 days (plus the days remaining in the month in which the 60-day period ends)
4. Family planning services, including tubal ligations
5. Services for conditions that may complicate the pregnancy

Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are the same as those for Aid Category 61 with the exception of sterilization procedures and family planning services. System eligibility verification will specify "PW unborn ch-no ster cov/FP."

- B. When verifying a **beneficiary's** eligibility, please note the "AID CATEGORY CODE" and "AID CAT DESCRIPTION" fields. The "AID CATEGORY CODE" field contains the 2-digit numeric code identifying the **beneficiary** aid category. The "AID CAT DESCRIPTION" field contains an abbreviation of the aid category description, comprising 2 or more characters, usually letters, **but** sometimes numerals as well as letters.

1. Pregnant Women (PW) eligibility will occasionally overlap with eligibility in another category, such as Aid Category 20, TEA-GR. If a PW-eligible **beneficiary** is seeking services that are not for pregnancy or conditions that may complicate pregnancy and are not family planning services, other eligibility segments may be reviewed on the transaction response and other available electronic options. The woman may have benefits for the date of service in question under another aid category. If so, the service may be performed and the claim may be filed **with** Medicaid as usual.

The **beneficiary** is responsible for payment of services not covered under the PW categories.

2. Medicaid also provides coverage in Aid Category 61 (PW-PL) to children who are eligible for all Medicaid benefits. The **aid category code** and **aid category description** are the same as those of a pregnant woman. The eighth digit of their Recipient Identification number (RID) is "2." The claims processing system distinguishes claims for children's services from claims for pregnant women's services by reading the eighth digit of the RID.

There is also a temporary Aid Category 62, Pregnant Women—Presumptive Eligibility (PW-PE). Coverage is restricted to prenatal services and services for conditions that may complicate the pregnancy. These services are further limited to the outpatient setting only.

Aid Categories 62 (PW-PE), 65 (PW-NG), 66 (PW-EC) and 67 (PW-SD) only cover the pregnant woman. Aid Categories 65, 66 and 67 have lower income limits than those listed above for Aid Category 61. Only Aid Category 61 may include eligible pregnant women and/or children.

215.320 Observation Status**7-1-06**

When billing for services to a patient in “observation status,” certified nurse-midwives must adhere to Arkansas Medicaid definitions of inpatient and outpatient. Observation status is an outpatient designation. Certified nurse-midwives must also follow the guidelines and definitions in *Physician’s Current Procedural Terminology* (CPT), under “Hospital Observation Services” and “Evaluation and Management Services Guidelines.”

The following Arkansas Medicaid criteria determine inpatient and outpatient status:

- A. If a patient is expected to remain in the hospital for less than 24 consecutive hours and this expectation is realized, the hospital and the certified nurse-midwife should consider the patient an outpatient; i.e., the patient is an outpatient unless the certified nurse-midwife has admitted her as an inpatient.
- B. If the certified nurse-midwife or hospital expects the patient to remain in the hospital for 24 hours or more, Medicaid deems the patient admitted at the time the patient’s medical record indicates the existence of such an expectation, even though the certified nurse-midwife has not yet formally admitted the patient.
- C. Medicaid also deems a patient admitted to inpatient status at the time they have remained in the hospital for 24 consecutive hours, even if the certified nurse-midwife or hospital had no prior expectation of a stay of that or greater duration.

215.322 Coverage Limitations**7-1-06**

Outpatient surgical procedures are covered as all inclusive services only. One evaluation and management service, including certified nurse-midwife non-emergency outpatient visits, is covered per beneficiary per day.

240.000 PRIOR AUTHORIZATION**7-1-06****240.100 Procedure for Obtaining Prior Authorization****7-1-06**

- A. Certain medical and surgical procedures are covered only when prior authorized because of federal requirements or because of the elective nature of the surgery. Arkansas Foundation for Medical Care, Inc., (AFMC) issues prior authorizations for restricted medical and surgical procedures covered by the Arkansas Medicaid Program.
- B. Prior authorization determinations are in accordance with established medical and administrative criteria combined with the professional judgment of AFMC physician advisors.
- C. Written documentation is not required for prior authorization. However, the patient’s records must substantiate the oral information given to AFMC. Any retrospective review of a case will rely on the written record.
- D. It is the responsibility of the certified nurse-midwife who will perform the procedure to initiate the prior authorization request. The certified nurse-midwife or the certified nurse-midwife’s office nurse must contact AFMC. [View or print AFMC contact information.](#)

The certified nurse-midwife or his or her office nurse must furnish the following specific information to AFMC: **(All calls will be tape recorded.)**

1. Patient Name and Address
2. Beneficiary Medicaid Identification Number
3. Certified Nurse-Midwife Name and License Number

4. Certified Nurse-Midwife Medicaid Provider Number
5. Hospital Name
6. Date of Service for Requested Procedure

The caller must provide **all** patient identification information and medical information related to the necessity of the procedure.

AFMC will give approval or denial of the Prior Authorization request by telephone with follow-up in writing. If **authorization is** approved, AFMC will assign a prior authorization control number that must be entered in the appropriate field in the CMS-1500 (formerly HCFA-1500) claim format on the system when billing for the procedure. If surgery is involved, a copy of the authorization will be mailed to the hospital where the service will be performed. If the hospital has not received a copy of the authorization before the time of admission, the hospital will contact the admitting certified nurse-midwife or AFMC to verify that prior authorization has been granted.

It is the responsibility of the primary surgeon to distribute a copy of the authorization to the assistant surgeon if the assistant has been requested and approved. The prior authorization control number must be entered in the appropriate field in the PES claim format when **the procedure is billed. The Medicaid Program will not pay for inpatient hospital services that require prior authorization if the prior authorization has not been requested and approved.**

Consulting physicians are responsible for calling AFMC to have their required and/or restricted procedures added to the PA file. They will be given the prior authorization number at the time of the call on those cases that are approved. A letter verifying the PA number will be sent to the consultant upon request.

Post-authorization will be granted only for emergency procedures and/or for services provided to a Medicaid **beneficiary** during a period of retroactive eligibility. Requests for emergency procedures must be applied for no later than the first working day after the procedure has been performed. In cases of retroactive eligibility, AFMC must be contacted for post-authorization within 60 days of the eligibility authorization date.

240.110 Post-Procedural Authorization Process

7-1-06

Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain a prior authorization number. **Providers must follow** the post-procedural authorization process when obtaining an authorization number for the procedures listed in section 213.500.

All requests for post-procedural authorizations for eligible **beneficiaries** are to be made to the Arkansas Foundation for Medical Care (AFMC) by telephone within 60 days of the date of service. These calls will be tape-recorded. [View or print AFMC contact information.](#)

The beneficiary and provider identifying criteria and all of the medical data necessary to justify the procedures must be provided to AMFC.

As medical information will be exchanged for the previously performed procedures, these calls must be made by the certified nurse-midwife or a nursing member of his or her staff.

The provider will be issued a PA number at the time of the call if the procedure requested is approved. A follow-up letter will be mailed to the certified nurse-midwife **on the same day**.

The Arkansas Medicaid Program continues to recommend **that** providers obtain prior authorization for procedures requiring prior authorization in order to prevent risk of denial due to lack of medical necessity.

A provider may request reconsideration of a **Medicaid** Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of **a procedure** rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director **of the** Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel, established by the Director of the Division of Medical Services, which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of **Health and** Human Services (**DHHS**) management staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

260.000	HOSPITAL/PHYSICIAN/CERTIFIED NURSE-MIDWIFE REFERRAL PROGRAM
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7-1-06

260.100	Introduction
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7-1-06

The intent of the Hospital/Physician/Certified Nurse-Midwife Referral Program is fourfold.

- A. It provides the hospital, physician and certified nurse-midwife with a means to identify needy individuals to the Arkansas Department of Health and Human Services (DHHS) through written referral and assures follow-up contact with interested individuals by DHHS.
- B. It provides DHHS with a means of reaching needy individuals who might not otherwise be aware of or apply for Medicaid benefits.
- C. It informs needy individuals of possible Medicaid coverage that would help defray their medical expenses.
- D. It enables the hospital, physician and certified nurse-midwife to know if an application is made and whether the patient is Medicaid eligible.

260.200	Hospital/Physician/Certified Nurse-Midwife Responsibility
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7-1-06

The hospital, physician or certified nurse-midwife should inform needy individuals of possible medical assistance available under the Medicaid Program **and** refer all interested individuals to Arkansas Department of **Health and** Human Services by means of form DMS-630, Referral for Medical Assistance. [View or print form DMS-630 and instructions for completion.](#)

The hospital, physician or certified nurse-midwife should be prepared to provide itemized statements on all individuals referred to the Arkansas Department of **Health and** Human Services for potential use in the eligibility determination. **The representative of the hospital, physician or certified nurse-midwife** is responsible for the accurate completion of the Referral for Medical Assistance Form (DMS-630). After the required information has been entered on the form, the representative will read and explain the authorization section to the **beneficiary** before securing **her** signature. Once the signature is obtained, the representative will sign and date the form and

forward it to the local county **Health and** Human Services office in the client's county of residence.

The county **Health and** Human Services Office addresses are available from the Arkansas Division of Medical Services.

260.300 County **Health and** Human Services Office Responsibility

7-1-06

Upon receipt of the Referral for Medical Assistance form DMS-630, the local Department of **Health and** Human Services county office will contact the **beneficiary**. Action must be completed within a specified period of time on all applications taken during follow-up. Once a determination has been made, the local County **Health and** Human Services office will notify the hospital, physician or certified nurse-midwife by completing Section 2 of form DMS-630. The three (3) types of disposition are:

- A. Did Not Respond or No Longer Interested - **individual** failed to respond to follow-up contact or stated he or she was no longer interested.
- B. Denied - Application taken; **individual** was determined ineligible or eligibility could not be determined.
- C. Approved - Application taken; **applicant** was determined eligible effective month/day/year.

The **beneficiary** is responsible for presenting his or her Medicaid identification card to the hospital, physician or certified nurse-midwife for billing purposes each time he or she receives a service.

260.400 Completion of Referral for Medical Assistance Form (DMS-630)

7-1-06

260.410 Purpose of Form

7-1-06

Section 1 of Form DMS-630 is used by hospitals/physicians/certified nurse-midwives to refer to the Arkansas Department of **Health and** Human Services any needy individuals who might not otherwise be aware of or apply for Medical Assistance under the Medicaid Program. Section 2 of Form DMS-630 is used by the Arkansas Department of **Health and** Human Services to notify the hospital/physician/certified nurse-midwife of the disposition of the referral on that patient.

260.420 Hospital/Physician/Certified Nurse-Midwife Completion - Section 1

7-1-06

Enter, in sequence, hospital/physician/certified nurse-midwife name and address; patient account number; local county **Department of Health and** Human Services office name and address; client's first name, middle initial and last name; signature of hospital/physician/certified nurse-midwife representative; date signed; name of hospital/physician/certified nurse-midwife; signature of client, address and date signed.

260.430 County **Department of Health and** Human Services Office Completion - Section 2

7-1-06

Leave blank; Section 2 will be completed by the local **Department of Health and** Human Services county office.

260.440 Ordering Forms

7-1-06

When ordering Form DMS-630 please complete a Medicaid Form Request (Form EDS-MFR-001) and mail it to the EDS Provider Assistance Center. [View or print the EDS Provider Assistance Center contact information.](#) Please give the provider's complete mailing address and the number of forms being requested. [View or print form DMS-630 and instructions for completion.](#)

260.500 Hospital/Physician/Certified Nurse-Midwife Referral for Newborns 7-1-06

Federal law mandates Medicaid coverage of infants born to Medicaid **beneficiaries** for a period of up to 12 months, as long as the mother remains Medicaid eligible (or would continue to be eligible if still pregnant) and as long as the infant resides with the mother.

A Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage Form (DCO-645) must be completed to report the birth of a Medicaid eligible infant. [View or print form DCO-645 and instructions for completion.](#) The referring provider must complete and mail the form to the **DHHS** County Office of the mother's resident county within 5 days of the infant's birth, when possible. The form will serve the Division of County Operations as verification of the birth date of the infant as well as documentation of relationship.

If all vital information and signatures are on the form when received and it is verified that the mother was an Arkansas Medicaid **beneficiary** at the time of delivery and the DHHS County Office has verified by collateral that the child lives with its mother, a newborn certification will be made within 20 working days from receipt of the completed Form DCO-645. The DHHS County Office service representative must then complete Part III of the form and return it to the provider within the 20-day period. A Form DCO-700 will be mailed to the infant's mother to notify her of the application's approval or denial.

260.510 Ordering Forms 7-1-06

When ordering Form DCO-645, please complete a Medicaid Form Request (Form EDS-MFR-001) and mail it to the EDS Provider Assistance Center. [View or print the EDS Provider Assistance Center contact information.](#) Please give the provider's complete mailing address and the number of forms being requested.

270.000 BILLING PROCEDURES 7-1-06

271.000 Introduction to Billing 7-1-06

Certified Nurse-Midwife providers use the CMS-1500 (formerly HCFA-1500) form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid **beneficiaries**. Each claim may contain charges for only one **beneficiary**.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claims submission.

272.000 CMS-1500 Billing Procedures 7-1-06

272.100 Certified Nurse-Midwife Procedure Codes 7-1-06

The following procedure codes are payable to a certified nurse-midwife. **Procedure** codes marked with an asterisk (*) require modifiers when applicable. Refer to section 272.400 for modifiers and other services requiring special billing procedures.

J0290	J0360	J0460	J0500	J0520	J0530	J0540
J0550	J0560	J0570	J0580	J0610	J0670	J0690
J0694	J0696	J0697	J0698	J0702	J0710	J0970
J1000	J1055*	J1100*	J1200	J1240	J1320	J1330
J1380	J1390	J1410	J1435	J1580	J1626	J1670
J1751	J1752	J1815	J1840	J1850	J1890	J1940

J1980	J2001	J2400	J2510	J2540	J2590	J2650
J2675	J2700	J2788	J2790	J2912	J2916	J3070
J3250	J3260	J3301	J3302	J3303	J3370	J3410
J7030	J7300*	J7302*	J7303*	J7306*	P9612	P9615
S0612*	T1015*	T1502*	10060	10120	10140	10160
11100	11200	11300	11305	11400	11420	11975*
11976*	11977*	12001	12002	12041	12042	17110
17111	17250	19000	19001	36000	36415*	54150
56405	56420	56501	56605	56606	56740	56820
56821	57061	57150	57160	57180	57420	57421
57452	57454	57455	57456	57500	57505	57511
57800	58300*	58301*	58999	59020	59025	59030
59050	59051	59160	59300	59400	59409	59410
59414	59425*	59426*	59610	59612	59614	59899
64430	76815	76816	76818	76819	76857	80055
81000	81001	81002	81003	81005	81007	81015
81025	82042	82043	82044	82247	82248	82270
82274	82947	82948	82950	82951	82962	83020
83021	83520	83896	84703	84830	84999	85013
85014	85018	85660	86060	86318	86403	86580
86585	86592	86593	86687	86701	87075	87081
87088	87177	87205	87210	87390	87470	87490
87536	87590	87880	89330	90371	90385	90656
90658	90703	90707	90732	90743	90744	90746
90748	90749	90765	90766	90767	90768	90774
90775	90779	99054	99058	99199	99201	99202
99203	99204	99205	99211	99212	99213	99214
99215	99217	99218	99219	99220	99221	99222
99223	99231	99232	99233	99234	99235	99236
99238	99281	99282	99283	99284	99285	99301
99302	99303	99311	99312	99313	99341	99342
99343	99347	99348	99349	99401*	99402*	99431
99432	99435	99440				

272.300

Billing Instructions

7-1-06

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

To bill for certified nurse-midwife services, use **form** CMS-1500. The numbered items correspond to numbered fields on the claim form. [View a CMS-1500 sample form.](#)

Read and carefully adhere to **the following instructions** 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.

272.310 Completion of CMS-1500 Claim Form

7-1-06

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 <u>last</u> name and <u>first</u> 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 <u>last</u> name, <u>first</u> name and <u>middle</u> 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 <u>last</u> name, <u>first</u> name and <u>middle</u> 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.

Field Name and Number	Instructions for Completion
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 not required for certified nurse-midwife services except for EPSDT services other than newborn care. 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 certified nurse-midwife.

Field Name and Number	Instructions for Completion
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. - On a single claim detail (one charge on one line), bill only for services within a single calendar month. - Providers may bill, on the same claim detail, for two (2) or more <i>sequential</i> 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/HCPSC	Enter the correct CPT or HCPSC procedure code from section 272.100. For unlisted procedure codes, enter the description of the service and attach a procedure report.
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.

Field Name and Number	Instructions for Completion
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, unless the recipient has an insurer that requires co-pay. In such a case, enter the sum of the insurer's payment and the recipient's co-pay. (See NOTE below Field 30.)
30. Balance Due	Enter the total amount due. 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 valid.

Field Name and Number	Instructions for Completion
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#."

272.400 Special Billing Procedures**7-1-06****272.410 Anesthesia Services****7-1-06**

Services for anesthesia must be billed in the CMS-1500 claim format.

272.430 Family Planning Services Program Procedure Codes**7-1-06**

The following list includes Family Planning Services Program procedure codes payable to certified nurse-midwives. When filing paper claims for family planning services, certified nurse-midwives must use type of service code "A." Applicable modifiers must be used for both electronic and paper claims. All procedure codes in this table require a family planning diagnosis code in each claim detail.

Procedure Code	Required Modifier(s)	Description
J1055	FP	Medroxyprogesterone Acetate for contraceptive use
J7300	FP	Intrauterine Copper Contraceptive
J7302	FP	Levonorgestrel-Releasing Intrauterine Contraceptive System
J7303	FP	Contraceptive supply, hormone containing vaginal ring, each
J7306	FP	Levonorgestrel (contraceptive) implant system, including implants and supplies
S0612*	FP, SB, UB	Annual Post-Sterilization Visit
11975	FP, SB	Implantation of Contraceptive Capsules
11976	FP, SB	Removal of Contraceptive Capsules
11977	FP, SB	Removal and Reinsertion of Contraceptive Capsules
36415	FP	Collection of Venous Blood by Venipuncture
58300	FP, SB	Insertion of Intrauterine Device
58301	FP, SB	Removal of Intrauterine Device
99402	FP, SB	Basic Family Planning Visit

Procedure Code	Required Modifier(s)	Description
99401	FP, SB, UA	Periodic Family Planning Visit

* Women in the FP-W category (eligibility category 69) who have undergone sterilization are eligible only for this annual follow-up visit.

272.440 Injections

7-1-06

272.441 Injections with Restrictions

7-1-06

The following services are covered for **beneficiaries** of all ages. However, when **these services are** provided to **individuals** age 21 and older, a diagnosis of ICD-9-CM 140.0 - 208.91, or 042 must exist.

These injections **are payable when** provided in the certified nurse-midwife's office. Multiple units may be billed.

J0290	J0360	J0460	J0500	J0520	J0530	J0540	J0550
J0560	J0570	J0580	J0610	J0670	J0690	J0694	J0696
J0697	J0698	J0702*	J0710	J0970	J1000	J1100*	J1200
J1240	J1320	J1330	J1380	J1390	J1410	J1435	J1580
J1626	J1670	J1815	J1840	J1850	J1890	J1940	J1980
J2000	J2001	J2400	J2510	J2540	J2590	J2650	J2675
J2700	J2912	J3070	J3250	J3260	J3301	J3302	J3303
J3370	J3410	J7030					

*When procedures **J0702** and **J1100** are furnished to patients aged 21 and older, a diagnosis of ICD-9-CM 140.0 – 208.91, 042 or 640 – 648.93 must exist.

272.442 Immunizations and Other Covered Injections

7-1-06

Certified nurse-midwives billing in the Arkansas Medicaid Program for injections should bill the appropriate procedure code for the specific injection being performed.

Certified nurse-midwives may bill the injection procedure codes on **form** CMS-1500 **or electronically**.

If the patient is scheduled for injection only, the provider **may** not bill for an office visit but **may bill for** the injection.

Procedure Code	Description of Special Coverage
J1751	Injection, iron dextran, 165, 50 mg (Effective for dates of service on and after 3-1-06, use procedure code J1751 in place of procedure code J1750. Payable when diagnosis is 280.9.)
J1752	Injection, iron dextran, 267, 50 mg (Effective for dates of service on and after 3-1-06, use procedure code J1752 in place of procedure code J1750. Payable when diagnosis is 280.9)

Procedure Code	Description of Special Coverage
J2788	Injection, Rho D immune globulin, human, mini dose 50 mcg (limited to one injection per pregnancy).
J2790	Injection, Rho D immune globulin, human, full dose, 300 mcg (limited to one injection per pregnancy).
90371	Hepatitis B Immune Serum Globulin (ISG). One unit equals ½ cc with a maximum of 10 units billable per day. This code is covered for all ages.
90385	Rho(D) immune globulin (Rhlg), human, mini-dose, for intramuscular use
90703	Tetanus absorbed, for intramuscular or jet injections.
90707	Maternal measles/mumps/rubella (MMR). Arkansas Medicaid extends coverage of Measles, Mumps and Rubella (MMR) vaccine to women of childbearing age (ages 21 through 44) who may be at risk of exposure to these illnesses. Coverage is limited to two (2) per lifetime.
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use. This code is payable for eligible individuals of all ages. Patients age 21 and older who receive the injections should be considered by the provider as high risk.
90746	Hepatitis B vaccine, adult dosage, for intramuscular use (covered for ages 19 and older).

Effective for dates of service on and after March 1, 2006, procedure code **90799** is non-payable. Procedure code **T1502** is to be used for “administration only” of IM and/or subcutaneous injections and requires a modifier **U1** when billed electronically or on paper. When filing paper claims use type of service “**9**”. Procedure code **T1502** must be used when the drug is not supplied by the provider who administers the drug.

272.471 Health Examinations for ARKids First-B Beneficiaries and Medicaid Beneficiaries Under Age 21 **7-1-06**

Providers should refer to the Child Health Services (EPSDT) Provider manual and the ARKids First-B Provider manual for covered services and billing procedures.

272.480 Nursing Home Visits **7-1-06**

Providers should use the appropriate CPT procedure codes when billing for certified nurse-midwife visits in a nursing facility.

272.491 Method 1 – “Global” or “All-Inclusive” Rate **7-1-06**

- A. One charge for total obstetrical care is billed. The single charge would include the following:
 1. Antepartum care, which includes:
 - a. initial and subsequent history
 - b. physical examinations
 - c. recording of weight
 - d. blood pressure
 - e. fetal heart tones

- f. routine chemical urinalyses
 - g. maternity counseling
 - h. office visit charge when diagnosis is pregnancy related
 - 2. Admission to the hospital. All admissions and subsequent hospital visits for the treatment of false labor.
 - 3. Delivery - vaginal delivery (with or without episiotomy, with or without forceps or breech delivery) and resuscitation of newborn infant when necessary.
 - 4. Postpartum care, which includes hospital and office visits following vaginal delivery.
- B. The global method must be used when the following conditions exist:
- 1. At least two months of antepartum care were provided culminating in delivery.
 - 2. The patient was continuously Medicaid eligible for at least two months before delivery.

If either condition is not met, the **claim** will be denied. **The denial will state** either “monthly billing required” or “**beneficiary** ineligible for service dates.”

- C. **When billing for global care, procedure code 59400 must be used. The provider should indicate in the date of service field of the claim form:**
- 1. The first date of antepartum care after Medicaid eligibility has been established
 - 2. The date of delivery
 - 3. If these two dates are not entered and are not at least two months apart, payment will be denied. The filing deadline will be calculated based on the date of delivery.
- D. No benefits are counted against the **beneficiary's annual office** visit benefit limit if the global method is used.
- E. The global method of billing should be used when one or more certified nurse-midwives in a group sees the patient for one or more prenatal visits. The certified nurse-midwife who delivers the baby should be listed as the attending provider on the claim for global obstetric care.

272.492 Method 2 – “Itemized Billing”

7-1-06

Itemized billing must be used when the following conditions exist:

- A. Less than two months of antepartum care was provided.
- B. The patient was NOT Medicaid eligible for at least the last two months of the pregnancy.
- C. If Method 2 is used to bill OB services, care should be taken to ensure that the services are billed within the 12-month filing deadline.
- D. If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure code 59409 should be billed for vaginal delivery. Procedure codes 59400 and 59410 may not be billed in addition to procedure code 59409. These procedures will be reviewed on a post-payment basis to ensure that they are not billed in addition to antepartum or postpartum care.
- E. **Providers may bill** laboratory and X-ray services separately using the appropriate CPT **procedure** codes if this is the certified nurse-midwife's standard office practice.
 - 1. **When** lab tests and/or x-rays are pregnancy related, the referring certified nurse-midwife must be sure to code appropriately when these services are sent to the lab or x-ray facility. The diagnostic facilities are completely dependent on the referring certified nurse-midwife for diagnosis information necessary for reimbursement.

2. The obstetrical laboratory profile procedure code 80055 consists of four components: complete blood count, VDRL, Rubella and blood typing **with** RH. If the ASO titer (procedure code 86060) is performed, the test should be billed separately using the individual code.
3. As with any laboratory procedure, if the specimen is sent to an outside laboratory, only a collection fee may be billed. The laboratory **may** then bill Medicaid for the laboratory procedure. Refer to section 272.450 of this manual.

NOTE: Payment will not be made for emergency room certified nurse-midwife charges for an OB patient admitted directly from the emergency room into the hospital for delivery.

272.493 Obstetrical Care Without Delivery

7-1-06

Certified nurse-midwives must use procedure code **59425** with modifier **UA** to bill for one to three visits for antepartum care without delivery.

Procedure code **59425** with no modifier must be used by providers to bill four to six visits for antepartum care without delivery. **Procedure code 59426 with no modifier is to be used for 7 or more visits without delivery.**

This enables certified nurse-midwives rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for their services provided. Coverage for this service will include routine sugar and protein analysis. One unit equals one visit. Units of service billed with this procedure code will not be counted against the patient's office visit benefit limit.

Providers must enter the "from" and "through" dates of service on the claim and the number of units being billed. One visit equals one unit of service. Providers must submit the claim within 12 months of the first date of service.

For example: An OB patient is seen by the certified nurse-midwife on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another provider prior to the delivery. The certified nurse-midwife may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. This claim must be received by EDS prior to 12 months from 1-10-05 to fall within the 12-month filing deadline. The certified nurse-midwife must have on file the patient's medical record that reflects each date of service being billed.

272.494 Fetal Non-Stress Test, Fetal Echography (Ultrasound) and External Fetal Monitoring

7-1-06

- A. The fetal non-stress test, procedure code **59025**, has a benefit limitation of two (2) per pregnancy. Prior authorization is not required.
- B. CPT procedure code 59050 is applicable only to internal fetal monitoring during labor by a consultant. **Procedure code 59050 with modifier U1, for external fetal monitoring, is payable to the certified nurse-midwife when performed in a certified nurse-midwife's office or clinic. Certified nurse-midwives may bill no more than one unit per day of external fetal monitoring, not to exceed two (2) per pregnancy.**
- C. Benefit limits apply to fetal echography (ultrasound), procedure codes 76815 **through** 76816. Fetal echography is limited to two (2) per pregnancy. If it is necessary to exceed these limits, the certified nurse-midwife must request an extension of benefits. See Section 214.000 for benefit extension procedures.

272.502 Non-Emergency Services

7-1-06

Procedure code **T1015** (modifier **U3**) should be billed for a non-emergency certified nurse-midwife visit.

272.530 Substitute Certified Nurse-Midwife**7-1-06**

The following are the requirements regarding substitute certified nurse-midwife billing identification:

- A. Under a reciprocal billing arrangement (not to exceed 14 continuous days), the regular certified nurse-midwife must identify the services as substitute certified nurse-midwife services by entering in **the appropriate** field **of the** claim a **"Q5"** modifier after the procedure code.
- B. Under a *locum tenens* billing arrangement (90 continuous days or longer), the regular certified nurse-midwife must identify the services as substitute certified nurse-midwife services by entering in **the appropriate** field **of the** claim a **"Q6"** modifier after the procedure code.
- C. Payment by Arkansas Medicaid will be limited to the amount that would have been paid to the primary certified nurse-midwife if the primary certified nurse-midwife had provided all the services billed. Medicaid will not split fees or accept billings from two providers.

Under the above billing arrangements, the billing (regular) certified nurse-midwife (or group) must keep on file a record that shows the substitute certified nurse-midwife's name and each service provided by the substitute certified nurse-midwife. This record must be made available upon request. A record of the service must include the date and place of the service, the procedure code, the charge and the **beneficiary** involved.

These billing requirements apply to all substitute certified nurse-midwife services regardless of whether a managed care primary care physician is involved.
