Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – Developmental Day Treatment Clinic Services**

DATE: **November 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #78**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	7-1-05	201.000	11-1-06
202.100	10-13-03	202.100	11-1-06
202.200	10-13-03	202.200	11-1-06
211.000	10-13-03	211.000	11-1-06
212.000	10-13-03	212.000	11-1-06
214.120	10-13-03	214.120	11-1-06
215.200	10-13-03	215.200	11-1-06
216.000	10-13-03	216.000	11-1-06
216.100	10-13-03	216.100	11-1-06
217.000	7-1-05	217.000	11-1-06
218.000	10-13-03	218.000	11-1-06
—	—	218.100	11-1-06
219.000	10-13-03	219.000	11-1-06
252.000	10-13-03	252.000	11-1-06
261.000	7-1-05	261.000	11-1-06
262.000	7-1-05	262.000	11-1-06
262.110	12-5-05	262.110	11-1-06
262.200	10-13-03	262.200	11-1-06
262.310	10-13-03	262.310	11-1-06
262.400	10-13-03	262.400	11-1-06

Explanation of Updates

Section 201.000 has been revised to include clarification of provider enrollment requirements for participation in the Medicaid program. The agency name has been changed to Department of Health and Human Services.

Section 202.100 has been revised to include clarification of documentation requirements for all Medicaid providers.

Sections 202.200 through 212.000 have been revised to change the word recipient to beneficiary in reference to those who receive services covered by Medicaid.

Section 214.120 has been revised to change the word recipient to beneficiary.

Sections 215.200 through 216.100 have been revised to change the word recipient to beneficiary.

Section 217.000 has been revised with minor wording changes for clarification. References to form DMS-699 have been deleted from this section since this form is no longer in use.

Section 218.000 has been revised to include new information policy for requesting administrative reconsideration of extension of benefits denial. Information previously located in this section has been moved to a new section 218.100.

Section 218.100 is a new section to include information previously located in section 218.000.

Section 219.000 has been revised to change the word recipients to beneficiaries.

Section 252.000 has been revised to change the agency name to Department of Health and Human Services.

Section 261.000 has been revised to change the word recipients to beneficiaries.

Section 262.000's title has been revised to delete unnecessary wording "formerly HCFA-1500".

Section 262.110 has been revised to change the word recipients to beneficiaries.

Section 262.200 has been revised to change place of service codes to 0 for paper claims and 99 for electronic claims.

Section 262.310 is included to revise instructions for completion of form CMS-1500. Unnecessary wording has been deleted from Field 17. Minor wording changes have been made in Fields 29, 30 and 31 instructions.

Section 262.400 has been revised by removing unnecessary wording.

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 have already been 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.

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Roy Jeffus, Director

TOC required due to deletion

201.000 Arkansas Medicaid Participation Requirements for Developmental Day Treatment Clinic Services (DDTCS) Providers 11-1-06

To participate in the Arkansas Medicaid Program, providers must adhere to all applicable professional standards of care and conduct. All providers of DDTCS services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program:

A. Each provider of DDTCS services must be licensed as a developmental day treatment clinic by the Division of Developmental Disabilities Services (DDS), Arkansas Department of Health and Human Services.

1. A copy of the current license must accompany the provider application and the Medicaid contract.

2. Copies of renewed licenses must be submitted to the Provider Enrollment Unit of the Division of Medical Services when they are issued.

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

C. Enrollment as a Medicaid provider is conditioned upon the approval of a completed provider application and the execution of a Medicaid Provider Agreement.

D. 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.

202.100 Documentation Requirements for All Medicaid Providers 11-1-06

A. The provider of Medicaid services must contemporaneously establish 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 signed. Providers must also 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.

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 will result in sanctions being imposed. (See Section I of this manual)

E. If an audit determines that recoupment of Medicaid payments is necessary, additional documentation will be accepted for only thirty (30) days after the date of the notification of recoupment. Additional documentation will not be accepted at a later date.

202.200 Clinical Records DDTCS Providers Must Keep 11-1-06

A. Providers must establish and maintain medical records for each beneficiary that include documentation of medical necessity for DDTCS services and a plan of care.

B. Sufficient written documentation for each beneficiary record must support the medical or remedial therapy services provided. This requirement applies to core services and optional services. Refer to Sections 214.000 through 214.210 of this manual for description of services.

C. *Daily* service documentation for each DDTCS beneficiary must, at a minimum, include the following items.

1. The specific services furnished,
2. The date and actual beginning and ending time of day the services were performed,
3. Name(s) and title(s) of the person(s) providing the service(s),
4. The relationship of the services to the goals and objectives described in the beneficiary's individualized plan of care, and
5. Daily progress notes, signed or initialed by the person providing the service(s), describing each beneficiary's status with respect to his or her goals and objectives.

211.000 Introduction 11-1-06

Medicaid assists eligible individuals to obtain medical care in accordance with the guidelines specified in Section I of this manual. Reimbursement may be made for covered developmental day treatment clinic services provided to Medicaid beneficiaries at qualified provider facilities.

212.000 Scope 11-1-06

A. Developmental day treatment clinic services in qualified facilities may be covered only when they are:

1. Provided to outpatients,
2. Determined medically necessary for the beneficiary,
3. Provided pursuant to a written prescription by a physician and
4. Provided in accordance with an individualized written plan of care.

B. Outpatients are individuals who travel to and from a treatment site on the same day, who do not reside in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR) and who are not inpatients of a hospital.

C. Please refer to Sections 215.000 through 216.100 of this manual for details regarding medical necessity and plans of care.

214.120 Habilitation 11-1-06

A. Habilitation is instruction in areas of self-help, socialization, communication, etc. Habilitation activities must be based on the goals and objectives of the client's individualized plan of care.. (Refer to section 216.000 of this manual.)

B. Medicaid covers habilitation services only in clinical settings licensed by DDS and enrolled in Medicaid.

C. DDTCS providers must ensure that a noon meal is available to each Medicaid beneficiary who receives at least four hours of DDTCS core services in a day and who is unable to provide his or her own meal on the date of the core services.

1. When being responsible for providing his or her own meal is a component of a beneficiary's plan of care, the provider may request the beneficiary furnish the meal.

2. A beneficiary may not be charged for a meal the facility provides, whether or not providing his or her own meal is included in the client's individualized plan of care.

215.200 Establishing Medical Necessity for Optional Services 11-1-06

A. Occupational, physical and speech therapy services for Medicaid beneficiaries under age 21 require a *referral* from the client's primary care physician (PCP) or attending physician if the individual is exempt from mandatory PCP referral requirements. The *referral* for occupational, physical and speech therapy services must be renewed every six months.

B. A written *prescription* for therapy services is required and is valid for one year unless the prescribing physician specifies a shorter period.

C. Form DMS-640, Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral, must be used to obtain the referral and/or written prescription. This form has been revised effective July 1, 2006. Use of the revised form is required for dates of service on or after July 1, 2006.

Copies of form DMS-640 can be obtained by completing the Medicaid Form Request and mailing it to the EDS Provider Assistance Center or by printing the form. **View or print form DMS-640**. **View or print the EDS PAC contact information**.

216.000 Plan of Care 11-1-06

For each beneficiary who enters the DDTCS Program, an individualized plan of care must be developed. This consists of a written, individualized plan to improve the beneficiary's condition. The plan of care must contain a written description of the treatment objectives for the beneficiary. It also must describe:

A. The treatment regimen—the specific medical and remedial services, therapies and activities that will be used to achieve the treatment objectives.

B. A schedule for service delivery—this includes the frequency and duration of each type of therapeutic session or encounter.

C. The job titles or credentials of personnel that will furnish each service.

D. A schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.

The plan of care may be authorized only by the physician determining that DDTCS services are medically necessary. The physician's original personal signature and the date signed must be recorded on the plan of care. Delegation of this function or a stamped signature is not allowed.

216.100 Periodic Review of Plan of Care 11-1-06

DDTCS staff must periodically review the plan of care to assess the appropriateness of services, the beneficiary's status with respect to treatment objectives and his or her need for continued participation in the program. The reviews must be performed at least every 90 days and documented in detail in the individual's case file.

The beneficiary's physician must authorize (by dated original signature) any revisions to the plan of care for any reason.

217.000 Procedures for Extension of Benefits for Occupational, Physical and Speech Therapy (Evaluation or Treatment) 11-1-06

A. Extensions of occupational, physical and speech therapy benefits may be approved for Medicaid beneficiaries under age 21 when medically necessary. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services, must be used to request extension of benefits for occupational, physical and speech therapy services. **View or print form DMS-671**

B. Submit the request form with attached summary and medical records as needed to justify medical necessity to Arkansas Foundation for Medical Care, Inc. (AFMC). **View or print Arkansas Foundation for Medical Care (AFMC) contact information**

218.000 Administrative Reconsideration of Extension of Benefits Denial 11-1-06

A 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.

B. The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC with 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days of a denial will be considered on an individual basis. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

218.100 Appeal Process 11-1-06

When the Division of Medical Services (DMS) denies coverage of services, the beneficiary may request a fair hearing to appeal the denial of services from the Department of Health and Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Health and Human Services within thirty (30) days of the date of the denial notification. **View or print DHHS Appeals and Hearings Section contact information.**

219.000 Utilization Review 11-1-06

A. The Utilization Review Section of the Arkansas Medicaid Program has the responsibility for assuring quality medical care for Medicaid beneficiaries and for protecting the integrity of state and federal funds supporting the Medical Assistance Program. Those responsibilities are mandated by federal regulations.

B. The Utilization Review team shall:

1. Conduct on-site medical audits for the purpose of verifying the nature and extent of services paid for by the Medicaid Program,
2. Research all inquiries from beneficiaries in response to the Explanation of Medicaid Benefits and
3. Retrospectively evaluate medical practice patterns and providers' patterns by comparing each provider's pattern to norms and limits set by all the providers of the same specialty. Prior authorization is not required for DDTCS core service or for occupational, physical and speech therapy services.

252.000 Rate Appeal Process 11-1-06

A provider may request reconsideration of a 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 its 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 of a conference, 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 provider disagrees with the decision made by the Assistant Director, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The Rate Review Panel 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 chairperson.

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. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the question(s) and will submit a recommendation to the Director.

261.000 Introduction To Billing 11-1-06

DDTCS service providers use form CMS-1500 to bill the Arkansas Medicaid Program for services provided to 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 claim submission.

262.000 CMS-1500 Billing Procedures 11-1-06

262.110 Occupational, Physical and Speech Therapy Procedure Codes 11-1-06

DDTCS therapy services may be provided only outside the time DDTCS core services are furnished. The following procedure codes must be used for therapy services in the DDTCS Program for Medicaid beneficiaries of all ages.

A. Occupational Therapy Procedure Codes

Procedure Code	Required Modifier(s)	Description
97003	—	Evaluation for occupational therapy (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)
97150	U1, UB	Group occupational therapy by occupational therapy assistant (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)
97150	U2	Group occupational therapy (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)
97530	—	Individual occupational therapy (15-minute unit; maximum of 4 units per day)

Procedure Code	Required Modifier(s)	Description
97530	UB	Individual occupational therapy by occupational therapy assistant (15-minute unit; maximum of 4 units per day)

B. Physical Therapy Procedure Codes

Procedure Code	Required Modifier(s)	Description
97001	—	Evaluation for physical therapy (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)
97110	—	Individual physical therapy (15-minute unit; maximum of 4 units per day)
97110	UB	Individual physical therapy by physical therapy assistant (15-minute unit; maximum of 4 units per day)
97150	—	Group physical therapy (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)
97150	U1, UB	Group physical therapy by physical therapy assistant (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)

C. Speech Therapy Procedure Codes

Procedure Code	Required Modifier(s)	Description
92506	—	Evaluation for speech therapy (maximum of four 30-minute units per state fiscal year, July 1 through June 30)
92507	—	Individual speech session (15-minute unit; maximum of 4 units per day)
92507	UB	Individual speech therapy by speech language pathology assistant (15-minute unit; maximum of 4 units per day)
92508	—	Group speech session (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)
92508	UB	Group speech therapy by speech language pathology assistant (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)

262.200 Place of Service and Type of Service Codes 11-1-06

Below are listed the place of service (POS) and type of service (TOS) codes for DDTCS procedures.

Place of Service	Paper Claims	Electronic Claims	Type of Service (paper claims)
Day Care Facility/DDTCS Clinic	0	99	9 – Other Medical

Place of Service	Paper Claims	Electronic Claims	Type of Service (paper claims)
			Service/DDTCS

262.310 Completion of CMS-1500 Claim Form 11-1-06

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 last name and first name.
3.	Patient's Birth Date		Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex		Check "M" for male or "F" for female.
4.	Insured's Name		Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address		Optional entry. Enter the patient's full mailing address, including street number and name, (post office box or RFD), city name, state name and zip code.
6.	Patient Relationship to Insured		Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address		Required if insured's address is different from the patient's address.
8.	Patient Status		This field is not required for Medicaid.
9.	Other Insured's Name		If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	a.	Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	b.	Other Insured's Date of Birth	This field is not required for Medicaid.
		Sex	This field is not required for Medicaid.
	c.	Employer's Name or School Name	Enter the employer's name or school name.
	d.	Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to:		
	a.	Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."

Field Name and Number	Instructions for Completion
b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter State postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
10d. Reserved for Local Use	This field is not required for Medicaid.
11. Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
a. Insured's Date of Birth	This field is not required for Medicaid.
Sex	This field is not required for Medicaid.
b. Employer's Name or School Name	Enter the insured's employer's name or school name.
c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12. Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13. Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14. Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15. If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16. Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17. Name of Referring Physician or Other Source	Enter the referring physician's name and title. DDTCS optional therapy services require primary care physician (PCP) referral.
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	For tracking purposes, DDTCS providers are required to enter one of the following therapy codes: <u>Code</u> — <u>Category</u> A — Individuals from birth through 2 years who are receiving therapy services under an Individualized Family Services Plan (IFSP) through the Division of Developmental Disabilities Services.

Field Name and Number	Instructions for Completion
B	Individuals ages 0 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Plan (IP) through the Division of Developmental Disabilities Services. **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Plan and 3) the Individualized Plan is through the Division of Developmental Disabilities Services.**
When using code C or D, providers must also include the 4-digit LEA (local education agency) code assigned to each school district. For example: C1234	
C (and 4-digit LEA code)	Individuals ages 3 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Education Plan (IEP) through an education service cooperative. **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 3 through 5 years and has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Education Plan and 3) the Individualized Education Plan is through an education service cooperative.**
D (and 4-digit LEA code)	Individuals aged 5 (by September 15) to 21 years who are receiving therapy services under an Individualized Education Plan (IEP) through a school district. **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 5 (by September 15 of the current school year) to 21 years, 2) the individual receiving services is receiving the services under an Individualized Education Plan and 3) the Individualized Education Plan is through a school district.**
E	Individuals aged 18 years and up who are receiving therapy services through the Division of Developmental Disabilities Services.
F	Individuals aged 18 years and up who are receiving therapy services through individual or group providers not included in any of the previous categories (A-E).

Field Name and Number	Instructions for Completion
G	Individuals aged birth through 17 years who are receiving therapy/pathology services through individual or group providers not included in any of the previous categories (A-F).
20. Outside Lab?	This field is not required for Medicaid.
21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with HCFA diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22. Medicaid Resubmission Code	Reserved for future use.
Original Ref No.	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number, if applicable.
24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See Section 262.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 262.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 262.100 through 262.110.
Modifier	Enter the applicable modifier from Section 262.110.
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.

Field Name and Number	Instructions for Completion
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 Column 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 beneficiary.
30. Balance Due	Enter the total amount due. **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.
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.

Field Name and Number	Instructions for Completion
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#."

262.400 Special Billing Procedures 11-1-06

Special billing procedures are not applicable to this program.