Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers – Portable X-Ray Services**

DATE: **November 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #59**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000 - 202.000	10-13-03	201.000 – 202.100	11-1-06
211.000 – 214.000	10-13-03	211.000 – 214.000	11-1-06
—	—	214.100 – 214.210	11-1-06
232.000	10-13-03	232.000	11-1-06
241.000 – 242.000	10-13-03	241.000 – 242.000	11-1-06
242.300	10-13-03	242.300 – 242.310	11-1-06

Explanation of Updates

Section 201.000 has been revised to include current requirements for provider participation in the Medicaid Program. Reference to the Arkansas Department of Health has been changed to the Division of Health.

Section 201.100 has been revised to include a change in format.

Section 201.200 has been revised to include new policy for participation of providers in states not bordering Arkansas.

Section 202.000 has been revised to include current documentation requirements for all Medicaid providers.

Section 202.100 is a new section added to include information on the records Portable X-Ray providers are required to keep.

Sections 211.000, 213.000 and 214.000 have been revised to delete the word recipient and replace it with the word beneficiary.

Section 214.100 – 214.210 are new sections added to include procedures for requesting extension of benefits for X-ray services.

Section 232.000 has been revised to change the name of the Department of Human Services to the Department of Health and Human Services.

Sections 241.000 and 242.000 have been revised to delete “formerly HCFA-1500” from reference to the CMS-1500 form.

Section 242.300 has been revised by correcting grammatical errors and rewording for clarity. In reference to CMS-1500 form, "formerly HCFA-1500" has been deleted. The CMS-1500 form and instructions have been moved to a new section, 242.310.

Section 242.310 is a new section that includes the CMS-1500 claim form and instructions, formerly included in section 242.300. Instructions have been revised with minor wording changes for clarification.

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

200.000 PORTABLE X-RAY SERVICES GENERAL INFORMATION 10-1-06

201.000 Arkansas Medicaid Participation Requirements for Portable X-Ray Providers 11-1-06

To participate in the Arkansas Medicaid Program, providers must adhere to all applicable professional standards of care and conduct. Providers of portable X-ray services are eligible for participation in the Arkansas Medicaid Program if the following criteria are met:

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 (DMS-652), a Medicaid contract (DMS-653) and a Request for Taxpayer Identification Number and Certification (W-9).**

B. The provider of portable X-ray services must be certified by the Division of Health as a Title XVIII (Medicare) participant. A copy of the current certification must accompany the provider application (form DMS-652) and Medicaid contract (form DMS-653).

1. Subsequent certifications must be forwarded to Provider Enrollment within 30 days of issue.

2. If the certification document is not received within this time period, the provider will have an additional, and final, 30 days to comply.

C. Enrollment as a Medicaid provider is conditioned upon 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.

201.100 Portable X-Ray Providers in Arkansas and Bordering States 11-1-06

A. Providers in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled in the Medicaid Program as routine services providers if they meet all Arkansas Medicaid participation requirements outlined above.

B. Reimbursement may be available for covered services in the Medicaid Program. Claims must be filed according to billing procedures included in this manual.

201.200 Providers of Portable X-Ray Services in States Not Bordering Arkansas 11-1-06

A. Providers in states not bordering Arkansas may enroll as closed-end providers. **View or print Provider Enrollment Unit contact information.**

A non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, **www.medicaid.state.ar.us/InternetSolution/Provider/Provider.aspx**, and then submit the application and claim for services provided to the Medicaid Provider Enrollment Unit.

B. Closed-end providers remain enrolled for one year.

1. If a closed-end provider submits another claim for an Arkansas Medicaid beneficiary during the provider's 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 the Medicaid fiscal agent.

3. Closed-end 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.

202.000 Documentation Required of All Medicaid Providers 11-1-06

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

202.100 Records Providers of Portable X-Ray Services Are Required to Keep 11-1-06

Providers of portable X-ray services are required to maintain the following records.

A. Provider certification by the Arkansas Division of Health as a Title XVIII (Medicare) participant.

B. A copy of the provider application and Medicaid contract to participate in the Arkansas Medicaid Program.

C. Written contracts between contract personnel and the provider.

D. Statistical, fiscal and other records necessary for reporting and accountability.

E. The original order signed by the patient's physician requesting portable X-ray services.

F. The diagnosis of the patient to verify the necessity for the service.

211.000 Introduction 11-1-06

Arkansas Medicaid assists Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual.

Reimbursement may be made for portable X-ray services within the Medicaid Program limitations.

213.000 Scope 11-1-06

Portable X-ray services may be covered for a Medicaid beneficiary upon the written order of the beneficiary's primary care physician (PCP). The claim for reimbursement must indicate the name of the physician who ordered the service before payment may be made.

Portable X-ray services may be provided to a beneficiary in his or her place of residence. In the Portable X-ray Program, the place of residence is defined by the Medicaid Program as the beneficiary's own dwelling, an apartment or relative's home, a boarding home, a residential care facility, a nursing facility or an intermediate care facility for the mentally retarded. Portable X-ray services are not covered in a hospital.

Portable X-ray services are limited to the following:

A. Skeletal films involving arms and legs, pelvis, vertebral column and skull;

B. Chest films that do not involve the use of contrast media and

C. Abdominal films that do not involve the use of contrast media.

214.000 Benefit Limits 11-1-06

Payments for portable X-ray services claims are applied to the laboratory and X-ray services benefit limit of $500.00 per state fiscal year. This yearly limit is based on the state fiscal year - July through June. Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

214.100 Extension of Benefits for X-Ray Services 11-1-06

A. Requests for extension of benefits for x-ray services must be mailed to Arkansas Foundation for Medical Care, Inc. (AFMC), Attention EOB Review. **View or print the Arkansas Foundation for Medical Care, Inc. contact information.**

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

B. A request for extension of benefits must be received by AFMC within 90 calendar days of the date of benefits-exhausted denial.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. *Do not* send a claim.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services" 11-1-06

A. Requests for extension of benefits for X-ray services must be submitted to AFMC for consideration. Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services (form DMS-671). **View or print form DMS-671.**

B. If the provider of service is a member of a provider group, the performing provider's number and the group provider number must be entered in the Medicaid provider ID number fields.

C. The provider's signature (with his or her credentials) and the date of the request are required on the form. Stamped or electronic signatures are accepted.

D. Claims for reimbursement must be filed in chronological order. Dates of service must be listed in chronological order on form DMS-671. When requesting benefit extension for more than four procedures, use a separate form for each set of four procedures.

E. Enter a valid type of service code using the applicable type of service code for paper claim(s). Some procedure codes require modifiers on paper claims.

F. Enter a valid diagnosis code and brief narrative description of the diagnosis.

G. Enter a valid procedure code and, if applicable, modifier(s) along with a brief narrative description of the procedure.

H. Enter the number of units requested under the extension.

214.120 Documentation Requirements for Extension of Benefits Request 11-1-06

A. To request extension of benefits for any benefit limited service, all applicable records that support the medical necessity of extended benefits are required.

B. Radiology reports *must* include:

1. Clinical indication for laboratory and x-ray services ordered
2. Signed orders for laboratory and radiology services
3. Results signed by the performing provider
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable

214.200 Administrative Reconsideration of Extensions 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 pursuant to section 212.130 of this manual.

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 within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

214.210 Appealing an Adverse Action 11-1-06

Please see section 190.000 *et al*. of this manual for information regarding administrative appeals.

232.000 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 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.

When the provider disagrees with the decision of the Assistant Director, Division of Medical Services, 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 of the 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.

241.000 Introduction to Billing 11-1-06

Portable X-ray providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper 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.

242.000 CMS-1500 Billing Procedures 11-1-06

242.300 Billing Instructions – Paper Only 11-1-06

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 portable X-ray services, use the CMS-1500 claim form. 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 must be typed. Submit paper claims to the EDS Claims Department. **View or print EDS Claims Department contact information.**

NOTE: A provider who renders services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

242.310 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.

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

Field Name and Number	Instructions for Completion
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.
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	Not applicable to portable X-ray.
19. Reserved for Local Use	Not applicable to portable X-ray claims.
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 or benefit extension control 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.

Field Name and Number		Instructions for Completion
B.	Place of Service	Enter the appropriate place of service code. See Section 242.200 for codes.
C.	Type of Service	Enter the appropriate type of service code. See Section 242.200 for codes.
D.	Procedures, Services or Supplies	
	CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 242.100 through 242.110.
	Modifier	Enter if applicable.
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 one diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F.	$ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G.	Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H.	EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
I.	EMG	Emergency - This field is not required for Medicaid.
J.	COB	Coordination of Benefit - This field is not required for Medicaid.
K.	Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25.	Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, 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.

Field Name and Number	Instructions for Completion
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 beneficiary. (See NOTE below Field 30.)
30. Balance Due	Enter the total amount due. **NOTE: For Fields 28, 29 and 30, up to 28 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
31. Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and zip code of the facility where services were performed.
33. Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
PIN #	This field is not required for Medicaid.
GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."