Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**

DATE: **July 1, 2007**

SUBJECT: **Provider Manual Update Transmittal # 90**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
242.100	10-1-06	242.100	7-1-07
242.140	10-1-06	242.140	7-1-07
242.200	10-13-03	242.200	7-1-07
242.300	10-13-03	242.300	7-1-07
242.310	10-13-03	242.310	7-1-07

Explanation of Updates

Effective for claims received on or after July 1, 2007, the following provider manual revisions will be implemented.

The Type of Service (TOS) field has been eliminated due to the implementation of the new CMS-1500 (08/05). This field is no longer required.

Section 242.100 is being included to remove references to the type of service codes and also to remove obsolete information from the section.

Section 242.140 has been included to remove information about the type of service code.

Section 242.200 has been included to revise the title of the heading, to add information about electronic and paper billing and to incorporate national place of services codes to paper claim filing. Section 242.300 has been included to update paper billing information.

Section 242.310 has been included to update billing instructions for the EPSDT (DMS-694) claim form.

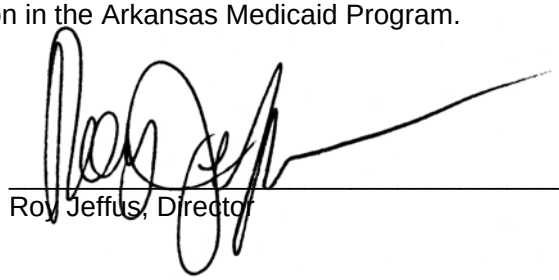
Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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.



Roy Jeffus, Director

SECTION II - CHILD HEALTH SERVICES (EPSDT)

CONTENTS

242.000 DMS-694 Billing Procedures

242.100 Procedure Codes 7-1-07

See section 212.000 for EPSDT screening terminology.

A primary care physician (PCP) may bill a sick visit and a Child Health Services (EPSDT) periodic screening for a patient on the same date of service if the screening is due to be performed.

Claims for EPSDT medical screenings must be billed electronically or using the DMS-694 EPSDT paper claim form. **View or print a DMS-694 sample claim form.**

Procedure Code	Modifier 1	Modifier 2	Description
99381-99385	EP	U1	EPSDT Periodic Complete Medical Screen (New Patient)
99391-99395	EP	U2	EPSDT Periodic Complete Medical Screen (Established Patient)
99431[1] 99432[1] 99435[1]	EP EP EP		Initial Newborn Care/EPSDT screen in hospital
99173[1]	EP		EPSDT Periodic Vision Screen
V5008[1]	EP		EPSDT Periodic Hearing Screen
DO120[1]			CHS/EPSDT Oral Examination
D0140[1]			EPSDT Interperiodic Dental Screen, with prior authorization
99401	EP		EPSDT Health Education - Preventive Medical Counseling
36415[2]			Collection of venous blood by venipuncture
83655			Lead

[1] Exempt from PCP referral requirements
[2] Covered when specimen is referred to an independent lab

Immunizations and laboratory tests may be billed separately from comprehensive screens.

The verbal assessment of lead toxicity risk is part of the complete CHS/EPSDT screen. The cost for the administration of the risk assessment is included in the fee for the complete screen.

Laboratory/X-ray and immunizations associated with an EPSDT screen may be billed on the DMS-694 EPSDT claim form.

Electronic and paper claims require use of the above modifiers. When filing paper claims for an EPSDT screening service, the applicable modifier must be entered on the claim form.

242.140 Vaccines for Children Program 7-1-07

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. To enroll in the VFC Program, contact the Arkansas Division of Health. Providers may also obtain the vaccines to administer from the Arkansas Division of Health. **View or print Arkansas Division of Health contact information.**

Vaccines available through the VFC program are covered for Medicaid-eligible children. Only the administrative fee is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ**. When filing **paper claims**, the modifiers **EP** and **TJ** must be entered on form DMS-694. **View or print a DMS-694 sample claim form.**

Medicaid policy regarding immunizations for adults remains unchanged by the VFC program.

Providers may consult the Physician's manual to view the list of vaccines that are non-VFC but are covered for beneficiaries who are 19 and 20 years of age. The following list contains the vaccines available through the VFC program.

* Effective for dates of service on and after March 1, 2006

** Effective for dates of service on and after July 10, 2006

Procedure Code	M1	M2	Age Range	Vaccine Description
90633*	EP	TJ	12 months-18 years	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90634*	EP	TJ	12 months-18 years	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use
90636	EP	TJ	18 years only	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645	EP	TJ	0-18 years	Hemophilus influenza b (Hib) HbOC conjugate (4 dose schedule) for intramuscular use
90646	EP	TJ	0-18 years	Hemophilus influenza b (Hib) PRP-D conjugate for booster use only, intramuscular use
90647	EP	TJ	0-18 years	Hemophilus influenza b (Hib) PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648	EP	TJ	0-18 years	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90655	EP	TJ	6 months-35 months	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90656	EP	TJ	3 years-18 years	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90657	EP	TJ	6 months-35 moths	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
90658	EP	TJ	3 years-18 years	Influenza virus vaccine, split virus, for use in individuals 3 years and above, for intramuscular use
90660	EP	TJ	5 years-18 years (not pregnant)	Influenza virus vaccine, live, for intranasal use
90669	EP	TJ	0-4 years	Pneumococcal conjugate vaccine polyvalent, for children under 5 years, for intramuscular use

Procedure Code	M1	M2	Age Range	Vaccine Description
90680**	EP	TJ	6 weeks to 32 weeks	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use
90700	EP	TJ	0-6 years	Diphtheria, tetanus toxoids and acellular pertussis vaccine (DTaP), for use in individuals younger than 7 years, for intramuscular use
90707	EP	TJ	0-18 years	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90710*	EP	TJ	0-18 years	Measles, mumps, rubella, and Varicella vaccine (MMRV), live, for subcutaneous use
90713	EP	TJ	0-18 years	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use
90714	EP	TJ	7-18 years	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals 7 years or older, for intramuscular use
90715*	EP	TJ	7-18 years	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use
90716	EP	TJ	0-18 years	Varicella virus vaccine, live, for subcutaneous use
90718	EP	TJ	7-18 years	Tetanus and diphtheria toxoids (Td) absorbed for use in individuals 7 years or older, for intramuscular use
90721	EP	TJ	0-18 years	Diphtheria, tetanus toxoids and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use
90723	EP	TJ	0-18 years	Diphtheria, tetanus toxoids and acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine , inactivated (DTaP-HepB-IPV)(for intramuscular use
90734*	EP	TJ	0-18 years	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90743	EP	TJ	0-18 years	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744	EP	TJ	0-18 years	Hepatitis B vaccine, pediatric/adolescent (3 dose schedule), for intramuscular use
90747	EP	TJ	0-18 years	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
90748	EP	TJ	0-18 years	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use

242.200 National Place of Service (POS) Codes 7-1-07

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Doctor's Office	11
Patient's Home	12
Other Locations	99

242.300 Billing Instructions—Paper Only 7-1-07

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

To bill for a Child Health Services (EPSDT) screening service, use the claim form DMS-694. The numbered items correspond to numbered fields on the claim form. **View or print a sample DMS-694 form.**

The DMS-694 is used as a combined referral, screening results document and a billing form. Each screening should be billed separately, providing the appropriate information for each of the screening components.

With the exception of codes **99201-99215** (office medical services), **99341-99353** (home medical services) and **99221-99223**, **99431**, **99231-99233** and **99238** (hospital inpatient medical services), specific procedures may be used at the provider's discretion as long as the federally mandated components (refer to Section 215.000) have been included in the screening package.

Medical services such as immunizations and laboratory procedures may also be billed on the DMS-694 when provided in conjunction with a Child Health Services (EPSDT) screening, as well as other treatment services provided.

Claims for Child Health Services (EPSDT) dental services are to be billed on the ADA claim form or the DMS-694. For dental screening to be paid, the ADA claim form must be completed and the box marked "child" in Field 2 must be checked.

Claims for Child Health Services (EPSDT) visual services are to be billed on the DMS-26-V claim form, Field 9, or on the DMS-694. If services were provided as a result of an EPSDT screen referral, check the "Yes" box on the DMS-26-V claim form. **View or print a DMS-26-V sample form.**

Carefully follow these instructions to help EDS efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if applicable information is omitted. Claims should be typed whenever possible.

Forward completed claim forms to the EDS Claims Department. **View or print the EDS Claims Department contact information.**

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

242.310 Completion of the EPSDT (DMS-694) Claim Form 7-1-07

Field Name and Number	Instructions for Completion
1. Patient's Last Name	Enter the patient's last name.
2. Patient's First Name	Enter patient's first name.

Field Name and Number	Instructions for Completion
3. Patient's Middle Initial	Enter patient's middle initial.
4. Patient's Sex	Check "M" for male or "F" for female.
5. Patient's Medicaid ID No.	Enter the entire 10-digit patient Medicaid identification number.
6. Casehead's Name	Enter the casehead name for TEA children only. Patient's name has been requested in Blocks 1, 2 and 3.
7. County of Residence	Enter the patient's county of residence.
8. Date of Birth	Enter the patient's date of birth in month and year format as it appears on the Medicaid identification card.
9. Street Address	Enter the patient's street address.
10. City	Enter the patient's city of residence.
11. If a Patient is a Referral Enter Name of Referring Physician Provider Number	If the patient is a referral, enter the name of the referring physician and 9-digit Medicaid provider number, if available.
12. Medical Record Number	This is an optional entry that the provider may use for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alpha characters will be accepted. This number will appear on the Remittance Advice (RA) and is a method of identifying payment of the claim.
13. Provider Phone Number Pay To: Provider Name and Address Pay To: Provider Number	Enter the provider's complete name, address and 9-digit Arkansas Medicaid provider number. If a clinic billing is involved, use the 9-digit clinic provider number. Telephone number is requested but not required.
14. Other Health Insurance Coverage (Enter Name of Plan and Policy Number)	If applicable, enter the name of the insurance plan and the policy number of any health insurance coverage carried by the patient other than Medicaid. The patient's Medicaid identification card should indicate "Yes" if other coverage is carried by the beneficiary.
15. Was Condition Related to:	
A. Patient's Employment	Check "Yes" if the patient's condition was employment related. If the condition was not employment related, check "No."
B. An Accident	Check "Yes" if the patient's condition was related to an accident. Check "No" if the condition was not accident related.
16. Primary Diagnosis or Nature of Injury	Enter the description of the primary reason for treatment of the patient.
Diagnosis Code	Enter the ICD-9-CM Code that identifies the primary diagnosis.

Field Name and Number	Instructions for Completion
18. Type of Screen Periodic Interperiodic	Not required for Medicaid. Completed by Human Services, if applicable.
SECTION II	
20. Examination Report	To be completed by screening provider at time of screen.
A. Basic Screening	
Item A, Numbers 1 through 6	Check “Normal” or “Abnormal” for each component. Check “Counseled,” “Treated” or “Referred” as applicable.
Item A, Number 7	Give results of the lab tests performed at the time of screen.
Item B	Immunization status appropriate for age and health history. If immunization cannot be performed, note the reason along with the return appointment in “Comments” section.
Item C	Enter any other services rendered.
21. Comments	Briefly explain any problems identified and describe treatment or referral. If referred, indicate the name of the provider to whom the referral was made.
22. A. Date of Service	Enter the “from” and “to” dates of service for each service provided in MM/DD/YY format. A single date of service need not be entered twice on the same line.
B. Place of Service	Enter the appropriate place of service code. See Section 242.200 for codes.
C. Fully Describe Procedures, Medical Services or Supplies Furnished For Each Date Given *(Explain Unusual Services or Circumstances)* Procedure Code (Identify)	Enter the appropriate HCPCS, CPT and state assigned procedure code and describe any services or circumstances, e.g., what age periodicity screen has been provided and describe procedures performed (including screen, lab test, immunizations, etc.).
D. Diagnosis Code	Enter the ICD-9-CM code, which corresponds with the procedures performed.
E. Charges	Enter the charges for the rendered services. These charges should be the provider’s current usual and customary fee to private clients.
F. Days or Units	Enter days or units of service rendered.
G. Performing Provider Number	If the billing provider noted in Block 13 is a clinic or group, enter the attending provider’s 9-digit Arkansas Medicaid provider number.
23. Total Charges	Enter the total of Column 22E. This block should contain a sum of charges for all services indicated on the claim form.

Field Name and Number	Instructions for Completion
24. Covered by Insurance	Enter the total amount of funds received from other sources. The source of payment should be indicated in Block 14. If payment was received from the patient, indicate in Block 14, but DO NOT include the amount in Block 24.
25. Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge.
26. Provider's Signature	The provider or designated authorized individual must sign 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, 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.
27. Billing Date	Enter date signed.