ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Rehabilitative Services for Persons with Mental Illness (RSPMI)**

DATE: **November 1, 2008**

SUBJECT: **Provider Manual Update Transmittal #99**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
202.000	6-1-05	202.000	11-1-08
202.100	10-13-03	202.100	11-1-08
—	—	202.200	11-1-08
219.141	8-1-05	219.141	11-1-08
226.200	8-1-05	226.200	11-1-08
252.110	5-1-08	252.110	11-1-08
252.200	7-1-07	252.200	11-1-08
252.310	7-1-07	252.310	11-1-08

Explanation of Updates

Effective 11-1-08, RSPMI providers will be required to enroll all certified sites. Medicaid will begin requiring the use of the individual site provider numbers for billing of services originating from each site. Claims received January 1, 2009 or later that do not contain this information will be rejected.

Prior authorizations requested and issued on or after 11-1-08 must be requested under the Medicaid Provider ID number of the site at which services for the beneficiary originates; however, any resulting prior authorization number issued may be utilized with any site numbers held by the provider for claims purposes. Existing prior authorizations will be billed the same as new numbers.

Section 202.000 is included to advise providers with multiple sites that each site must enroll with Arkansas Medicaid.

Section 202.100 is included to delete the specifics of provider certification by the Division of Behavioral Services (DBHS) and refer providers to the DBHS web site for instructions.

Section 202.200 is a new section created to provide information on the process for enrolling multiple sites of one parent organization.

Section 219.141 is included to clarify that this set of services is available to residents of ICF/MR as well as nursing home residents.

Section 226.200 is included to clarify type of information required to distinguish the setting in which services were provided.

Section 252.110 is included to add information previously included in Official Notice DMS-2003-YY-6, reinstating the procedure for medication administration by a licensed nurse.

Section 252.200 is included to expand the list of national place of service codes.

Section 252.310 is included to update instructions for completion of Fields 21 and 32b. of the CMS-1500 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

TOC required

202.000 Arkansas Medicaid Participation Requirements for RSPMI 11-1-08

In order to ensure quality and continuity of care, all mental health providers approved to receive Medicaid reimbursement for services to Medicaid recipients must meet specific qualifications for their services and staff. Providers with multiple service sites must enroll and bill for each site separately.

To enroll as an RSPMI Medicaid provider, the following must occur:

A. Providers must be located within the State of Arkansas.

B. A 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) with the Arkansas Medicaid Program. **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. A provider must be certified by the Division of Behavioral Health Services (DBHS). (See section 202.100 for certification requirements.)

D. A copy of the current DBHS certification as an RSPMI provider must accompany the provider application and Medicaid contract. Subsequent certifications must be provided when issued.

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

DMS shall exclude providers for the reasons stated in 42 U.S.C. §1320a-7(a) and implementing regulations and may exclude providers for the reasons stated in 42 U.S.C. §1320a-7(b) and implementing regulations. The following factors shall be considered by DHS in determining whether sanction(s) should be imposed:

A. Seriousness of the offense(s)

B. Extent of violation(s)

C. History of prior violation(s)

D. Whether an indictment or information was filed against the provider or a related party as defined in DHS Policy 1088, titled DHS Participant Exclusion Rule.

202.100 Certification Requirements by the Division of Behavioral Health Services (DBHS) 11-1-08

Providers of RSPMI Services must furnish documentation of certification from the Division of Behavioral Health Services (DBHS) establishing that the provider is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other national accreditation approved by DBHS and that the accreditation encompasses the RSPMI services to be furnished. Providers must meet all other certification requirements in addition to accreditation.

Certification requirements may be found at **www.arkansas.gov/dhs/dmhs/**.

202.200 Providers with Multiple Sites 11-1-08

Providers with multiple service sites must apply for enrollment for each site. A cover letter must accompany the provider application for enrollment of each site that attests to their satellite status and the name, address and Arkansas Medicaid number of the parent organization.

A letter of attestation must be submitted to the Medicaid Enrollment Unit by the parent organization annually that lists the name, address and Arkansas Medicaid number of each site affiliated with the parent. The attestation letter must be received by Arkansas Medicaid no later than June 15 of each year beginning in June 2009.

Failure by the parent organization to submit a letter of attestation by June 15 each year may result in the loss of Medicaid enrollment. The Enrollment Unit will verify the receipt of all required letters of attestation by July 1 of each year. A notice will be sent to any parent organization if a letter is not received advising of the impending loss of Medicaid enrollment.

219.141 Services Available to Residents of Long Term Care Facilities 11-1-08

The following RSPMI services may be provided to residents of nursing homes and ICF/MR facilities who are Medicaid eligible when the services are prescribed according to policy guidelines detailed in this manual:

A. Diagnosis,

B. Diagnosis – Psychological Test/Evaluation,

C. Diagnosis – Psychological Testing Battery,

D. Treatment Plan,

E. Interpretation of Diagnosis,

F. Individual Outpatient –Therapy Session,

G. Crisis Intervention,

H. Medication Maintenance by a Physician (limited to the administration of psychotropic drugs) and

I. Periodic Review of Treatment Plan/Plan of Care.

Services provided to nursing home and ICF/MR residents may be provided on- or off-site from the RSPMI provider. The services may be provided in the long-term care (LTC) facility, if necessary.

226.200 Documentation 11-1-08

The RSPMI provider must develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity or session for which Medicaid reimbursement is sought. This documentation, at a minimum, must consist of:

A. The specific services provided,

B. The date and actual time the services were provided (Time frames may not overlap between services. All services must be outside the time frame of other services.),

C. Name and title of the person who provided the services,

D. The setting in which the services were provided. For all settings other than the provider's enrolled sites, the name and physical address of the place of service must be included,

E. The relationship of the services to the treatment regimen described in the plan of care and

F. Updates describing the patient's progress.

Documentation must be legible and concise. The name and title of the person providing the service must reflect the appropriate professional level in accordance with the staffing requirements found in section 213.000.

For Therapeutic Day/Acute Day and Rehabilitative Day Services, progress notes must be entered daily. Daily notes may be brief; however, they must meet requirement of item F above. Providers may enter weekly progress notes that summarize the recipient's progress in relationship to the plan of care.

All documentation must be available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. No more than thirty (30) days will be allowed after the date on the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30-day period.

252.110 Non-Restricted Outpatient Procedure Codes 11-1-08

National Code	Required Modifier	Local Code	Definition	Max Units Per Day for Services Not Requiring PA
92506	HA	—	*Diagnosis: Speech Evaluation* 1 unit = 30 minutes Maximum units per state fiscal year (SFY) = 4 units	4

National Code	Required Modifier	Local Code	Definition	Max Units Per Day for Services Not Requiring PA
90801	HA, UI	Z0560	*Diagnosis* The purpose of this service is to determine the existence, type, nature and most appropriate treatment of a mental illness or related disorder as described in DSM-IV. This psychodiagnostic process must be provided by a Mental Health professional and must be supervised by a physician, as indicated by the physician's dated, signed approval of the related treatment plan. It may include, but is not limited to, a psychosocial and medical history, a mental status examination, diagnostic findings and initial treatment plan. This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes and formulating the initial treatment plan. Note: Telemedicine POS 99	8
90801	—	Z0560	*Diagnosis:* Use the above description Additional requirement: 90801 with no modifier is for service provided via telemedicine only.	8
96101	HA, UA	Z0561	*Diagnosis - Psychological Test / Evaluation* This service allows for the administration of a single diagnostic test to a client by a Psychologist or Psychological Examiner. This procedure should reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the client as prescribed by the purpose of the evaluation.	8
96101	HA, UA, UB	Z0562	*Diagnosis - Psychological Testing Battery* This service allows for the administration of two (2) or more diagnostic tests to a client by a Psychologist or Psychological Examiner. This battery should assess the mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics of the client.	8

National Code	Required Modifier	Local Code	Definition	Max Units Per Day for Services Not Requiring PA
90885	HA, U2	Z0563	*Treatment* Plan The plan of treatment for Medicaid beneficiaries who are not SMI or SED is to be developed by a Mental Health Professional at the direction of the responsible physician in accordance with DBHS program standards and Section 224.000 of this manual. It must include short- and long-term goals for treatment of the beneficiary's mental health needs and must be reviewed every ninety (90) days.	2 May be billed 1 time upon entering care
90885	HA	Z1578	*Periodic Review of Treatment Plan* The periodic review and revision of the treatment plan by a mental health professional to determine the beneficiary's progress toward the treatment plan objectives, efficacy of the services provided and need for the enrolled beneficiary's continued participation in the RSPMI program. This service must be completed every 90 days at a minimum. If performed more frequently, there must be documentation of significant acuity or change in clinical status (e.g., onset of psychotic symptoms or suicidal feelings) requiring an update in the beneficiary's treatment plan.	2
90885	HA, U1	Z1578	*Periodic Review of Treatment Plan* Apply the above description. Additional information: 90885 plus modifier "U1" is for this service when provided by a non-physician.	2
90887	HA, U2	Z0564	*Interpretation of Diagnosis* This is a direct service provided by a Mental Health Professional for interpreting the results of diagnostic activities to the beneficiary and/or significant others. If significant others are involved, appropriate consent forms may need to be obtained. Note: Telemedicine POS 99	4

National Code	Required Modifier	Local Code	Definition	Max Units Per Day for Services Not Requiring PA
90887	U3	Z0564	*Interpretation of Diagnosis* Use above description Additional information: 90887 plus modifier "U3" is for service provided via telemedicine only. Note: Telemedicine POS 99	4
H0004	HA	Z0568	*Individual Outpatient – Therapy Session* Scheduled individual outpatient therapy provided by a Mental Health Professional to a beneficiary for the purposes of treatment and remediation of a condition described in DSM-IV and subsequent revisions. Individual therapy services will not be authorized for beneficiaries under the age of three except in documented exceptional cases.	4
H0004	—	Z0568	*Individual Outpatient – Therapy Session* Use above description. Additional information: H0004 with no modifier is for ages 21 and over.	4
H0004	—	Z0568	*Individual Outpatient –Therapy Session* Use above description. Additional information: H0004 with no modifier is for services provided via telemedicine only.	4
90846	HA, U3	Z0571	*Marital/Family Therapy – Beneficiary is not present* Marital/Family Therapy shall be treatment provided by a mental health professional to member(s) of a family in the same session. The purpose of this service is to treat the symptoms of the mental illness or emotional disturbance of the identified beneficiary by improving the functional capacity of the beneficiary within marital/family relationships. Documentation to support the appropriateness of excluding the identified beneficiary must be maintained in the beneficiary's record.	6

National Code	Required Modifier	Local Code	Definition	Max Units Per Day for Services Not Requiring PA
90846	—	Z0571	*Marital/Family Therapy – Beneficiary is not present* Use the above description. Additional information: 90846 with no modifier is for ages 21 and over.	6
90846	U5	Z0571	*Marital/Family Therapy – Beneficiary is not present* Use the above description. Additional information: 90846 with the modifier “U5” is for a service provided via telemedicine only.	6
90847	HA, U3	Z0571	*Marital/Family Therapy – Beneficiary is present* Marital/Family Therapy shall be treatment provided by a mental health professional to more than one member of a family in the same session. The purpose of this service is to treat the symptoms of the mental illness or emotional disturbance of the identified beneficiary by improving the functional capacity of the beneficiary within marital/family relationships. Additional information: 90847 plus modifiers “HA U3” is for under age 21.	6
90847	—	Z0571	*Marital/Family Therapy – Beneficiary is present* Use the above description. Additional information: 90847 with no modifier is for ages 21 and over.	6
90847	U5	Z0571	*Marital/Family Therapy – Beneficiary is present* Use the above description. Additional information: 90847 with the modifier “U5” is for a service provided via telemedicine only.	6

National Code	Required Modifier	Local Code	Definition	Max Units Per Day for Services Not Requiring PA
92507	HA	Z1926	*Individual Outpatient – Speech Therapy, Speech Language Pathologist* Scheduled individual outpatient care provided by a licensed speech pathologist supervised by a physician to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.	4
92507	HA, UB	Z2265	*Individual Outpatient – Speech Therapy, Speech Language Pathologist Assistant* Scheduled individual outpatient care provided by a licensed speech pathologist assistant supervised by a qualified speech language pathologist to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.	4
92508	HA	Z1927	*Group Outpatient – Speech Therapy, Speech Language Pathologist* Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.	4
92508	HA, UB	Z2266	*Group Outpatient – Speech Therapy, Speech Language Pathologist Assistant* Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist assistant for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.	4

National Code	Required Modifier	Local Code	Definition	Max Units Per Day for Services Not Requiring PA
90853	HA, U1	Z0574	*Group Outpatient – Group Therapy* A direct service contact between a group of beneficiaries and one or more Mental Health Professionals for the purposes of treatment and remediation of a psychiatric condition. This procedure does not include *psychosocial* group activities.	6
90853	—	Z0574	*Group Outpatient – Group Therapy* Apply the above description. Additional information: 90853 with no modifier is for ages 21 and over.	6
H2012	HA	Z0577	*Therapeutic Day/Acute Day Treatment* – 8 units minimum See Section 219.110 for service description.	32
H2012	UA	Z0577	*Therapeutic Day/Acute Day Treatment* – 8 units minimum H2012 with modifier “22” is for ages 21 and over. See Section 219.110 for service description.	32
H2011	HA, U7	Z1536	*Crisis Intervention* The purposes of this service are to prevent an inappropriate or premature more restrictive placement and/or to maintain the eligible beneficiary in an appropriate outpatient modality. This procedure is an unscheduled direct service contact occurring either on- or off-site between an eligible beneficiary with a diagnosable psychiatric disorder and a mental health professional.	8
H2011	U4	Z1536	*Crisis Intervention* Apply the above description. Additional information: H2011 plus modifier “U4” is for service provided via telemedicine only.	8

National Code	Required Modifier	Local Code	Definition	Max Units Per Day for Services Not Requiring PA
99201 99202 99203 99204 99212 99213 99214 99215	HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB	Z1544	*Physical Examination – Psychiatrist or Physician* A direct service contact provided to an enrolled RSPMI beneficiary by a psychiatrist or a physician to review a beneficiary's medical history and to examine the beneficiary's organ and body systems functioning for the purpose of determining the status of the beneficiary's physical health. This procedure may occur either on- or off-site and may be billed only by the RSPMI provider. The physician may not bill for an office visit, nursing home visit or any other outpatient medical services procedure for the same date of service.	3
90862	HA	Z1545	*Medication Maintenance by a Physician* Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy.	2
90862	HA, HQ	Z0575	*Group Outpatient - Medication Maintenance by a physician* Group outpatient care by a licensed physician involving evaluation and maintenance of the Medicaid-eligible beneficiary on a medication regimen with simultaneous supportive psychotherapy in a group setting.	6
90862	—	Z1545	*Medication Maintenance by a Physician* Apply description above. Additional information: 90862 with no modifier is for ages 21 and over.	2
90862	—	Z1545	*Medication Maintenance by a Physician* Apply description above. Additional information: 90862 with no modifier is for services provided via telemedicine only.	2
90862	HA, UB	—	*Pharmacologic Management* Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner	2

National Code	Required Modifier	Local Code	Definition	Max Units Per Day for Services Not Requiring PA
T1502	_	_	*Medication Administration by a Licensed Nurse* Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit.	1
36415	HA	Z1913	*Routine Venipuncture for Collection of Specimen* Inserting a needle into a vein to draw the specimen with a syringe or vacutainer.	Per routine
90887	HA	Z1547	*Collateral Intervention, Mental Health Professional* An on-site or off-site, face-to-face service contact by a mental health professional with caregivers, family members, gatekeepers, or other parties on behalf of an identified beneficiary to obtain or share relevant information necessary to the enrolled beneficiary's assessment, treatment plan and/or rehabilitation. Contact between individuals in the employ of RSPMI facilities is not a billable collateral intervention.	4
90887	U1	Z1547	*Collateral Intervention, Mental Health Professional* Apply the above description. Additional information: 90887 plus modifier "U1" is for service provided via telemedicine only.	4
90887	HA, UB	Z1548	*Collateral Intervention, Mental Health Paraprofessional* An on-site or off-site, face-to-face service contact by a mental health paraprofessional with caregivers, family members, gatekeepers, or other parties on behalf of an identified beneficiary to obtain or share relevant information necessary to the enrolled beneficiary's assessment, treatment plan and/or rehabilitation. Contact between individuals in the employ of RSPMI facilities is not a billable collateral intervention.	4

252.200 Place of Service Codes 11-1-08

Electronic and paper claims now require the same national place of service codes.

Place of Service	POS Codes
Outpatient Hospital	22
Office	11
Patient's Home	12
Nursing Facility	32
Skilled Nursing Facility	31
School	03
Homeless Shelter	04
Assisted Living Facility	13
Group Home	14
ICF/MR	54
Other Locations	99
RSPMI Clinic (Telemedicine)	99
Emergency Services in ER	23

252.310 Completion of the CMS-1500 Claim Form 11-1-08

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).

Field Name and Number			Instructions for Completion
	CITY		Name of the city in which the beneficiary or participant resides.
	STATE		Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE		Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)		The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone
6.	PATIENT RELATIONSHIP TO INSURED		If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)		Required if insured's address is different from the patient's address.
	CITY		
	STATE		
	ZIP CODE		
	TELEPHONE (Include Area Code)		
8.	PATIENT STATUS		Not required.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)		If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b.	OTHER INSURED'S DATE OF BIRTH	Not required.
		SEX	Not required.
	c.	EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a-d are required. Name of the insured individual's employer and/or school.
	d.	INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:		
	a.	EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b.	AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
		PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.

Field Name and Number	Instructions for Completion
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
10d. RESERVED FOR LOCAL USE	Not used.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. EMPLOYER'S NAME OR SCHOOL NAME	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9a through 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for RSPMI services for individuals under age 21. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.

Field Name and Number	Instructions for Completion
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. RESERVED FOR LOCAL USE	Not applicable to RSPMI.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis code for the primary medical condition for which services are being billed. Up to three additional diagnosis codes can be listed in this field for information or documentation purposes. Use the International Classification of Diseases, Ninth Revision Clinical Modification (ICD-9-CM) diagnosis coding, current as of the date of service.
22. MEDICAID RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Reserved for future use.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 252.200 for codes.
C. EMG	Not required.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure codes from Sections 252.100 through 252.150.
MODIFIER	Use applicable modifier.

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter in each detail the single number—1, 2, 3, or 4—that corresponds to a diagnosis code in Item 21 (numbered 1, 2, 3, or 4) and that supports most definitively the medical necessity of the service(s) identified and charged in that detail. Enter only one number in E of each detail. Each DIAGNOSIS POINTER number must be only a 1, 2, 3, or 4, and it must be the only character in that field.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail. .
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
	NPI	Not required.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30.	BALANCE DUE	From the total charge, subtract amounts received from other sources and enter the result.

Field Name and Number	Instructions for Completion
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. SERVICE FACILITY LOCATION INFORMATION	Enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. Service Site Medicaid ID number	Enter the 9-digit Arkansas Medicaid provider ID number of the service site.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.