ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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TO: **Arkansas Medicaid Health Care Providers – Targeted Case Management**

DATE: **October 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #105**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
262.310	6-1-08	262.310	10-1-09

Explanation of Updates

Section 262.310 has been included to add information to the instructions for the CMS-1500 form. Providers are advised to add the Local Education Agency (LEA) code that identifies the school district in which services are provided.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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 not required

262.310 Completion of CMS-1500 Claim Form 10-1-09

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).
	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.

Field Name and Number		Instructions for Completion
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.
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.

Field Name and Number	Instructions for Completion
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 not required for targeted case management services. 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.
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	Local Education Agency (LEA) code that identifies the school district in which services are provided.
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 (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.

Field Name and Number			Instructions for Completion
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 262.200 for codes.
	C.	EMG	Not required.
	D.	PROCEDURES, SERVICES, OR SUPPLIES	
		CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Section 262.100.
		MODIFIER	Modifier(s) if applicable.
	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.

Field Name and Number	Instructions for Completion
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 co-payments.
30. BALANCE DUE	From the total charge, subtract amounts received from other sources and enter the result.
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	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
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.