TO: **Arkansas Medicaid Health Care Providers – Section I**

EFFECTIVE DATE: **April 1, 2018**

SUBJECT: **Provider Manual Update Transmittal SecI-4-17**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
172.100	1-1-16	172.100	4-1-18

Explanation of Updates

Effective 1/1/2018 Section 172.100 has been updated to indicate that Chiropractic Services no longer require a Primary Care Physician Referral.

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

_____

Rose M. Naff
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – Chiropractic**

EFFECTIVE DATE: **April 1, 2018**

SUBJECT: **Provider Manual Update Transmittal CHIRO-1-17**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
211.000	11-1-06	211.000	4-1-18
242.310	9-1-14	242.310	4-1-18

Explanation of Updates

Effective for dates of service on or after 1/1/2018 Section 211.000 has been updated to not require a PCP referral for Chiropractic services.

Section 242.310 has been updated so instructions for Completion of CMS-1500 Claim Form no longer require a PCP referral for Chiropractic services.

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

Rose M. Naff
Director

TOC not required

211.000 Introduction 4-1-18

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

Chiropractic services are covered by Medicaid **only** to correct a subluxation of the spine (by manual manipulation). Chiropractic services do not require a referral from the Medicaid beneficiary's primary care physician (PCP). Chiropractic services are covered by Medicaid for beneficiaries of all ages.

242.310 Completion of the CMS-1500 Claim Form 4-1-18

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	

Field Name and Number		Instructions for Completion
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
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. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	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.
	d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
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. OTHER CLAIM ID NUMBER	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 9, 9a and 9d. Only one box can be marked.

Field Name and Number	Instructions for Completion
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
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. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Not required.
17a. (blank)	Not required.
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. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.

Field Name and Number	Instructions for Completion
20. OUTSIDE LAB?	Not required
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
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 242.200 for codes.
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) if applicable.

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
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 #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
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.	RESERVED	Reserved for NUCC use.

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	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)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

b. Optometrists' Services (Continued)

(2) One eye exam every twelve (12) months for eligible recipient under 21 years of age in the Child Health Services (EPSDT) Program. Extensions of the benefit limit will be provided if medically necessary for recipients in the Child Health Services (EPSDT) Program.

(3) Office medical services provided by an optometrist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and over. The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, certified nurse midwife services and advanced practice nurse or registered nurse practitioner or a combination of the six. For services beyond the twelve (12) visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

c. Chiropractors' Services

(1) Services are limited to licensed chiropractors meeting minimum standards promulgated by the Secretary of HHS under Title XVIII.

(2) Services are limited to treatment by means of manual manipulation of the spine which the chiropractor is legally authorized by the State to perform.

(3) Effective for dates of service on or after July 1, 1996, chiropractic services will be limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for eligible Medicaid recipients age 21 and older. Services provided to recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

(4) Effective for dates of service on or after January 1, 2018, chiropractic services do not require a referral by the beneficiary's primary care physician (PCP).

d. Advanced Nurse Practitioners and Registered Nurse Practitioners

Office medical services provided by an advanced nurse practitioner and registered nurse practitioner are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and over. The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, certified nurse midwife services and advanced practice nurse or registered nurse practitioner or a combination of the six. For services beyond the twelve (12) visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

b. Optometrists' Services (Continued)

(2) One eye exam every twelve (12) months for eligible recipients under 21 years of age in the Child Health Services (EPSDT) Program. Extensions of the benefit limit will be provided if medically necessary for recipients in the Child Health Services (EPSDT) Program.

(3) Office medical services provided by an optometrist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and over. The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, certified nurse midwife and services provided by an advanced practice nurse or registered nurse practitioner or a combination of the six. For services beyond the twelve (12) visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

c. Chiropractors' Services

(1) Services are limited to licensed chiropractors meeting minimum standards promulgated by the Secretary of HHS under Title XVIII.

(2) Services are limited to treatment by means of manual manipulation of the spine which the chiropractor is legally authorized by the State to perform.

(3) Effective for dates of service on or after July 1, 1996, chiropractic services will be limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for eligible Medicaid recipients age 21 and older. Services provided to recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

(4) Effective for dates of service on or after January 1, 2018, chiropractic services do not require a referral by the beneficiary's primary care physician (PCP).

d. Advanced Nurse Practitioners and Registered Nurse Practitioners

Office medical services provided by an advanced nurse practitioner and registered nurse practitioner are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and over. The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, certified nurse midwife services and advanced practice nurse or registered nurse practitioner or a combination of the six. For services beyond the twelve (12) visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.