Arkansas Department of Health and Human Services

Division of Medical Services

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

DATE: **July 1, 2007**

SUBJECT: **Provider Manual Update Transmittal # 101**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
261.000	4-1-05	261.000	7-1-07
262.300	6-1-06	262.300	7-1-07
262.400	5-1-06	262.400	7-1-07
263.100	4-1-05	263.100	7-1-07
263.200	4-3-06	263.200	7-1-07
263.210	6-1-06	—	—
263.220	4-3-06	—	—
263.300	4-1-05	263.300	7-1-07
—	—	263.310	7-1-07
263.400	4-1-05	263.400	7-1-07
263.410	4-1-05	263.410	7-1-07
263.420	4-1-05	263.420	7-1-07
263.421	10-13-03	263.421	7-1-07
263.422	4-1-05	263.422	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 field has been eliminated due to the implementation of the new CMS-1500 (08/05). This field is no longer required.

Section 261.000 has been included to change text content. The change does not affect policy.

Section 262.300 has been included to change the heading title and to advise that the national place of service codes will be used for both electronic and paper billing. The local codes that were used for paper billing have been removed from the section.

Section 262.400 has been included to revise the billing instructions for the American Dental Association (ADA) claim form.

Section 263.100 has been included to remove information about type of service codes. Text within the section has been revised and transferred from below the chart to the top of the section for clarification of information.

Section 263.200 has been included to revise the heading title. The chart originally found in section 263.210 has been revised to remove local place of service codes and has been transferred to this section. Information has been added to advise that the national place of service codes will be used for both electronic and paper billing.

Section 263.210 has been deleted and the chart originally located in the section has been transferred to section 263.200.

Section 263.220 has been deleted because it contained information only about type of service codes.

Section 263.300 has been included to add instructions for paper billing for the CMS-1500 (08/05) claim form. The CMS-1500 claim form billing instructions chart has been transferred to section 263.310.

Section 263.310 has been created to add the CMS-1500 (08/05) claim form billing instructions chart. The instructions chart was previously located in section 263.300.

Section 263.400 has been included to remove references to type of service codes, and to make minor text changes that do not affect policy the section.

Section 263.410 has been included to make minor text changes that do not affect policy in the section.

Section 263.420 has been included to remove references to type of service codes, to update information for oral surgeons and to remove obsolete information from the section.

Section 263.421 has been included to remove references to type of service codes and to advise that oral surgeons must use the procedure codes found in the section when billing on paper.

Section 263.422 has been included to remove obsolete information. The section header is being reserved for future changes.

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

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260.000 BILLING PROCEDURES

261.000 Introduction to Billing 7-1-07

Dental providers must use the American Dental Association (ADA) form to bill the Arkansas Medicaid Program on paper for services provided to eligible 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.

262.300 ADA 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/Clinic	11
Other location	99

262.400 Billing Instructions - ADA Claim Form - Paper Claims Only 7-1-07

Dental providers must complete the ADA Claim form when:

A. Billing for services when using the ADA procedure codes

B. Requesting prior authorization

C. Approving prior authorization

D. Requesting prior authorization for all orthodontic services

For prior authorizations, the provider should send the ADA claim form to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

Claims submitted on paper will be paid only once a month. The only claims exempt from this process are those that require attachments or manual pricing.

The same ADA claim form on which the treatment plan was submitted to obtain prior authorization must be used to submit the claim for payment. If this is done, the header information and the “Request for Payment for Services Provided” portions of the form are to be completed.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

If this form is being used to request Prior Authorization, it should be forwarded to the Division of Medical Services Medical Assistance Attention Dental Services. **View or print the Division of Medical Services Dental Unit contact information**.

Completed claim forms should be forwarded to the EDS Claims Department. **View or print the EDS Claims Department contact information**.

To bill for dental or orthodontic services, the ADA claim form must be completed. The following numbered items correspond to the numbered fields on the claim form. **View or print ADA-J400.**

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

COMPLETION OF FORM

Field Number and Name	Instructions for Completion
HEADER INFORMATION	
1. Type of Transaction	Check one of the following: Statement of Actual Services EPSDT/Title XIX Request for Predetermination/Preauthorization
2. Predetermination/ Preauthorization Number	If the procedure(s) being billed requires prior authorization and authorization is granted by the Medicaid Dental Program, enter the 10-digit PA control number assigned by the Medicaid Program.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company/Plan Name, Address, City, State, Zip Code	Enter the carrier's name and address.
OTHER COVERAGE	
4. Other Dental or Medical Coverage?	Check No or Yes. If No, skip items 5 through 11.
5. Name of Policyholder/Subscriber in #4.	Enter Policyholder/Subscriber's name. Format: Last name, first name.
6. Date of Birth	Enter Policyholder/Subscriber's date of birth. Format: MM/DD/CCYY.
7. Gender	Check M for male or F for female.
8. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
9. Plan/Group Number	Not required.
10. Patient's Relationship to Person Named in #5	Check one of the following: Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the name and address of the other company providing dental or medical coverage.
POLICYHOLDER/SUBSCRIBER INFORMATION	
12. Policyholder/Subscriber Name…Address, city, State, Zip Code	Enter the name and address of the policyholder/subscriber of the insurance identified in item 3.

Field Number and Name	Instructions for Completion
13. Date of Birth	Enter the policyholder/subscriber's date of birth. Format: MM/DD/CCYY.
14. Gender	Check M for male or F for female.
15. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
16. Plan/Group Number	Enter the plan or group number for the insurance identified in item 3.
17. Employer Name	Not required.
PATIENT INFORMATION	
18. Relationship to Policyholder/Subscriber in #12 above.	Check one of the following: Self Spouse Dependent Child Other
19. Student Status	Check one of the following, if applicable: FTS – Full-time student PTS – Part-time student
20. Name…Address, City, State, Zip Code	Enter last name, first name on first line of field 20. Enter address, city, state, and zip code on second and third lines.
21. Date of Birth	Enter the patient's date of birth. Format: MM/DD/CCYY.
22. Gender	Check "M" for male or "F" for female.
23. Patient ID/Account #	Enter the 10-digit patient Medicaid identification number.
RECORD OF SERVICES PROVIDED	
24. Procedure date	Enter the date on which the procedure was performed. Format: MM/DD/CCYY.
25. Area of Oral Cavity	Not required.
26. Tooth System	Not required.
27. Tooth Number(s) or Letter(s)	Required if applicable. List only one tooth number per line.
28. Tooth Surface	Required if applicable. Enter one of the following: M – Mesial D – Distal L – Lingual I – Incisal B – Buccal O – Occlusal L – Labial F - Facial
29. Procedure Code	Required for Medicaid. These codes are listed in Section 262.100 for beneficiaries under age 21 or Section 262.200 for medically eligible beneficiaries age 21 and older.
30. Description	Required for Medicaid.

Field Number and Name	Instructions for Completion
31. Fee	List the usual and customary fee.
32. Other Fee(s)	Enter the total of payments previously received on this claim from any private insurance. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B copayments.
33. Total Fee	Required for Medicaid. Enter the total fee charged.
MISSING TEETH INFORMATION	
34. (Place an 'X' on each missing tooth)	Draw an X through the number or letter of each missing permanent and primary tooth.
35. Remarks	Not required.
AUTHORIZATIONS	
36. Agreement of responsibility	Patient or guardian must sign and date here.
37. Authorization of direct payment	Subscriber must sign and date here.
ANCILLARY CLAIM/TREATMENT INFORMATION	
38. Place of Treatment	Check one of the following: Provider's Office Hospital ECF Other
39. Number of Enclosures	Enter the number of radiographs, oral images, and models in the applicable boxes.
40. Is Treatment for Orthodontics?	Check No or Yes. If No, skip items 41 and 42.
41. Date Appliance Placed	Enter date appliance placed. Format: MM/DD/CCYY.
42. Months of Treatment Remaining	Enter months of orthodontic treatment remaining.
43. Replacement of Prosthesis?	Check No or Yes. If Yes, complete item 44.
44. Date Prior Placement?	Enter the date of prior placement of the prosthesis. Format: MM/DD/CCYY.
45. Treatment Resulting from	Check one of the following, if applicable: Occupational illness/injury Auto accident Other accident If item 45 is applicable, complete item 46. If item 45 is "Auto accident," also complete item 47.
46. Date of accident	Enter date of accident. Format: MM/DD/CCYY.
47. Auto Accident State	Enter two-letter abbreviation for state in which auto accident occurred.
BILLING DENTIST OR DENTAL ENTITY	
48. Name, Address, City, State, Zip Code	Enter the name and address of the billing dentist or dental entity.
49. NPI	Not required.
50. License Number	Optional.

Field Number and Name	Instructions for Completion
51. SSN or TIN	Optional.
52. Phone Number	Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code.
52A. Additional Provider ID	Enter the Dentist or Oral Surgeon's 9-digit Arkansas Medicaid billing provider number. The provider number should end with "08" for an individual Dentist number or "31" for a Dental group. The provider number should end in "79" for an individual Oral Surgeon number or "80" for an Oral Surgeon group.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. Certification	The provider or designated authorized individual must sign and date the claim form 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.
54. NPI	Not required.
55. License Number	Optional.
56. Address, City, State, Zip Code	Enter the complete address of the treating dentist.
56A. Provider Specialty Code	Not required.
57. Phone Number	Enter the 10-digit telephone number of the treating dentist, beginning with area code.
58. Additional Provider ID	If the billing provider number in Field 52A is a group or clinic ending in "31" for Dentists or "80" for Oral Surgeons, the individual provider number must be entered for the provider rendering the service. The provider number should end with "08" for an individual Dentist number or "79" for an individual Oral Surgeon number.

263.100 CPT Procedure Codes 7-1-07

The provider should carefully read and adhere to the following instructions so that claims may be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

A. If these procedures are the result of a Child Health Services (EPSDT) screen/referral, enter "E" in Field 24H.

B. These procedures are restricted to the following places of service: inpatient hospital, outpatient hospital, doctor's office, patient's home, nursing home and skilled nursing facility.

C. Radiology procedures are payable only in the dentist's office. The place of service (POS) codes may be found in section 262.300 of this manual. **These services require a PCP referral**.

The claim form CMS-1500 must be used by dentists billing the Medicaid Program for these medical procedures. Each service must be billed on a separate form. See section 263.300 for complete billing instructions.

A. When billing for extractions (procedure code 41899), a listing of teeth extracted by date, tooth number and ADA code number must be attached.

B. Recipients in the Child Health Services (EPSDT) Program are not benefit limited.

Procedure Codes

10060	10061	10120	10121	10140	10160	10180	11000
11001	11040	11041	11042	11043	11044	11050	11051
11052	11101	11200	11201	11305	11306	11307	11308
11310	11311	11312	11313	11420	11440	11620	11621
11622	11623	11624	11626	11640	11641	11642	11643
11644	11646	12001	12002	12004	12005	12006	12007
12011	12013	12014	12015	12016	12017	12018	12020
12021	12031	12032	12034	12035	12036	12037	12041
12042	12044	12045	12046	12047	12051	12052	12053
12054	12055	12056	12057	13120	13121	13131	13132
13150	13151	13152	13160	13300	14020	14021	14040
14041	14060	14061	14300	15000	15100	15101	15120
15121	15220	15221	15240	15241	15260	15261	15350
15400	15570	15572	15574	15576	15580	15600	15610
15620	15630	15732	15740	15750	15755	15760	15770
15840	15841	15842	15845	15850	15851	15852	15860
16000	16010	16015	16020	16025	16030	16035	16040
16041	16042	17000	17001	17002	17010	17107	17108
17110	17200	17201	17250	17270	17271	17272	17273
17274	17276	17280	17281	17282	17283	17284	17286
17304	17305	17306	17307	17310	17340	17999	20000
20005	20525	20605	20615	20670	20680	20690	20692
20693	20694	20900	20902	20910	20912	20920	20922
20924	20926	20960	20962	20969	20970	20971	20999
21010	21015	21025	21026	21029	21030	21031	21032
21034	21040	21041	21044	21045	21050	21060	21070
21100	21110	21116	21206	21210	21215	21230	21235
21240	21242	21243	21260	21261	21263	21267	21268

Procedure Codes

21270	21275	21280	21282	21295	21296	21299	21300
21315	21320	21325	21330	21335	21336	21337	21338
21339	21340	21343	21344	21345	21346	21347	21348
21355	21356	21360	21365	21366	21385	21386	21387
21390	21395	21400	21401	21406	21407	21408	21421
21422	21423	21431	21432	21433	21435	21436	21440
21445	21450	21451	21452	21453	21454	21461	21462
21465	21470	21480	21485	21490	21493	21494	21495
21499	21501	21550	21555	21557	29800	29804	29909
30000	30020	30100	30117	30118	30120	30124	30125
30130	30140	30150	30160	30200	30210	30220	30300
30310	30320	30520	30540	30545	30560	30580	30600
30620	30630	30801	30802	30901	30903	30905	30906
30915	30920	30930	30999	31000	31002	31020	31030
30132	30140	31050	31051	31070	31075	31080	31081
31084	31085	31086	31087	31090	31225	31230	31231
31233	31235	31237	31238	31239	31240	31276	31287
31288	31290	31291	31292	31293	31294	31299	31500
31502	31513	31515	31530	31531	31535	31536	31600
31601	31603	31605	31820	31825	31830	36000	36400
36405	36406	36410	36600	36620	36625	38300	38505
38525	38542	38700	38720	38724	38740	38745	40490
40500	40510	40520	40525	40527	40530	40650	40652
40654	40700	40701	40702	40720	40761	40799	40800
40801	40806	40808	40810	40812	40814	40816	40818
40820	40830	40831	40840	40842	40843	40844	40845
40899	41000	41005	41006	41007	41008	41009	41010
41015	41016	41017	41018	41108	41110	41112	41113
41114	41116	41120	41130	41135	41140	41145	41150
41153	41155	41250	41251	41252	41500	41510	41520
41599	41800	41805	41806	41820	41821	41822	41823
41825	41826	41827	41828	41830	41850	41870	41872
41874	41899	42000	42100	42104	42106	42107	42120
42140	42145	42160	42180	42182	42200	42205	42210
42215	42220	42225	42226	42227	42235	42260	42280
42281	42299	42300	42305	42310	42320	42325	42326

Procedure Codes							
42330	42335	42340	42400	42405	42408	42409	42410
42415	42420	42425	42426	42440	42450	42500	42505
42507	42508	42509	42510	42550	42600	42650	42660
42665	42699	42720	42725	42800	42802	42804	42806
42808	42810	42815	42880	42900	42950	42953	42960
42961	42962	42970	42971	42972	42999	43204	43205
43219	43227	43228	64400	64402	64405	64550	64716
64722	64727	64732	64734	64736	64738	64740	64742
64744	64788	64790	64792	64795	64830	64864	64872
64874	64885	64886	64901	64902	64905	64907	64999
67599	67715	67810	67820	67825	67830	67835	67875
67880	67882	67902	67903	67904	67906	67908	67909
67911	67930	67935	67950	67961	67966	67971	67973
67974	67975	67999	68400	68420	68440	68530	68720
68745	68750	68760	68761	68770	68800	68825	68840
68850	68899	69100	69110	69200	69205	69210	69399
70030	70100	70110	70140	70150	70160	70170	70210
70220	70250	70260	70300	70310	70320	70328	70330
70332	70336	70350	70355	70360	70380	70390	76000
76100	76140	76499	90780	90799	92511	95831	95851
95868	95937	95999	97010	97014	97124	97703	99201
99202	99203	99204	99205	99211	99212	99213	99214
99215	99217	99218	99219	99220	99221	99222	99223
99231	99232	99233	99238	99241	99242	99243	99244
99245	99251	99252	99253	99254	99255	99271	99272
99273	99274	99275	99281	99282	99283	99284	99285
99288	99301	99302	99303	99311	99312	99313	99341
99342	99343	99351	99352	99353	99354	99355	99356
99357							

263.200 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/Clinic	11

Place of Service	POS Codes
Other location	99
Ambulatory Surgical Center	24

263.300 Billing Instructions - CMS-1500 - Paper Claims 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 rule are those that require attachments or manual pricing.

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

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

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.

263.310 Completion of CMS-1500 Claim Form 7-1-07

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.

Field Name and Number	Instructions for Completion
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.
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.

Field Name and Number	Instructions for Completion
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 not required for Children's Services TCM. 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	Not used.
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 U.S. Department of Health and Human Services diagnosis coding, current as of the claim date (not the service date), from ICD-9-CM.
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.
26. PATIENT'S ACCOUNT N O.	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.

Field Name and Number	Instructions for Completion
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 ARKids First-B 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.

263.400 Special Billing Procedure for the CMS-1500 Claim Form 7-1-07

CPT-4 procedure codes must be billed on the CMS-1500 claim form by dentists enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid beneficiary and is medically necessary. **View a CMS-1500 sample form.** These procedure codes and their descriptions are located in the *American Medical Association Current Procedural Terminology (CPT)*. Refer to Section III for information on how to purchase a copy of this publication.

NOTE: Procedure code 99238 (Hospital Discharge Day Management) is payable for medical services. Procedure code 99238 may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes 99221 through 99233). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

NOTE: Covered CPT-4 procedure codes listed in this section are covered by Medicaid for eligible beneficiaries of all ages. The Arkansas Medicaid ADA Procedure Codes are covered only for eligible beneficiaries under the age of 21 years participating in the Child Health Services (EPSDT) Program.

263.410 Multiple Quadrants Billing Instructions 7-1-07

When billing for multiple applications of any of the following procedures on the same date of service in varying quadrants of a patient's mouth, indicate the number of quadrants (1, 2, 3, 4) in Field 24G:

D1110	D1120	41872	41874

263.420 Anesthesia Services 7-1-07

Anesthesia services are billed using the CMS-1500 claim format.

A. The Arkansas Medicaid Program covers the anesthesia procedure codes (code range 00100 through 01999) listed in the Current Procedural Terminology (CPT-4) code book.

B. Providers must bill anesthesia time.

C. Providers must use anesthesia modifiers P1 through P5 as listed in the CPT manual.

D. Providers may bill electronically unless paper attachments are required.

E. When providers bill on paper, any applicable modifier(s) are also required.

The procedure code and the time involved must be entered in Field 24D. The number of units (each 15 minutes, or portion thereof, of anesthesia equals 1 time unit) must be entered in Field 24G.

The procedure code listed under the "Qualifying Circumstances" in the Anesthesia Guidelines in the CPT requires medical care services. When surgical field avoidance is a qualifying factor of the anesthesia service, the provider must bill, in addition to the basic anesthesia procedure code, modifier 22, and must bill "1" unit of service.

Procedure code 00170 may be billed by oral surgeons for anesthesia for inpatient or outpatient dental surgery using place of service code 24, 21, 22, or 11, as appropriate. The code does not require prior approval for anesthesia claims.

263.421 Anesthesia Procedure Codes 7-1-07

Oral surgeons must use the following anesthesia procedure codes when billing on paper.

00100	00102	00103	00140	00160	00162	00164	00170
00172	00174	00176	00190	00192	00300		

263.422 Reserved 7-1-07