



Division of Medical Services
Program Planning & Development

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TO: Arkansas Medicaid Health Care Providers –Personal Care
DATE: October 1, 2008
SUBJECT: Provider Manual Update Transmittal #107

Table with 4 columns: REMOVE Section, REMOVE Date, INSERT Section, INSERT Date. Row 1: 262.410, 7-1-07, 262.410, 10-1-08

Explanation of Updates

Section 262.410 is amended primarily to advise providers when to enter a Local Education Agency (LEA) number on a form CMS-1500 paper claim, which LEA number to enter on a given claim, and to enter the number in field 19 when applicable.

Instructions in field 21 regarding diagnosis coding have been corrected. The text inadvertently had been written, in a previous update transmittal, contradictorily to established Medicaid rules. Additional revisions in this section are to explain and clarify billing instructions.

The only amended rule in this section is the instruction in field 19 regarding the LEA number.

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.

Roy Jeffus, Director



## TOC required

262.410

## Completing a CMS-1500 Claim Form for Personal Care

10-1-08

When a provider must bill on a paper claim, the fiscal agent accepts only red-lined, sensor-coded CMS-1500 claim forms. Claim photocopies and claim forms that are not sensor-coded cannot be processed.

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 10-digit Medicaid or ARKids First-A identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's date of birth as given on the individual's Medicaid or ARKids First-A 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 complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary resides.
STATE	Two-letter postal code for the state in which the beneficiary resides.
ZIP CODE	Five-digit ZIP code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary'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 the insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. PATIENT STATUS	Not required.

Field Name and Number	Instructions for Completion
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.
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.

Field Name and Number	Instructions for Completion
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	Name and title of <b>the</b> referral source.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician <b>when applicable.</b>
17b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	<b>Not applicable.</b>
19. RESERVED FOR LOCAL USE	<b>Schools, school districts and education service cooperatives must enter the LEA number of the facility or district providing the service.</b>
20. OUTSIDE LAB? \$ CHARGES	Not required. 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. <b>Use the International Classification of Diseases, Ninth Revision (ICD-9-CM) diagnosis coding current as of the date of service.</b>
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 <b>when</b> applicable.

Field Name and Number	Instructions for Completion
24A. DATE(S) OF SERVICE	<p>The “from” and “to” dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> <li>1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month.</li> <li>2. A provider 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 service on each day of the date sequence.</li> <li>3. RCFs may bill for a date span of any length within the same calendar month, provided the client was present every day of the date span and all services provided within the date span were at the same Level of Care.</li> </ol>
B. PLACE OF SERVICE	Two-digit national standard place of service code.
C. EMG	Not required.
D. PROCEDURES, SERVICES, OR SUPPLIES	<p>CPT/HCPCS One CPT or HCPCS procedure code for each detail.</p> <p>MODIFIER Modifier(s) when applicable.</p>
E. DIAGNOSIS POINTER	<p>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.</p>
F. \$ CHARGES	<p>The full charge for the services totaled in the detail. This charge must be the usual charge to any client patient, or other recipient of the provider’s services.</p> <p>RCFs’ charges should equal no less than the product of the number of units (days) times the client’s Daily Service Rate. If the charge is less, Medicaid will pay the billed charge.</p>
G. DAYS OR UNITS	The units (in whole numbers) of service 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 and referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Not applicable.

Field Name and Number	Instructions for Completion
NPI	Not required.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, advise Provider Enrollment so that the year-end 1099 will be correct and reported correctly.
26. PATIENT'S ACCOUNT NO.	Optional entry for providers' accounting and account-retrieval purposes. Enter up to 16 numeric, alphabetic or alpha-numeric characters. This character set 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 of all charges on the claim.
29. AMOUNT PAID	Enter the total of payments received from other sources on this claim. Do not include amounts previously paid by Medicaid.
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 performing provider or an individual authorized by the performing provider or by an institutional, corporate, business or other provider organization, must sign and date the claim, certifying that the services were furnished by the provider, under (when applicable) the direction of the individual provider or other qualified individual, and in strict and verifiable accordance with all applicable rules of the Medicaid program in which the provider participates. A "provider's signature" is the provider's or authorized individual's personally written signature, a rubber stamp of the signature, an automated signature or a typed signature. The name of a group practice, a facility or institution, a corporation, a business or any other organization will prevent the claim from being processed.
32. SERVICE FACILITY LOCATION INFORMATION	If services were not performed at the beneficiary's home or at the provider's facility (e.g., school, DDS facility etc.) enter the name, street address, city, state and zip code of the facility, workplace etc. where services were performed. If services were furnished at multiple sites (for instance, when job-seeking), indicate "multiple locations" or leave blank.
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.

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Field Name and Number	Instructions for Completion
a. (blank)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

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