



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 – Rural Health Clinic
DATE: June 1, 2009
SUBJECT: Provider Manual Update Transmittal #99

Table with 4 columns: REMOVE Section, REMOVE Date, INSERT Section, INSERT Date. Rows include sections 211.000, 214.000, 217.110, 217.230, and 252.310 with their respective update dates.

Explanation of Updates

Sections 211.000, 214.000, 217.110, 217.230 are revised to change the word recipient to beneficiary.
Section 252.310 is revised to correct the instructions in Field 4 of the CMS-1450 claim form.
Paper versions of this update transmittal have updated pages attached to file in your provider manual.
If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator...
If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center...
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 not required**211.000 Scope 6-1-09**

The Medical Assistance (Medicaid) Program is designed to assist eligible Medicaid **beneficiaries** in obtaining medical care within the guidelines specified in this manual. All Medicaid benefits are based on medical necessity. See the Glossary for the definition of medical necessity.

- A. A provider-based rural health clinic is one which is an integral part of a hospital, skilled nursing facility or home health agency that participates in Medicare and which is licensed, governed and supervised with other departments of the facility.
- B. An independent (free-standing) rural health clinic is one that participates in Medicare and is not provider based.
- C. Visit is defined as a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, nurse midwife or other specialized nurse practitioner whose services are reimbursed under the rural health clinic payment method. Encounters with more than one health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

214.000 A Patient of the RHC 6-1-09

Any Medicaid **beneficiary** who receives RHC services and/or other ambulatory services at the RHC is considered a patient of the RHC. Also, any Medicaid **beneficiary** who receives RHC services by the RHC off-site from the RHC is considered a patient of the RHC.

217.110 Basic Family Planning Visits 6-1-09

The Basic Family Planning Visit includes:

- A. Medical history and medical examination that includes: head, neck, breast, chest, pelvis, abdomen, extremities, weight and blood pressure.
- B. Counseling and education regarding
 - 1. Breast self-exam,
 - 2. The full range of contraceptive methods available and
 - 3. HIV/STD prevention.
- C. Prescription for any contraceptives selected by the **beneficiary**.
- D. Laboratory services, including:
 - 1. Pregnancy test,
 - 2. Urinalysis testing for albumin and glucose,
 - 3. Hemoglobin and Hematocrit,
 - 4. Papanicolaou smear for cervical cancer,
 - 5. Sickle cell screening and
 - 6. Testing for sexually transmitted diseases

217.230 Sterilization

6-1-09

Sterilization is a covered benefit in the RHC program only when sterilization takes place in the RHC.

- A. Medicaid covers sterilization of men and women.
 1. All adult (aged 21 or older) male and female Medicaid **beneficiaries** who are mentally competent are eligible for sterilization procedures and medically necessary follow-ups as long as they remain Medicaid-eligible.
 2. Adult (aged 21 or older) women in the Family Planning Waiver (FP-W) category, aid category 69, who are mentally competent, are eligible for sterilization procedures and one annual post-sterilization visit as long as they retain their eligibility in that category.
- B. Medicaid coverage of sterilizations is contingent upon the provider's documented compliance with federal and state regulations, including obtaining the patient's signed consent in a manner prescribed by law.
- C. Non-therapeutic sterilization means any procedure or operation for which the primary purpose is to render an individual permanently incapable of reproducing.
 1. Non-therapeutic sterilization is neither:
 - a. A necessary part of the treatment of an existing illness or injury nor
 - b. Medically indicated as an accompaniment of an operation of the genitourinary tract.
 2. The reason the individual decides to take permanent and irreversible action is irrelevant. It may be for social, economic or psychological reasons or because a pregnancy would be inadvisable for medical reasons.
- D. Prior authorization is not required for a sterilization procedure. However, all applicable criteria described in this manual must be met.
- E. Federal regulations are very explicit concerning coverage of non-therapeutic sterilization. Therefore, all the following conditions must be met:
 1. The person on whom the sterilization procedure is to be performed voluntarily requests such services.
 2. The person is mentally and legally competent to give informed consent.
 3. The person is 21 years of age or older at the time informed consent is obtained.
 4. The person to be sterilized shall not be an institutionalized individual. The regulations define "institutionalized individual" as a person who is:
 - a. Involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including those for mental illness, or
 - b. Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
 5. The person has been counseled, both orally and in writing, concerning the effect and impact of sterilization and alternative methods of birth control.
 6. Informed consent and counseling must be properly documented. Only the official Sterilization Consent Form DMS-615, properly completed, complies with documentation requirements. [View or print Sterilization Consent Form DMS-615.](#)

7. Copies may be ordered from EDS. See Section III. If the patient needs the Sterilization Consent Form in an alternative format, such as large print, contact our Americans with Disabilities Act Coordinator. [View or print Americans with Disabilities Act Coordinator contact information.](#)
8. Available by order from EDS are two free informational publications: Sterilization Consent Form-Information for Women (PUB-019) and Sterilization Consent Form-Information for Men (PUB-020). See Section III of any Arkansas Medicaid provider manual for instructions for ordering forms and publications.
9. If you have any questions regarding any of these requirements, contact the Arkansas Medicaid Program **before** the sterilization.

252.310

Completion of CMS-1450 (UB-04) Claim Form

6-1-09

Field #	Field name	Description
1.	(blank)	Enter the provider's name, city, state, zip code, and telephone number.
2.	(blank)	Unassigned data field.
3a.	PAT CNTL #	The provider may use this optional field for accounting purposes. It appears on the RA beside the letters "MRN." Up to 16 alphanumeric characters are accepted.
3b.	MED REC #	Required. Enter up to 15 alphanumeric characters.
4.	TYPE OF BILL	Type of Bill Enter the three digit numeric code found in the Data Specifications Manual to indicate the specific type of bill.
5.	FED TAX NO	Not required.
6.	STATEMENT COVERS PERIOD	Enter the beginning and ending service dates of the period covered by this bill. To bill on a single claim for services occurring on multiple dates, enter the beginning and ending service dates in the FROM and THROUGH fields. The "FROM" and "THROUGH" dates may not span calendar months. When billing for multiple dates of service on a single claim, a date of service is required in field 45 for each HCPCS code in field 44 and/or each revenue code in field 42.
7.	(blank)	Unassigned data field.
8a.	PATIENT NAME	Enter the patient's last name and first name. Middle initial is optional.
8b.	(blank)	Not required.
9.	PATIENT ADDRESS	Enter the patient's full mailing address. Optional.
10.	BIRTH DATE	Enter the patient's date of birth. Format: MMDDYYYY.
11.	SEX	Enter M for male, F for female, or U for unknown.

Field #	Field name	Description
12.	ADMISSION DATE	Not applicable.
13.	ADMISSION HR	Not applicable.
14.	ADMISSION TYPE	Not applicable.
15.	ADMISSION SRC	Not applicable.
16.	DHR	Not applicable.
17.	STAT	Not applicable.
18.- 28.	CONDITION CODES	Required when applicable. See the UB-04 Manual for requirements and for the codes used to identify conditions or events relating to this bill.
29.	ACDT STATE	Not required.
30.	(blank)	Unassigned data field.
31.- 34.	OCCURRENCE CODES AND DATES	Required when applicable. See the UB-04 Manual.
35.- 36.	OCCURRENCE SPAN CODES AND DATES	See the UB-04 Manual.
37.	(blank)	Unassigned data field.
38.	Responsible Party Name and Address	See the UB-04 Manual.
39.	VALUE CODES	Not required.
a.	CODE	Not applicable.
	AMOUNT	Not applicable.
b.	CODE	Not applicable.
	AMOUNT	Not applicable.
40.	VALUE CODES	Not applicable.
41.	VALUE CODES	Not applicable.
42.	REV CD	Enter 0521 for an RHC Visit (encounter).
43.	DESCRIPTION	Enter the Revenue Code's corresponding Standard Abbreviation found in the UB-04 Manual.
44.	HCPCS/RATE/HIPPS CODE	See the UB-04 Manual.
45.	SERV DATE	When the "FROM" and "THROUGH" dates indicate the claim is for multiple dates of service, enter the service (encounter) date for each revenue code. Always enter the service date of each HCPCS or CPT procedure code. Format: MMDDYY.

Field #	Field name	Description
46.	SERV UNITS	Enter the number of units furnished of each itemized service per date of service.
47.	TOTAL CHARGES	The total charge for the line-item number of units reported in field 46. See the UB-04 Manual for additional information.
48.	NON-COVERED CHARGES	Not required.
49.	(blank)	Unassigned data field.
50.	PAYER NAME	Line A is required. See the UB-04 for additional regulations.
51.	HEALTH PLAN ID	Not required.
52.	REL INFO	Required.
53.	ASG BEN	Required. See "Notes" at field 53 in the UB-04 Manual.
54.	PRIOR PAYMENTS	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.
55.	EST AMOUNT DUE	Situational. See the UB-04 Manual.
56.	NPI	Not required.
57.	OTHER PRV ID	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider on first line of field.
58. A, B, C	INSURED'S NAME	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
59. A, B, C	P REL	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
60. A, B, C	INSURED'S UNIQUE ID	On line A, enter the RHC patient's Arkansas Medicaid or ARKids First (A or B) identification number on first line of field.
61. A, B, C	GROUP NAME	Using the plan name if the patient is insured by another payer or other payers, follow instructions for field 60.
62. A, B, C	INSURANCE GROUP NO	When applicable, follow instructions for fields 60 and 61.
63. A, B, C	TREATMENT AUTHORIZATION CODES	Enter any applicable prior authorization or benefit extension number on line 63A.
64. A, B, C	DOCUMENT CONTROL NUMBER	Field used internally by Arkansas Medicaid. No provider input.

Field #	Field name	Description
65. A, B, C	EMPLOYER NAME	When applicable, based upon fields 51 through 62, enter the name(s) of the individuals and entities that provide health care coverage for the patient (or may be liable).
66.	DX	Diagnosis Version Qualifier. Not applicable.
67. A-H	(blank)	Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Fields are available for up to 8 codes.
68.	(blank)	Unassigned data field.
69.	ADMIT DX	Not required.
70.	PATIENT REASON DX	Not applicable.
71.	PPS CODE	Not required.
72	ECI	See the UB-04 Manual. Required when applicable (for example, TPL and torts).
73.	(blank)	Unassigned data field.
74.	PRINCIPAL PROCEDURE CODE AND DATE and OTHER PROCEDURE CODES AND DATES	Not required.
75.	(blank)	Unassigned data field.
76.	ATTENDING NPI QUAL LAST FIRST	NPI not required. Enter 0B, indicating state license number. Enter the state license number in the second part of the field. Enter the last name of the primary attending physician. Enter the first name of the primary attending physician.
77.	OPERATING NPI QUAL LAST FIRST	NPI not required. Not applicable. Not applicable. Not applicable.
78.	OTHER NPI QUAL LAST FIRST	NPI not required. When applicable, enter 0B, indicating state license number. Enter the state license number in the second part of the field. Enter the last name of the primary care physician. Enter the first name of the primary care physician.

Field #	Field name	Description
79.	OTHER NPI/QUAL/LAST/FIRST	Not used.
80.	REMARKS	For provider's use.
81.	CC	Not used.
