



Arkansas Department of Human Services

Division of Medical Services

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TO: Arkansas Medicaid Physician/Independent Lab/CRNA/Radiation
Therapy Center Providers

DATE: October 1, 2004

SUBJECT: Provider Manual Update Transmittal No. 86

REMOVE

Section	Date
292.440	10-13-03
292.447	10-13-03
292.730	10-13-03

INSERT

Section	Date
292.440	10-13-03
292.447	10-13-03
292.730	10-13-03

Explanation of Updates

Section 292.440 has been revised to correct errors in billing instructions effective October 13, 2003. Information that is no longer applicable to this program has been deleted. This section of the manual has been reformatted for clarification and readability. Information has been added to notify providers that anesthesia procedure codes with a base of 4 or less are eligible to be billed with a second modifier, 22, referencing surgical field avoidance.

Information previously included in Section 292.440, part A has been moved to an added part of this section, part C. The information in part C has been revised to delete national CPT procedure code 00840 as an appropriate crosswalk for local code Z9940. Locally assigned procedure code Z9940 is the correct procedure code when billing anesthesia services for abdominal hysterectomy. The description for Z9940 has been changed to "anesthesia for abdominal hysterectomy." Information previously included in part B of section 292.440 has been moved to an added part of this section, part D. Information in part D has been revised to delete procedure code 00855 and add procedure codes 01962 and 01963 as replacement codes.

Section 292.447 includes minor changes to the example of a completed claim for clarification.

Section 292.730 includes information regarding the billing of professional and technical components for covered laboratory and radiology services and use of new modifiers, TC for the technical component and 26 for the professional component.

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 or 1-877-708-8191. Both telephone numbers are voice and TDD.

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.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

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.

292.440 Anesthesia Services

10-13-03

Anesthesia procedure codes (00100 through 01999) must be bill in anesthesia time. Anesthesia modifiers P1 through P5 listed under Anesthesia Guidelines in the CPT must be used. When appropriate anesthesia procedure codes that have a base of 4 or less, type of service code “7”, are eligible to be billed with a second modifier, “22”, referencing surgical field avoidance.

Any surgical procedure with local/topical anesthesia is computed to include the administration of the local anesthetic agent, as it is already computed into the reimbursement amount and is billed by the primary surgeon. No modifiers or time may be billed with these procedures.

A. Electronic Claims

PES or electronic claims submission may be used unless paper attachments are required.

B. Paper Claims

If paper billing is required, enter the procedure code, time and units as shown in Section 292.447. Enter again the number of units (each 15 minutes of anesthesia equals 1 time unit) in Field 24G. (See cutaway section of a completed claim in Section 292.447.)

A type of service code is required along with applicable modifiers when filing paper claims. Providers must use type of service code “7” with procedure codes 00100 through 01999.

Any surgical procedure that includes local/topical anesthesia must be billed by the primary surgeon with a type of service code “2”.

The procedure codes listed under “Qualifying Circumstances” in the Anesthesia Guidelines of CPT require a type of service code (paper only) “1.”

C. The following national CPT procedure code for abortion and locally assigned procedure code for anesthesia for abdominal hysterectomy are to be billed with a type of service code “7” to indicate anesthesia, time units and modifiers as appropriate. These codes must be billed on CMS-1500 (formerly HCFA-1500) paper claims only because they require attachments.

National Code	Local Code	Local Code Description	Documentation Required
01964	Z2288	Abortion/Rape or incest	Certification Statement for Abortion (DMS-2698) (See Section 251.220 of this manual.) View or print form DMS-2698 and instructions for completion.
None	Z9940	Anesthesia for Abdominal Hysterectomy	Acknowledgement of Hysterectomy (DHS-2606) View or print form DMS-2606 and instructions for completion.

NOTE: Where both a national code and a local code (“Z code”) are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a national code is available, it can be used indefinitely for both electronic and paper claims.

- D. **The following CPT procedure codes must be billed on CMS-1500 (formerly HCFA-1500) paper claims because they require attachments or documentation:**

Procedure Code	Documentation Required
00846	Acknowledgement of Hysterectomy Information (DMS-2606) View or print form DMS-2606 and instructions for completion.
00848	Operative Report
01962	Acknowledgement of Hysterectomy Information (DMS-2606)
01963	View or print form DMS-2606 and instructions for completion.
00922	Operative Report
00944	Acknowledgement of Hysterectomy Information (DMS-2606) View or print form DMS-2606 and instructions for completion.
01999	Procedure Report
00800	Required to name each procedure done on females only, by surgeon in "Procedures, Services or Supplies" column. Example - 1. colon resection 2. lysis of adhesions 3. appendectomy
00840	Required to name each procedure done on females only, by surgeon in "Procedures, Services or Supplies" column.
00940	Required to name each procedure done by surgeon in "Procedures, Services or Supplies" column.

Anesthesiologist/anesthetists may bill procedure code **00170** with a type of service code (paper only) "7" for any inpatient or outpatient dental surgery using place of service code "B," "1," "2" or "3," as appropriate. This code does not require prior approval for anesthesia claims.

A maximum of 17 units of anesthesia is allowed for a vaginal delivery or C-Section. **Refer to Anesthesia Guidelines of the CPT book for procedure codes related to vaginal or C-section deliveries.**

292.730 Professional and Technical Components

10-13-03

Covered laboratory and radiology (procedure codes in code range **70010** through **89399**) as well as covered codes listed in the **90780** through **99199** range that require the use of a machine may be billed electronically or on paper.

When filing paper claims, a type of service code must be used along with applicable modifiers. The type of service code indicates whether the charge billed is for the technical component, professional component or complete procedure. The type of service codes are:

- A. Type of Service Code C - Complete Procedure. This charge consists of the combination of both the technical and the professional components. A complete procedure charge would be made if a physician has a private office and does the procedure within his own office. In these circumstances, he is billing for what is normally considered the technical component and the professional component in one single charge. In a private office environment, the radiologist is personally responsible for the personnel expenses, equipment expenses and also for his own professional services.
- B. Type of Service Code P - Professional Component. This charge consists of the fee for the professional involvement of the physician in the procedure. This consists of interpretation of the report, personal supervision of the procedure, dictation of the report, consultation with referring physicians and injection of contrast media where required.
- C. Type of Service Code T - Technical Component. This would be the portion of the charge relating exclusively to the execution of the procedure, exclusive of any service rendered by the physician. The technical component consists of such things as technician's time, salary, film costs, equipment costs, maintenance, space rental, utilities and all other charges normally associated with the provision of the radiology service.

Paper claims require the correct type of service code, C, P, or T, to be entered in Field 24C in the CMS-1500 (formerly HCFA-1500) claim form. Appropriate modifiers should be entered in Field 24D along with the procedure code. Modifier TC must be used for the technical component and modifier 26 must be used for the professional component.

Electronic billing of covered laboratory and radiology services requires the appropriate modifier for the component, modifier TC for the technical component and modifier 26 for the professional component.