Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us
Telephone (501) 682-8292 TDD (501) 682-6789 or 1-877-708-8191
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TO: Arkansas Medicaid Health Care Providers

DATE: July 1, 2002

SUBJECT: Section I Update Transmittal

Provider Manual	Transmittal Number
Alternatives for Adults with Physical Disabilities Waiver	
Ambulatory Surgical Center	
Certified Nurse-Midwife	
Child Health Management Services	
Child Health Services/Early and Periodic Screening, Diagnosis and Treatment	
Chiropractic	
DDS Alternative Community Services Waiver	
Dental	
Developmental Day Treatment Clinic Services	
Domiciliary Care	
ElderChoices Home and Community-Based 2176 Waiver	
Federally Qualified Health Center	
Hearing Services	
Home Health	
Hospice	
Hospital/End-Stage Renal Disease	
Hyperalimentation	
Inpatient Psychiatric Services for Under Age 21	
Licensed Mental Health Practitioners	
Medicare/Medicaid Crossover Only	
Nurse Practitioner	
Occupational, Physical, Speech Therapy Services	
Personal Care	
Pharmacy	
Physician/Independent Lab/CRNA/Radiation Therapy Center	
Podiatrist	
Portable X-Ray Services	
Private Duty Nursing Services	
Prosthetics	
Rehabilitative Hospital	
Rehabilitative Services for Persons with Mental Illness	

Provider Manual	Transmittal Number
Rehabilitative Services for Persons with Physical Disabilities	
Rural Health Clinic Services	
School-Based Mental Health Services	
Targeted Case Management	
Transportation	
Ventilator Equipment	
Visual Care	

REMOVE		INSERT	
Page	**Date**	**Page**	**Date**
I-85	12-1-98	I-85	7-1-02

Explanation of Updates

Page I-85, section 185.51, has been revised to include billing requirements for all substitute physician services in addition to the requirements listed for primary care physician substitutes. Section 313.490 of the Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual is referenced for billing requirements that pertain to all substitute physician services, including managed care primary care physician services.

A change bar in the left margin denotes a revision.

Attached are updated pages 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 at (501) 682-1461 (voice) or (501) 682-6789 and 1-877-708-8191 (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.

Ray Hanley, Director
Division of Medical Services

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.**

185.30 PCP Services

A PCP agrees to provide primary care services and health education; and to refer patients to specialty physicians, hospital care, or other services when necessary. The PCP will assess the recipient's medical condition and initiate or recommend treatment or therapy as needed. The PCP must assist the recipient in locating needed medical services. The PCP will also coordinate and monitor, on behalf of the recipient, prescribed medical and rehabilitation services.

185.40 PCP Referrals

Recipients participating in the PCP Managed Care Program may receive services only from their PCP unless the PCP refers them to another provider, or unless they access a service not requiring a PCP referral. A PCP may refer a recipient to a specific, named provider only if they name more than one provider and allow the recipient to choose. If the recipient elects to see a provider without a referral, the recipient will be responsible for the charges incurred. With respect to the quality and appropriateness of services, PCPs must accept co-responsibility for the ongoing care of referred patients. Services requiring a PCP referral may not begin until the PCP makes the referral. The PCP must renew, at least every 6 months, any referral for ongoing care. Medicaid defers to the physician's professional judgment in this regard and does not require that the PCP see the patient before making or renewing a referral.

185.41 Referral Form (DMS-2610)

Medicaid provides an optional referral form, the DMS-2610, located on page I-88 that the PCP may use to facilitate referrals. A PCP may also make a referral orally or by note or letter. Medicaid requires documentation of the referral in the recipient's medical record, regardless of the means by which the PCP makes the referral. Medicaid requires the provider receiving the referral to document it also, and to correspond with the PCP regarding the case when appropriate and when the PCP so requests.

185.50 PCP Substitutes

185.51 PCP Substitutes; General Requirements

Medicaid permits physicians to substitute for PCPs in some situations. In addition to the requirements found in section 313.490 of the Physicians/Independent Lab/CRNA/Radiation Therapy Center Provider Manual, the following 3 requirements apply to all PCP substitutions *by physicians*.

1. The PCP and the substitute physician must document the substitution in the patient's record(s) as a referral, and include the specific reason for the substitution.

2. The substitute physician must provide the PCP's name and provider number to any other service provider to whom they refer the patient.

3. The substitute physician need not be a PCP.

185.52 PCP Substitutes; Rural Health Clinics and Physician Group Practices

Physicians affiliated with a Rural Health Clinic or enrolled in a Medicaid-enrolled physician group may substitute for a recipient's PCP if the PCP is unavailable. Acceptable reasons for a PCP not to be available are: the PCP's schedule is full because of an unusual number of urgent or time-consuming cases; recipients require services outside the PCP's normal working hours; or the PCP is ill, on vacation or other leave of absence, or in surgery. Habitual overscheduling of patients is not an acceptable reason for a PCP's use of a substitute. PCPs and substitutes must fully document each substitution as a PCP referral.

185.53 PCP Substitutes; Individual Practitioners

Individual practitioners must designate a substitute physician to take telephone calls, see recipients and make appropriate referrals when the PCP is unavailable. Acceptable reasons for a PCP not to be available are: recipients require services outside the PCP's normal working hours; or the PCP is ill, on vacation or other leave of absence, or in surgery. Habitual overscheduling or having too great a caseload are not acceptable reasons for a PCP's use of a substitute. PCPs and substitutes must fully document each substitution as a PCP referral.

185.60 Nurse Practitioners and Physician Assistants in Rural Health Clinics

Licensed nurse practitioners or licensed physician assistants, employed by a Medicaid-enrolled Rural Health Clinic (RHC) provider, may not function as PCP substitutes. However, they may provide primary care for the PCP's recipients, with certain restrictions.

1. The PCP affiliated with the RHC must issue a standing referral for primary care services rendered by nurse practitioners and physician assistants in or on behalf of the RHC.

2. The nurse practitioner or physician assistant may not make any referrals for medical services except for pharmacy services per established protocol.

3. The PCP must maintain a supervisory relationship with the nurse practitioner or physician assistant.

186 Payment of Primary Care Physicians

PCPs will continue to bill Medicaid on a fee for service basis. Additionally, Medicaid will pay the PCP a monthly management fee. Medicaid will pay a set amount per month, for each recipient enrolled with the PCP on the last day of the month, regardless of the duration of the recipient's enrollment with the PCP. The PCP will receive the payments quarterly; in October, January, April and July. An accompanying Remittance Advice and Status Report (RA) will itemize the payments, by recipient and enrollment month. The RA will list each PCP's managed care patients alphabetically, and will include each recipient's Medicaid identification number and address.

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TO: Health Care Provider - Physician

DATE: July 1, 2002

SUBJECT: Update Transmittal No. 80

REMOVE		INSERT	
Page	**Date**	**Page**	**Date**
III-93	4-1-01	III-93	7-1-02
Appendix A	4-1-01	Appendix A	7-1-02

Explanation of Updates

Page III-93, section 313.490, has been revised to include minor wording changes to clarify billing requirements for Primary Care Physician Managed Care Program services that are provided by substitute physicians.

A change bar in the left margin denotes a revision.

Attached are updated pages 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 at (501) 682-1461 (voice) or (501) 682-6789 and 1-877-708-8191 (TDD).

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313.460 Services Prior to Medicare Entitlement

If Medicare denies a service with the explanation "Services Prior to Medicare Entitlement" submit the Medicaid claim electronically to EDS. If EDS rejects or denies the claim because this recipient has Medicaid, submit a hard copy claim to: EDS Inquiry Unit, P.O. Box 8036, Little Rock, AR 72203 for processing. A copy of the Medicare denial should be attached to the claim.

A claim inquiry form must accompany these claims in order that they may receive special handling.

313.470 Services Not Medicare Approved

Services that are not Medicare approved, are usually not payable by Medicaid.

313.480 Sexual Abuse Examination for Recipients Under Age 21

Procedure code **Z2263, Sexual Abuse Examination,** is payable to physicians when provided in the physician's office or in a hospital outpatient department, emergency or non-emergency, with Place of Service - 3, X or 2 and Type of service - 1. This procedure is exempt from the PCP referral requirement and is covered for recipients under the age of 21 only.

313.490 Substitute Physicians

To comply with Section 4708 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), the Arkansas Medicaid Program implemented the following requirements regarding substitute physician billing identification:

A. Under a **reciprocal** billing arrangement (not to exceed 14 continuous days), the regular physician must identify the services as substitute physician services by entering in field 24D in the HCFA-1500 claim format an "11" modifier after the procedure code.

B. Under a **locum tenens** billing arrangement (90 continuous days or longer), the regular physician must identify the services as substitute physician services by entering in field 24D in the HCFA-1500 claim format a "12" modifier after the procedure code.

Under both the above billing arrangements, the billing (regular) physician (or medical group) must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's name, and make this record available upon request. A record of the service would include the date and place of the service, the procedure code, the charge, and the recipient involved.

These billing requirements apply to all substitute physician services including Primary Care Physician Managed Care Program services.

313.500 Surgical Prostheses

Surgical prostheses which are routinely covered are:

A. Pacemakers

B. Orthopedic prostheses - Nails, Pins, Rods, etc.

C. Shunts

D. Lens Prosthesis

Charges for an internal surgical prosthesis will be billed on the HCFA-1500 claim form. The appropriate CPT procedure code for the surgery should be entered in Field 24D of the HCFA-1500 form. The surgery charges should be entered in Field 24F of the HCFA-1500 claim form. The prosthesis should be billed on a separate line of the claim form. The CPT procedure code to use for the prosthesis is the miscellaneous CPT procedure code closest to the surgery code. (The miscellaneous codes end in "99.") The charge should be entered in Field 24F of the HCFA-1500 claim form. Payment of the surgical prosthesis is based on the invoice amount; therefore, an invoice must accompany the claim form.

313.501 Cochlear Implant and External Sound Processor

Procedure code **69930** - Cochlear device implantation, with or without mastoidectomy - must be billed by the physician performing the procedure. When the cochlear device is provided by the physician, the physician may bill procedure code **69949** - Unlisted procedure, inner ear - for the device. Procedure code **69930** requires prior authorization. The physician must attach a copy of the invoice to the HCFA-1500 claim form. If the cochlear device is provided by the hospital, the physician may not bill separately for the device. Refer to Section 251.230 of this manual for coverage information.

Procedure code **Z1982** - External Sound Processor - is covered for eligible Medicaid recipients under age 21 in the EPSDT Program. This procedure code requires prior authorization, and the physician must attach a copy of the invoice to the HCFA-1500 claim form. Refer to Section 251.230 of this manual for coverage information.

Arkansas Medicaid Manual:	PHYSICIAN/INDEPENDENT LAB/CRNA/RADIATION THERAPY CENTER	Page:	APPENDIX A
		Effective Date:	10-1-85
Subject:	UPDATE CONTROL LOG	Revised Date:	7-1-02

Update No.	Release Date	Update No.	Release Date	Update No.	Release Date	Update No.	Release Date
1.	10-1-85	21.	6-1-92	41.	12-1-94	61.	3-1-97
2.	2-1-86	22.	7-1-92	42.	4-1-95	62.	2-15-97
3.	4-1-86	23.	10-1-92	43.	1-1-95	63.	3-15-97
4.	7-1-86	24.	12-1-92	44.	4-1-95	64.	4-1-97
5.	10-1-86	25.	3-1-93	45.	7-1-95	65.	5-1-97
6.	1-1-87	26.	12-1-92	46.	8-1-95	66.	9-1-97
7.	5-1-87	27.	6-1-93	47.	7-1-95	67.	1-1-98
8.	8-1-87	28.	7-1-93	48.	9-15-95	68.	4-1-98
9.	9-1-88	29.	8-1-93	49.	10-15-95	69.	12-1-98
10.	9-9-88	30.	9-1-93	50.	8-1-95	70.	8-1-99
11.	4-1-89	31.	10-1-93	51.	10-1-95	71.	12-1-99
12.	4-1-89	32.	11-15-93	52.	1-1-96	72.	4-1-01
13.	10-1-89	33.	1-1-94	53.	4-1-96	73.	12-1-00
14.	4-1-90	34.	1-1-94	54.	5-1-96	74.	5-1-01
15.	10-1-90	35.	4-1-94	55.	7-1-96	75.	7-1-01
16.	7-1-91	36.	7-1-94	56.	5-1-96	76.	8-1-01
17.	4-1-91	37.	7-26-94	57.	9-1-96	77.	11-1-01
18.	3-1-92	38.	8-1-94	58.	7-1-96	78.	11-1-01
19.	4-1-92	39.	9-1-94	59.	7-1-96	79.	3-1-02
20.	5-1-92	40.	9-1-94	60.	1-15-97	80.	7-1-02

Arkansas Medicaid Manual:	PHYSICIAN/INDEPENDENT LAB/CRNA/RADIATION THERAPY CENTER	Page:	APPENDIX A
		Effective Date:	7-1-02
Subject:	UPDATE CONTROL LOG	Revised Date:	

Update No.	Release Date	Update No.	Release Date	Update No.	Release Date	Update No.	Release Date
81.	7-1-02	101.		121.		141.	
82.		102.		122.		142.	
83.		103.		123.		143.	
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85.		105.		125.		145.	
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93.		113.		133.		153.	
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