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TO: **Arkansas Medicaid Health Care Providers - Developmental Day Treatment Clinic Services**

DATE: **July 1, 2005**

SUBJECT: **Provider Manual Update Transmittal No. 60**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	10-13-03	201.000	7-1-05
214.210	10-13-03	214.210	7-1-05
217.000	10-13-03	217.000	7-1-05
261.000 – 262.110	10-13-03	262.000 – 262.110	7-1-05
262.300 – 262.310	10-13-03	262.300 – 262.310	7-1-05

Explanation of Updates

Section 201.000 has been revised to add a statement informing providers that persons and entities that are excluded or debarred under state or federal law, regulation or rule are not eligible to enroll, or remain enrolled, as Medicaid providers.

Section 214.210, part B, has been revised to identify early intervention, pre-school and adult development as levels of care of the habilitation core service. This change is made for clarification only.

Section 217.000 has been revised to inform providers that effective for dates of service on and after July 1, 2005, extension of benefits for therapy services must be requested using form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services. Effective for dates of service on and after July 1, 2005, all requests for extension of benefits must be submitted to Arkansas Foundation for Medicare, Inc. (AFMC).

Sections 261.000 through 262.110 have been revised. The wording “formerly HCPCS-1500” has been removed from references to form CMS-1500. Other revisions include changes in required modifiers for use when filing claims for services. These changes are effective for dates of service on and after July 1, 2005.

Sections 262.300 and 262.310 have been revised. The wording “formerly HCPCS-1500” has been removed from references to form CMS-1500. Instructions for the completion of form CMS-1500, field 17, have been changed to include the requirement for primary care physician referral for DDTCS optional therapy services. Unnecessary information has been deleted from field 29. Wording in field 30 has been added to clarify the information to be entered into this field of form CMS-1500.

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 will be automatically incorporated.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

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.

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.

201.000 Arkansas Medicaid Participation Requirements for Developmental Day Treatment Clinic Services (DDTCS) Providers 7-1-05

All providers of DDTCS services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program:

A. Each provider of DDTCS services must be licensed as a developmental day treatment clinic by the Division of Developmental Disabilities Services (DDS), Arkansas Department of Human Services.

1. A copy of the current license must accompany the provider application and the Medicaid contract.

2. Copies of renewed licenses must be submitted to the Provider Enrollment Unit of the Division of Medical Services when they are issued.

B. The DDTCS provider must complete a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

C. The provider application (form DMS-652) and Medicaid contract (form DMS-653) must be approved by the Arkansas Medicaid Program as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

214.210 Occupational, Physical and Speech Therapy 7-1-05

Optional services available through DDTCS include occupational, physical and speech therapy and evaluation as an essential component of the plan of care for an individual accepted for developmental disabilities services. Therapy services are not included in the core services and are provided in addition to the core services.

A. The DDTCS client's primary care physician (PCP) or attending physician must prescribe occupational, physical and/or speech therapy services. The prescribed therapy must be included in the individual's DDTCS plan of care. A copy of the prescription must be maintained in the beneficiary's records. The original prescription is to be maintained by the physician.

B. Therapies in the DDTCS Program may be provided only to individuals whose plan of care includes one of the three levels of care (early intervention, pre-school or adult development). Medicaid does not cover optional therapy services furnished by a DDTCS provider as "stand-alone" services.

1. When a DDTCS provider renders therapy services in conjunction with a DDTCS core service, therapy services must be billed by the DDTCS provider according to billing instructions in Section II of this manual.
2. DDTCS providers may not bill under the Medicaid Occupational, Physical, Speech Therapy Program for therapy services available in the DDTCS Program and provided to DDTCS clients.
3. Therapy services may not be provided during the same time period DDTCS core services are provided.

C. Therapy evaluation services are limited to no more than four 30-minute units per state fiscal year. Therapy sessions are limited to no more than four 15-minute units per day. To ensure quality care, group therapy sessions are limited to no more than four persons in a group.

D. Make-up therapy sessions are covered in the event a therapy session is canceled or missed. Make-up therapy sessions are covered if determined medically necessary and prescribed by the beneficiary's PCP.

E. Therapy services carried out by an unlicensed therapy student may be covered only when the following criteria are met:

1. Therapies performed by an unlicensed student must be under the direction of a licensed therapist and the direction is such that the licensed therapist is considered to be providing the medical assistance.
2. The licensed therapist must be present and engaged in student oversight during the entirety of any encounter.

217.000 Procedures for Extension of Benefits for Occupational, Physical and Speech Therapy (Evaluation or Treatment) 7-1-05

A. Extension of benefit limits for occupational, physical and speech therapy may be provided if medically necessary for Medicaid-eligible clients under age 21. Form DMS-699, Request for Extension of Benefits, must be used to request extension of benefits. **View or print form DMS-699**.

Effective for dates of service on and after July 1, 2005, form DMS-671, Request for Extension of Benefits, must be used to request extension of benefits for therapy services. **View or print form DMS-671**.

B. Submit the request form, attaching a summary and medical records as needed to justify medical necessity to the Division of Medical Services, Benefit Extension Request Section. **View or print DMS Benefit Extension Requests Section contact information**.

Effective for dates of service on and after July 1, 2005, all requests for extension of benefits must be submitted to Arkansas Foundation for Medical Care, Inc. (AFMC). **View or print Arkansas Foundation for Medical Care (AFMC) contact information**.

261.000 Introduction To Billing 7-1-05

DDTCS service providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid recipients. Each claim should contain charges for only one recipient.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 CMS-1500 Billing Procedures 7-1-05

262.100 DDTCS Core Services Procedure Codes 7-1-05

DDTCS core services are reimbursable on a per unit basis. Partial units are not reimbursable. Service time less than a full unit of service may not be rounded up to a full unit of service and may not be carried over to the next service date.

Code	Required Modifier	Description
T1015	U4	Early Intervention Services (1 unit equals 1 encounter of two hours or more; maximum of 1 unit per day.)
T1015	—	Adult Development Services (1 unit equals 1 hour of service; maximum of 5 cumulative units per day.)
T1015	U1	Pre-School Services (1 unit equals 1 hour of service; maximum of 5 cumulative units per day.)
T1023	52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52.	Diagnosis and Evaluation Services (not to be billed for therapy evaluations) (1 unit equals 1 hour of service; maximum of 1 unit per date of service.)

262.110 Occupational, Physical and Speech Therapy Procedure Codes 7-1-05

All therapy services must be provided outside the time DDTCS core services are furnished. The following procedure codes must be used for therapy services for Medicaid-eligible recipients of all ages.

A. Occupational Therapy Procedure Codes

Code	Required Modifier(s)	Description
97003	—	Evaluation for occupational therapy (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)
97530	—	Individual occupational therapy (15-minute unit; maximum of 4 units per day)

97150	U2	Group occupational therapy (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)
97530	52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52.	Individual occupational therapy by occupational therapy assistant (15-minute unit; maximum of 4 units per day)
97150	U1, 52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52.	Group occupational therapy by occupational therapy assistant (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)

B. Physical Therapy Procedure Codes

Code	Required Modifier(s)	Description
97001	—	Evaluation for physical therapy (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)
97110	—	Individual physical therapy (15-minute unit; maximum of 4 units per day)
97150	—	Group physical therapy (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)
97110	52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52.	Individual physical therapy by physical therapy assistant (15-minute unit; maximum of 4 units per day)
97150	U1, 52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52.	Group physical therapy by physical therapy assistant (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)

C. Speech Therapy Procedure Codes

Code	Required Modifier(s)	Description
92506	—	Evaluation for speech therapy (maximum of four 30-minute units per state fiscal year, July 1 through June 30)
92507	—	Individual speech session (15-minute unit; maximum of 4 units per day)
92508	—	Group speech session (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)
92507	52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52.	Individual speech therapy by speech language pathology assistant (15-minute unit; maximum of 4 units per day)
92508	52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52.	Group speech therapy by speech language pathology assistant (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)

Extension of the benefit limits may be provided for occupational, physical and speech therapy if medically necessary for Medicaid beneficiaries under the age of 21. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services, must be used to request extension of benefits. Providers may order copies of form DMS-671 by completing the Medicaid Form Request and mailing it to the EDS Provider Assistance Center. **View or print the EDS PAC contact information**. **View or print form DMS-671**.

262.300 Billing Instructions – Paper Only 7-1-05

EDS offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.

To bill for DDTCS services, use form CMS-1500. The numbered items correspond to numbered fields on the claim form. **View a CMS-1500 sample form**.

Providers must read and carefully adhere to the following instructions so that EDS can efficiently process claims. 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.

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

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.

262.310 Completion of CMS-1500 Claim Form 7-1-05

Field Name and Number		Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
1a.	Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2.	Patient's Name	Enter the patient's last name and first name.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name (post office box or RFD), city name, state name and ZIP code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
9.	Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	b. Other Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.

	c. Employer's Name or School Name	Enter the employer's name or school name.
	d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to:	
	a. Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."
	b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two-letter state postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
	c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
10d.	Reserved for Local Use	This field is not required for Medicaid.
11.	Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
	a. Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer's Name or School Name	Enter the insured's employer's name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13.	Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14.	Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15.	If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17.	Name of Referring Physician or Other Source	If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title. DDTCS optional therapy services require primary care physician (PCP) referral.
17a.	I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18.	Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.

19. Reserved for Local Use

For tracking purposes, DDTCS providers are required to enter one of the following therapy codes:

Code	Category
A	Individuals from birth through 2 years who are receiving therapy services under an Individualized Family Services Plan (IFSP) through the Division of Developmental Disabilities Services.
B	Individuals ages 0 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Plan (IP) through the Division of Developmental Disabilities Services.

NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Plan and 3) the Individualized Plan is through the Division of Developmental Disabilities Services.

When using code C or D, providers must also include the 4-digit LEA (local education agency) code assigned to each school district. For example: C1234

C (and 4-digit LEA code)	Individuals ages 3 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Education Plan (IEP) through an education service cooperative.

NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 3 through 5 years and has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Education Plan and 3) the Individualized Education Plan is through an education service cooperative.

D (and 4-digit LEA code)	Individuals ages 5 (by September 15) to 21 years who are receiving therapy services under an Individualized Education Plan (IEP) through a school district.

NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 5 (by September 15 of the current school year) to 21 years, 2) the individual receiving services is receiving the services under an Individualized Education Plan and 3) the Individualized Education Plan is through a school district.

E	Individuals ages 18 years and up who are receiving therapy services through the Division of Developmental Disabilities Services.

F	Individuals ages 18 years and up who are receiving therapy services through individual or group providers not included in any of the previous categories (A-E).
G	Individuals ages birth through 17 years who are receiving therapy/pathology services through individual or group providers not included in any of the previous categories (A-F).
20. Outside Lab?	This field is not required for Medicaid.
21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with HCFA diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22. Medicaid Resubmission Code	Reserved for future use.
Original Ref No.	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number, if applicable.
24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See Section 262.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 262.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 262.100 through 262.110.
Modifier	Enter the applicable modifier from Section 262.110.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.

	G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
	H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
	I. EMG	Emergency - This field is not required for Medicaid.
	J. COB	Coordination of Benefit - This field is not required for Medicaid.
	K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25.	Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28.	Total Charge	Enter the total of Column 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. (See NOTE below Field 30.)
30.	Balance Due	Enter the total amount of funds. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the beneficiary. **NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
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.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and ZIP code of the facility where services were performed.
33.	Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
	PIN #	This field is not required for Medicaid.
	GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."