



Arkansas Department of Human Services

Division of Medical Services

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TO: Arkansas Medicaid Health Care Providers – Certified Nurse-Midwife
DATE: July 1, 2005
SUBJECT: Provider Manual Update Transmittal No. 59

REMOVE

| Section | Date |
|-------------------|----------|
| 202.000 | 10-13-03 |
| 272.430 – 272.431 | 10-13-03 |
| 272.451 | 10-13-03 |
| 272.493 | 10-13-03 |
| 272.495 | 10-13-03 |

INSERT

| Section | Date |
|-------------------|--------|
| 202.000 | 7-1-05 |
| 272.430 – 272.431 | 7-1-05 |
| 272.451 | 7-1-05 |
| 272.493 | 7-1-05 |
| 272.495 | 7-1-05 |

Explanation of Updates

Section 202.000 has been revised to add a statement informing certified nurse-midwife providers that persons or 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.

Sections 272.430 and 272.431 have been revised to include correct procedure codes, changes in modifiers effective July 1, 2005, and correct billing instructions for family planning services.

Section 272.451 has been revised to include correct procedure codes for specimen collection.

Section 272.493 has been revised to include the correct modifier and to provide information about a modifier change to be effective July 1, 2005.

Section 272.495 has been revised to include benefit limits in service descriptions and to include correct procedure code with modifiers. Modifier changes effective July 1, 2005 are included as well.

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.

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.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

202.000

Arkansas Medicaid Participation Requirements for Certified Nurse-Midwife Providers

7-1-05

All providers of certified nurse-midwife services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

- A. The provider must complete a provider application (DMS-652), a Medicaid contract (DMS-653) and a Request for Taxpayer Identification Number and Certification (W-9). [View or print a provider application \(DMS-652\), a Medicaid contract \(DMS-653\) and a Request for Taxpayer Identification Number and Certification \(W-9\).](#)
- B. A current copy of the certified nurse-midwife license from the Arkansas State Board of Nursing must accompany the provider application and Medicaid contract. Subsequent renewals of license must be provided when issued.
- C. The certified nurse-midwife who provides intrapartum care must have a consulting agreement with a Medicaid enrolled physician and must furnish the name of the consulting physician with the provider application and the Medicaid contract. The consulting physician must be available within thirty (30) minutes of the hospital admitting the certified nurse-midwife's laboring patients or within thirty (30) minutes of the alternative birth site if the patient is not transported to the hospital.
- D. Subsequent changes in the name of the consulting physician must be immediately provided to Arkansas Medicaid.
- E. The certified nurse-midwife who has prescriptive authority must furnish the Certificate of Prescriptive Authority Number issued by the Arkansas State Board of Nursing with the provider application and Medicaid contract. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.
- F. The provider application and the Medicaid contract 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.

272.430 Family Planning Services Program Procedure Codes

7-1-05

The following list contains Family Planning Services Program procedure codes payable to certified nurse-midwives. Certified nurse-midwives must use Type of Service (paper only) code "A" with these procedure codes. All procedure codes in this table require a family planning diagnosis code in each claim detail.

| Procedure Code | Required Modifier(s) | Description |
|----------------|---|--|
| A4260 | FP | Norplant System (Complete Kit) |
| J1055 | FP | Medroxyprogesterone Acetate for contraceptive use |
| J7300 | FP | Intrauterine Copper Contraceptive |
| J7302 | FP | Levonorgestrel-Releasing Intrauterine Contraceptive System |
| S0612* | FP, SB, 52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52. | Annual Post-Sterilization Visit |
| 11975 | FP, SB | Implantation of Contraceptive Capsules |
| 11976 | FP, SB | Removal of Contraceptive Capsules |
| 11977 | FP, SB | Removal and Reinsertion of Contraceptive Capsules |
| 36415 | FP | Collection of Venous Blood by Venipuncture |
| 58300 | FP, SB | Insertion of Intrauterine Device |
| 58301 | FP, SB | Removal of Intrauterine Device |
| 99402 | FP, SB | Basic Family Planning Visit |
| 99401 | FP, SB, 22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22. | Periodic Family Planning Visit |

*HCPCS procedure code S0612 is unique to the Family Planning Services Demonstration Waiver. Women in the FP-W category (eligibility category 69) who have undergone sterilization are eligible only for this annual follow-up visit.

272.431 Family Planning Services Laboratory Procedure Codes

7-1-05

This table contains laboratory procedure codes payable in the Family Planning Services Program. They are also payable when used for purposes other than family planning. **When filing paper claims for** procedure codes in this table, **use** type of service code "A" when the service diagnosis indicates family planning. **For both electronic and paper claims, modifier FP must be used.**

| | | | | |
|-------|-------|-------|-------|-------|
| 81000 | 81001 | 81002 | 81003 | 81025 |
| 83020 | 83520 | 83896 | 84703 | 85014 |
| 85018 | 85660 | 86592 | 86593 | 86687 |
| 86701 | 87075 | 87081 | 87088 | 87210 |
| 87390 | 87470 | 87490 | 87590 | |

272.451 Specimen Collection

7-1-05

The policy in regard to collection, handling and/or conveyance of specimens is:

- A. Reimbursement will not be made for specimen handling fees.
- B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or (2) collecting a urine sample by catheterization.
- C. Specimen collection is not reimbursable when the provider collecting the specimen also performs laboratory tests on the specimen.

The following procedure codes **may** be used when billing for specimen collection:

P9612

P9615

36415

272.493 Obstetrical Care Without Delivery

7-1-05

Certified nurse-midwives may use procedure code **59425** with modifier **22** when billing for antepartum care without delivery (use for 1 – 3 visits). Effective for dates of service on and after July 1, 2005, providers must use modifier **UA** in place of modifier **22**.

Procedure code **59425** with no modifier may be used when filing claims for obstetrical care without delivery (use for 4 – 6 visits).

Procedure code **59426** may be used when filing claims for obstetrical care without delivery (use for 7 or more visits).

This procedure code enables certified nurse-midwives rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for their services provided. Coverage for this service will include routine sugar and protein analysis. One unit equals one visit. Units of service billed with this procedure code will not be counted against the patient's office visit benefit limit.

Providers must enter the "from" and "through" dates of service on the CMS-1500 claim form and the number of units being billed. One visit equals one unit of service. Providers must submit the claim within 12 months of the first date of service.

For example: An OB patient is seen by the certified nurse-midwife on 1-10-01, 2-10-01, 3-10-01, 4-10-01, 5-10-01 and 6-10-01. The patient then moves and begins seeing another provider prior to the delivery. The certified nurse-midwife may submit a claim with dates of service shown as 1-10-01 through 6-10-01 and 6 units of service entered in the appropriate field. This claim must be received by EDS prior to 12 months from 1-10-01 to fall within the 12-month filing deadline. The certified nurse-midwife must have on file the patient's medical record that reflects each date of service being billed.

272.495 Risk Management Services for Pregnancy

7-1-05

A certified nurse-midwife may provide the risk management services listed below if he or she employs the professional staff indicated in the service descriptions below. If a certified nurse-midwife does not choose to provide the risk management services but believes the patient would benefit from them, he or she may refer the patient to a clinic that offers risk management services for pregnancy. Each of the risk management services described in parts A through E has a limited number of units of service that may be furnished. Coverage of these risk management services is limited to a maximum of 32 cumulative units.

A. Risk Assessment

A medical, nutritional and psychosocial assessment by the certified nurse-midwife or registered nurse to designate patients as high or low risk.

1. Medical assessment using the Hollister Maternal/Newborn Record System or equivalent form to include:
 - a. Medical history
 - b. Menstrual history
 - c. Pregnancy history
2. Nutritional assessment to include:
 - a. 24-hour diet recall
 - b. Screening for anemia
 - c. Weight history
3. Psychosocial assessment to include criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: 2 units per pregnancy

Procedure code 99402 – modifiers SB, U1, 22

Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22.

B. Case Management Services

Services by a certified nurse-midwife, a licensed social worker or registered nurse that will assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational and other services. (Examples: locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver newborn, following-up to verify patient kept appointment, rescheduling appointment).

Maximum: 1 unit per month. A minimum of two contacts per month must be provided. A case management service contact may be with the patient, other professionals, family and/or other caregivers.

Low-risk: use procedure code 99402 – modifiers SB, U4, 22

High-risk: use procedure code 99402 – modifiers SB, U5, 22

Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22.

C. Perinatal Education

1. Educational classes provided by a health professional (Certified Nurse-Midwife, Public Health Nurse, Nutritionist or Health Educator) to include:
2. Pregnancy
3. Labor and delivery
4. Reproductive health
5. Postpartum care
6. Nutrition in pregnancy

Maximum: 6 classes (units) per pregnancy

Procedure code **99402** – modifiers **SB, 22**

Effective for dates of service on and after July 1, 2005, modifier **UA** must be used in place of modifier **22**.

D. Nutrition Consultation – Individual

Services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration to include at least one of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan or
2. Nutritional care plan follow-up and reassessment, as indicated.

Maximum: 9 units per pregnancy

Procedure code **99402** – modifiers **SB, U2, 22**

Effective for dates of service on and after July 1, 2005, modifier **UA** must be used in place of modifier **22**.

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker to include at least one of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan or
2. Social work plan follow-up, appropriate intervention and referrals.

Maximum: 6 units per pregnancy

Procedure code **99402** – modifiers **SB, U3, 22**

Effective for dates of service on and after July 1, 2005, modifier **UA** must be used in place of modifier **22**.

F. Early Discharge Home Visit

If a certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours), the certified nurse-midwife may provide a home visit to the mother and baby within 72 hours of the hospital discharge or the certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by certified nurse-midwife order (includes hospital discharge order).

A certified nurse-midwife may order a home visit for the mother and/or infant discharged later than 24 hours if there is specific medical reason for home follow-up.

Procedure codes: CPT procedure codes **99341, 99342, 99343, 99347, 99348 and 99349** as applicable.