Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 TDD: 501-682-6789 & 1-877-708-8191 Internet Website: www.medicaid.state.ar.us

TO: **Arkansas Medicaid Health Care Providers – Certified Nurse-Midwife**

DATE: **December 5, 2005**

SUBJECT: **Provider Manual Update Transmittal #66**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
272.430	10-1-05	272.430	12-5-05
272.493	7-1-05	272.493	12-5-05
272.495	7-1-05	272.495	12-5-05

Explanation of Updates

Sections 272.430, 272.493, and 272.495 are included in this update to revise the effective date for using the modifiers **UA** and **UB**. Effective for claims received on and after *December 5, 2005*, modifier **UA** must be used instead of modifier **22** and modifier **UB** must be used instead of modifier **52**.

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Roy Jeffus, Director

272.430 Family Planning Services Program Procedure Codes 12-5-05

The following list includes Family Planning Services Program procedure codes payable to certified nurse-midwives. When filing paper claims for family planning services, certified nurse-midwives must use type of service code **"A."** Applicable modifiers must be used for both electronic and paper claims. 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, UB	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, UA	Periodic Family Planning Visit

* Women in the FP-W category (eligibility category 69) who have undergone sterilization are eligible only for this annual follow-up visit.

272.493 Obstetrical Care Without Delivery 12-5-05

Certified nurse-midwives must use procedure code **59425** with modifier **UA** to bill for one to three visits for antepartum care without delivery.

Procedure code **59425** with no modifier must be used by providers to bill for four to six visits for antepartum care without delivery.

Use procedure code **59426** for seven or more visits for antepartum care without delivery.

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 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. 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 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. This claim must be received by EDS prior to 12 months from 1-10-05 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 12-5-05

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**, **UA**

B. Case Management Services

Services by a certified nurse-midwife, 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 perform delivery following-up to verify that the 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**, **UA**

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

C. Perinatal Education

Educational classes provided by a health professional (certified nurse-midwife, public health nurse, nutritionist or health educator) to include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health

4. Postpartum care
5. Nutrition in pregnancy

Maximum: 6 classes (units) per pregnancy

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

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**, **UA**

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**, **UA**

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 after delivery), 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 made 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 a specific medical reason for home follow-up.

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

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Fax: 501-682-2480 TDD: 501-682-6789 & 1-877-708-8191 Internet Website: www.medicaid.state.ar.us

TO: **Arkansas Medicaid Health Care Providers – Developmental Day Treatment Clinic Services (DDTCS)**

DATE: **December 5, 2005**

SUBJECT: **Provider Manual Update Transmittal #67**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
262.100 - 262.110	7-1-05	262.100 - 262.110	12-5-05

Explanation of Updates

Section 262.100 is included to revise the effective date for using **UB** modifier. Effective for claims received on and after December 5, 2005, modifier **UB** must be used with procedure code **T1023** in place of modifier **52**.

Section 262.110 is included to revise the effective date for using **UB** modifier. Effective for claims received on and after December 5, 2005, modifier **UB** must be used with procedure code **97110**, **97150**, **92507** and **92508** instead of modifier **52**.

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262.100 DDTCS Core Services Procedure Codes 12-5-05

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.

Procedure 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	UB	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 12-5-05

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

Procedure 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)
97150	U1, UB	Group occupational therapy by occupational therapy assistant (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)
97150	U2	Group occupational therapy (15-minute unit; maximum of 4 units per day, maximum of 4 clients per group)
97530	—	Individual occupational therapy (15-minute unit; maximum of 4 units per day)
97530	UB	Individual occupational therapy by occupational therapy assistant (15-minute unit; maximum of 4 units per day)

B. Physical Therapy Procedure Codes

Procedure 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)

97110	UB	Individual physical therapy by physical therapy assistant (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)
97150	U1, UB	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

Procedure 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)
92507	UB	Individual speech therapy by speech language pathology assistant (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)
92508	UB	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 benefits 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**

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Fax: 501-682-2480 **TDD: 501-682-6789 & 1-877-708-8191** **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers – Nurse Practitioner**

DATE: **December 5, 2005**

SUBJECT: **Provider Manual Update Transmittal #59**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
252.430	7-1-05	252.430	12-5-05
252.450	7-1-05	252.450	12-5-05

Explanation of Updates

Sections 252.430 and 252.450 are included in this update to revise the effective date for using **UA** and **UB** modifiers. Effective for claims received on and after *December 5, 2005*, modifier **UA** must be used instead of modifier **22** and modifier **UB** must be used instead of modifier **52**.

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Roy Jeffus, Director

252.430 Family Planning Services Program Procedure Codes 12-5-05

The following table contains Family Planning Services Program procedure codes payable to nurse practitioners. For claims filed on paper, type of service (TOS) code **"A"** is required with these procedure codes. All of the following procedure codes require a family planning diagnosis code in each claim detail.

Procedure Code	Required Modifiers	Description
A4260	FP	Norplant System (Complete Kit)
J1055	FP	Medrozyprogesterone acetate for contraceptive use
J7300	FP	Supply of Intrauterine Device
J7302	FP	Levonorgestrel-releasing intrauterine contraceptive system
J7303	FP	Contraceptive supply, hormone containing vaginal ring
S0612*	FP, SA, UB	Annual Post-Sterilization Visit*
11975	FP, SA	Implantation of Contraceptive Capsules
11976	FP, SA	Removal of Contraceptive Capsules
11977	FP, SA	Removal and Reinsertion of Contraceptive Capsules
36415	FP	Routine venipuncture for blood collection
58300	FP,SA	Insertion of Intrauterine Device
58301	FP,SA	Removal of Intrauterine Device
99402	FP, SA	Basic Family Planning Visit
99401	FP, SA, UA	Periodic Family Planning Visit

* Women in the aid category 69, FP-W, who have undergone sterilization are eligible only for this annual follow-up visit.

252.450 Obstetrical Care and Risk Management Services for Pregnancy 12-5-05

Covered nurse practitioner obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A nurse practitioner may provide risk management services listed below if he or she receives a referral from the patient's physician or certified nurse-midwife and if the nurse practitioner employs the professional staff required. Complete service descriptions and coverage information may be found in section 214.620 of this manual. The services in the list below are considered to be one service and are limited to 32 cumulative units.

National Code	Required Modifiers	Description
99402	SA, U1, UA	Risk Assessment
99402	SA, U4, UA	Case Management Services, low-risk case
99402	SA, U5, UA	Case Management Services, high-risk case
99402	SA, UA	Perinatal Education
99402	SA, U3, UA	Social Work Consultation
99402	SA, U2, UA	Nutrition Consultation – Individual

For an early discharge home visit, use one of the applicable CPT procedure codes: **99341**, **99343**, **99347**, **99348** and **99349**.

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TO: **Arkansas Medicaid Health Care Providers – Physician/Independent Lab/ CRNA/Radiation Therapy Center**

DATE: **December 5, 2005**

SUBJECT: **Provider Manual Update Transmittal #103**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
262.000	7-1-05	262.000	12-5-05
292.510	7-1-05	292.510	12-5-05
292.521	7-1-05	292.521	12-5-05
292.550	7-1-05	292.550	12-5-05
292.675 – 292.676	Dates vary	292.675 – 292.676	12-5-05
292.700	7-1-05	292.700	12-5-05
292.822	7-1-05	292.822	12-5-05

Explanation of Updates

Minor wording changes and corrections of grammatical errors are included throughout the update.

Sections 262.000, 292.510, 292.521, 292.550, 292.675, 292.700, and 292.822 are included in this update to revise the effective date for using **UA** and **UB** modifiers. Effective for claims received on and after *December 5, 2005*, modifier **UA** must be used instead of modifier **22** and modifier **UB** must be used instead of modifier **52**.

Section 292.676 is included to advise providers that effective for claims received on and after *December 5, 2005,* modifier **UA** must be used with procedure code **99402** in place of modifier **22** for risk management services. Unnecessary information has been removed from this section.

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262.000 Procedures That Require Prior Authorization 12-5-05

A. Effective March 1, 2005, procedure codes **22520, 22521** and **22522** became payable without prior authorization.

B. The following procedure codes require prior authorization:

Procedure Codes							
J7320	J7340	S0512	V5014	00170	01964	11960	11970
11971	15342	15343	15400	15831	19316	19318	19324
19325	19328	19330	19340	19342	19350	19355	19357
19361	19364	19366	19367	19368	19369	19370	19371
19380	20974	20975	21076	21077	21079	21080	21081
21082	21083	21084	21085	21086	21087	21088	21089
21120	21121	21122	21123	21125	21127	21137	21138
21139	21141	21142	21143	21145	21146	21147	21150
21151	21154	21155	21159	21160	21172	21175	21179
21180	21181	21182	21183	21184	21188	21193	21194
21195	21196	21198	21199	21208	21209	21244	21245
21246	21247	21248	21249	21255	21256	27412	27415
29866	29867	29868	30220	30400	30410	30420	30430
30435	30450	30460	30462	32851	32852	32853	32854
33140	33282	33284	33945	36470	36471	37785	37788
38240	38241	38242	42820	42821	42825	42826	42842
42844	42845	42860	42870	43257	43644	43645	43842
43843	43845	43846	43847	43848	43850	43855	43860
43865	47135	48155	48160	48554	48556	50320	50340
50360	50365	50370	50380	51925	54360	54400	54415
54416	54417	55400	57335	58150	58152	58180	58260
58262	58263	58267	58270	58280	58290	58291	58292
58293	58294	58345	58550	58552	58553	58554	58672
58673	58750	58752	59135	59840	59841	59850	59851
59852	59855	59856	59857	59866	60512	61850	61860
61862	61870	61875	61880	61885	61886	61888	63650
63655	63660	63685	63688	64573	64585	64809	64818
65710	65730	65750	65755	67900	69300	69310	69320
69714	69715	69717	69718	69930	76012	76013	87901
87903	87904	92081	92100	92326	92393	93980	93981

Procedure Code	Modifier	Description
E0779	RR	Ambulatory infusion device
D0140	EP	EPSDT interperiodic dental screen
L8619	EP	External sound processor
S0512		Daily wear specialty contact lens, per lens
V2501	UA	Supplying and fitting Keratoconus lens (hard or gas permeable) - 1 lens
V2501	U1	Supplying and fitting of monocular lens (soft lens) - 1 lens
92002	UB	Low vision services - low vision evaluation

292.510 Dialysis 12-5-05

A. Hemodialysis

The following procedure codes must be used by the nephrologist when billing for acute hemodialysis on hospitalized patients. Class I and Class II must have a secondary diagnosis listed to justify the level of care billed. Hemodialysis must be billed with type of service code (paper claims only) **"1"**.

Procedure Code	Required Modifier	Description
90937		Class I – Acute renal failure complicated by illness or failure of other organ systems
90935		Class II – Acute renal failure without failure of other organ systems but with other dysfunction in other areas requiring attention
99221 99231	U1 U1	Class III – Acute renal failure with minor or no other complicating medical problems

These are global codes. Hospital visits are included and must not be billed separately.

B. Peritoneal Dialysis

The following procedure codes must be used when billing for physician inpatient management of peritoneal dialysis. Class I and Class II must have a secondary diagnosis code listed to justify the level of care billed. Peritoneal dialysis must be billed with type of service code (paper only) **"1."**

Procedure Code	Required Modifier(s)	Description
90947		Class I – Acute renal failure complicated by illness or failure of other organ systems (peritoneal dialysis)
90945		Class II – Acute renal failure, without failure of other organ systems but with dysfunction in other areas receiving attention (peritoneal dialysis)
99221 99231	UB UB	Class III – Acute renal failure with minor or no other complicating medical problems

These are global codes. Hospital visits are included and must not be billed separately.

C. Outpatient Management of Dialysis

The Arkansas Medicaid Program will reimburse for outpatient management of dialysis under procedure codes **90922**, **90923**, **90924** and **90925**.

One day of dialysis management equals one unit of service. A provider may bill one day of outpatient management for each day of the month unless the beneficiary is hospitalized. When billing for an entire month of management, be sure to include the dates of management in the "Date of Service" column. Only one month of management must be reflected per claim line with a maximum of 31 units per month. If a patient is hospitalized, these days must not be included in the monthly charge. These days must be split billed. An example is:

Date of Service	Procedures, Services, or Supplies CPT/HCPCS	Days or Units
6-1-05 through 6-14-05	90922	14
6-21-05 through 6-30-05	90922	11

Arkansas Medicaid also covers Iron Dextran for beneficiaries of all ages who receive dialysis due to acute renal failure. Use procedure code **J1750** when administering in a physician's office. Units billed are equal to the milliliters administered (1 unit = 50 mg).

Procedure code **J0636** (Injection, Calcitrol, 1 mcg, ampule) is payable for eligible Medicaid beneficiaries of all ages who receive dialysis due to acute renal failure (diagnosis codes 584 - 586).

292.520 Evaluations and Management 7-1-05

292.521 Consultations 12-5-05

When billing for office consultations when the place of service is the provider's office (POS: Paper **3**/Electronic **11**) or inpatient hospital (POS: Paper **1**/Electronic **21**), use the appropriate CPT procedure codes according to the description of each level of service. When filing paper claims, use type of service code **"1."**

The consultation procedure codes listed below must be used when the place of service is outpatient hospital or emergency room-hospital (POS: Paper **2** or **X**, respectively/Electronic **22** or **23**, respectively) or ambulatory surgical center (POS: Paper **B**/Electronic **24**).

Procedure Code	Required Modifier(s)	Description
99241	UA, UB	Other Outpatient Consultation for a new or established patient, which requires these three key components: A problem-focused history, A problem-focused examination and Straightforward medical decision-making.
99242	UA, UB	Other Outpatient Consultation for a new or established patient, which requires these three key components: An expanded problem-focused history, An expanded problem-focused examination and Straightforward medical decision-making.
99243	UA, UB	Other Outpatient Consultation for a new or established patient, which requires these three key components: A detailed history; A detailed examination and Medical decision making of low complexity.
99244	U1, UA	Other Outpatient Consultation for a new or established patient, which requires these three key components: A comprehensive history, A comprehensive examination and Medical decision making of moderate complexity.

Procedure Code	Required Modifier(s)	Description
99245	U1, UA	Other Outpatient Consultation for a new or established patient, which requires these three key components: A comprehensive history, An expanded problem-focused examination and Medical decision making of high complexity.

Medicaid does not cover follow-up consultations. A consulting physician assuming care of a patient is providing a primary evaluation and management service and bills Medicaid accordingly within CPT standards.

For information on benefit limits for all consultation (inpatient and outpatient) refer to section 226.100 of this manual.

292.550 Family Planning Services Program Procedure Codes 12-5-05

The following table contains Family Planning Services Program procedure codes payable to physicians. Physicians must use type of service code (paper only) **"A"** with these procedure codes. All procedure codes in this table require a family planning or sterilization diagnosis code in each claim detail.

Procedure Codes							
11975	11976	11977	55250	55450	58300	58301	58600
58605	58611	58615	58661*	58670	58671	58700*	J1055

* CPT codes **58661** and **58700** represent procedures to treat medical conditions as well as for elective sterilizations. When filing paper claims for either of these services for elective sterilizations, enter type of service code **"A"**. When using either of these codes for treatment of a medical condition, type of service code **"2"** must be entered for the primary surgeon or type of service code **"8"** for an assistant surgeon.

Effective for dates of service on and after April 1, 2005, procedure code **58565** is covered as a family planning service. Procedure code **58565** includes payment for the device.

Procedure Code	Modifier(s)	Description
A4260	FP	Norplant System (Complete Kit)
J7300	FP	Supply of Intrauterine Device
J7302	FP	Levonorgestrel-releasing intrauterine contraceptive system
J7303	FP	Contraceptive Supply, Hormone Containing Vaginal Ring
S0612**	FP, TS	Annual Post-Sterilization Visit (This procedure code is unique to aid category 69, FP-W. After sterilization, this is the only service covered for individuals in aid category 69.)
36415		Routine Venipuncture for Blood Collection
99401	FP, UA, UB	Periodic Family Planning Visit
99401	FP, UA, U1	Arkansas Division of Health Periodic/Follow-Up Visit
99402	FP, UA	Arkansas Division of Health Basic Visit
99402	FP, UA, UB	Basic Family Planning Visit
99401	FP, UA, U1	Arkansas Dept. of Health Periodic/Follow-Up Visit

When filing family planning claims for physician services in an outpatient clinic, use modifiers **U6**, **UA** for the basic family planning visit and the periodic family planning visit. If filing on paper, use type of service code **"J"**.

292.675 Obstetrical Care Without Delivery 12-5-05

Obstetrical care without delivery may be billed using procedure code **59425**, modifier **UA**, and procedure code **59426** with no modifier.

These procedure codes enable physicians rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for these services. Units of service billed with these procedure codes will not be counted against the patient's physician visit benefit limit and will include routine sugar and protein analysis. Other lab tests must be billed separately and within 12 months of the date of service.

The procedure codes must be billed with a type of service code **"1"** when filing paper claims. Providers must enter the dates of service in the CMS-1500 claim format 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.

View a CMS-1500 sample form.

For example: An OB patient is seen by Dr. Smith on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another physician prior to the delivery. Dr. Smith may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. EDS must receive the claim within the 12 months from the first date of service. Dr. Smith must have on file the patient's medical record that reflects each date of service being billed. Dr. Smith must bill the appropriate code: **59425** with modifier **UA** for antepartum care only (4-6 visits) or **59426** for antepartum care only (7 or more visits).

292.676 Risk Management for Pregnancy 12-5-05

A physician may provide risk management services for pregnant women if he or she employs the professional staff indicated in service descriptions found in section 247.200 of this manual. These services may be billed separately from obstetrical fees. The services in the list below are considered to be one service and are limited to 32 cumulative units. Use the modifiers when filing claims to identify the service provided.

Procedure Code	**Modifier(s)**	**Description**
99402	U1, UA	Risk Assessment
99402	U4, UA	Case Management Services, low-risk
99402	U5, UA	Case Management Services, high-risk
99402	UA	Perinatal Education
99402	U3, UA	Social Work Consultation
99402	U2, UA	Nutrition Consultation – Individual

For early discharge home visits, use one of the applicable CPT procedure codes: **99341**, **99343**, **99347**, **99348**, and **99349**.

292.700 Physical and Speech Therapy Services 12-5-05

Occupational therapy services are payable only to a qualified occupational therapist. Some speech and physical therapy services may be payable to the physician, when provided. The following procedure codes must be used when filing claims for therapy services.

Procedure Code	Modifier(s)	Description	Benefit Limit
92506		Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation	30-minute unit. Maximum of 4 units per State Fiscal Year (July 1 through June 30)
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
97110	UB	Individual Physical Therapy by Physical Therapy Assistant	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
97150	UB	Group Physical Therapy by Physical Therapy Assistant	15-minute unit. Maximum of 4 units per day; Maximum of 4 clients per group

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extension of the benefit may be requested for physical and speech therapy if medically necessary for Medicaid beneficiaries under the age of 21.

Refer to section 227.000 of this manual for more information on benefit limits.

292.822 Billing for Renal (Kidney) Transplants 12-5-05

A. The following CPT procedure codes are payable for renal transplants with prior approval: **50320**, **50340**, **50360**, **50365**, **50370** and **50380**. CPT procedure code **50300** is non-payable.

1. A separate claim must be filed for the donor. If the donor is not Medicaid eligible, the claim should be filed under the Medicaid beneficiary's name and Medicaid ID number. Diagnosis code V59.4 (Donors, kidney) must be used for the renal donor and diagnosis code V70.8 (Other specified general medical examination - examination of potential donor of organ or tissue) must be used for the tissue typing of the donor.

2. If the donor is a Medicaid beneficiary, the claim must be filed utilizing the donor's Medicaid ID number. However, the diagnosis codes listed above must be used.

B. HCPCS procedure code **A0434**, modifier **UA**, must be used by providers billing for the transportation and preservation of the cadaver kidney. The physician must bill HCPCS procedure code **A0434**, modifier **UA**, on the claim in conjunction with the transplant surgery. An itemized statement for the transportation and preservation of the kidney must accompany form CMS-1500. **View a CMS-1500 sample form.**