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TO: **Arkansas Medicaid Podiatrist Health Care Providers**

DATE: **August 1, 2004**

SUBJECT: **Provider Manual Update Transmittal No. 45**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
211.000 – 212.000	10-13-03	211.000 – 212.000	8-1-04
242.100 – 242.110	10-13-03	242.100 – 242.110	8-1-04
242.130	10-13-03	242.130	8-1-04
242.310	10-13-03	242.310	8-1-04
242.440 – 242.450	10-13-03	242.440	8-1-04

Explanation of Updates

Section 211.000 has been included to establish a link to the Glossary.

Section 212.000 has been revised to advise that podiatrist services are covered for Medicaid eligible individuals of all ages and require a primary care physician (PCP) referral.

Section 242.100 has been updated to correct typographical errors in the list of procedure codes. Current Procedural Terminology (CPT) procedure codes 11731 and 28358 have been removed because they have been deleted from the CPT handbook.

Section 242.110 has been revised to remove procedure code 11731, which has been deleted in the CPT handbook. The title of this section has been revised to “Procedure Codes Payable in a Nursing Care Facility”.

Section 242.130 has been revised to remove procedure code 85022, which has been deleted from the CPT handbook.

Section 242.310, number 17, has been revised to advise that PCP referral is required for podiatrist services.

Section 242.440 has been revised and titled “Bilaminate Graft or Skin Substitute Procedures”. The section was previously titled “New Patient Visit”. That information is also found in section 214.100.

Section 242.450 has been deleted.

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.

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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**.

211.000 Introduction 8-1-04-

A. The Arkansas Medicaid Program reimburses enrolled providers for the medical care of eligible Medicaid recipients.

B. Medicaid reimbursement is conditional upon providers' compliance with program policy as stated in provider manuals, manual update transmittals and official program correspondence.

C. All Medicaid benefits are based on medical necessity. Refer to the Glossary for a definition of medical necessity. **View or print the Glossary.**

1. Service coverage will be denied and reimbursement recouped if a service is not medically necessary.
2. The finding of medical necessity may be made by any of the following:
   a. Medical Director for the Medicaid Program
   b. Quality Improvement Organization (QIO)
   c. Peer Review Committee for the Medicaid Program

212.000 Scope 8-1-04

A. The Arkansas Medicaid Program covers podiatrist services through 42 Code of Federal Regulations, Section 440.60.

B. Arkansas Medicaid covers podiatrist services for eligible Medicaid recipients of all ages.

C. Podiatrist services require a primary care physician (PCP) referral.

D. Podiatrist services include, but are not limited to, office and outpatient services, home visits, office and inpatient consultations, laboratory and X-ray services, physical therapy and surgical services. Section 242.100 contains the full list of procedure codes applicable to podiatrist services.

A. Many podiatrist services covered by the Arkansas Medicaid Program are restricted or limited.

1. Section 214.000 describes the benefit limits on the *quantity* of covered services clients may receive.
2. Section 220.000 describes *prior authorization requirements* for certain services.

242.100 Procedure Codes 8-1-04

The following list of procedure codes must be used to bill for podiatrist's services. Several procedure codes from the large list below are payable only in certain situations that are described in separate sections.

A. Procedure codes that must be billed when services are provided in a nursing care facility are located in Section 242.110.

B. Procedure codes requiring prior authorization before services may be provided are located in Section 242.120.

C. Procedure codes payable for laboratory and X-ray services are located in Section 242.130.

D. Procedure code 99238, Hospital Discharge Day Management, may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes 99221 through 99233). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

E. In addition to the CPT codes shown below, T1015 (Z0636), an HCPCS code, is also a payable code for podiatrists.

The listed procedure codes and their descriptions are located in the *Physician's Current Procedural Terminology (CPT) book*. Section III of the Podiatrist Manual contains information on how to purchase a copy of the CPT publication.

Procedure Codes							
J7340	10060	10061	10120	10140	10160	11000	11040
11041	11042	11055	11056	11057	11100	11200	11420
11421	11422	11423	11424	11426	11620	11621	11622
11623	11624	11626	11719	11720	11721	11730	11732
11740	11750	11752	11760	11762	12001	12002	12004
12020	12021	12041	12042	12044	13131	13132	13160
14040	14350	15000	15001	15050	15100	15101	15120
15121	15220	15221	15240	15241	15342	15343	15620
15999	16000	16010	16015	17000	17003	17004	17110
17111	17999	20000	20005	20200	20205	20206	20220
20225	20240	20500	20501	20520	20525	20550	20600
20605	20650	20670	20680	20900	20910	20974	20975
28001	28002	28003	28005	28008	28010	28011	28020
28022	28024	28030	28035	28043	28045	28046	28050
28052	28054	28060	28062	28070	28072	28080	28086
28088	28090	28092	28100	28102	28103	28104	28106
28107	28108	28110	28111	28112	28113	28114	28116
28118	28119	28120	28122	28124	28126	28130	28140
28150	28153	28160	28171	28173	28175	28190	28192

28193	28200	28202	28208	28210	28220	28222	28225
28226	28230	28232	28234	28238	28240	28250	28260
28261	28262	28264	28270	28272	28280	28285	28286
28288	28290	28292	28293	28294	28296	28297	28298
28299	28300	28302	28304	28305	28306	28308	28310
28312	28313	28315	28320	28322	28340	28341	28344
28345	28360	28400	28405	28406	28415	28420	28430
28435	28436	28445	28450	28455	28456	28465	28470
28475	28476	28485	28490	28495	28496	28505	28510
28515	28525	28530	28540	28545	28546	28555	28570
28575	28576	28585	28600	28605	28606	28615	28630
28635	28645	28660	28665	28666	28675	28705	28715
28725	28730	28735	28737	28740	28755	28760	28800
28805	28810	28820	28825	28899	29345	29355	29358
29365	29405	29425	29435	29440	29445	29450	29505
29515	29520	29540	29550	29580	29750	29893	29894
29895	29897	29898	64450	64550	64704	64782	73592
73600	73610	73615	73620	73630	73650	73660	82962
87070	87101	87102	87106	87184	93922	93923	93924
93925	93926	93930	93931	93965	93970	93971	95831
95851	99201	99202	99203	99204	99205	99211	99212
99213	99214	99215	99221	99222	99223	99231	99232
99233	99238	99241	99242	99243	99244	99245	99251
99252	99253	99254	99255	99271	99272	99273	99281
99282	99283	99284	99301	99302	99303	99341	99342
99343	99347	99348	99349				

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.

242.110 Procedure Codes Payable in a Nursing Care Facility 8-1-04

The following procedure codes must be billed when services are provided in a nursing care facility.

10060	10061	10120	10160	11040	11055	11056	11057
11200	11420	11421	11422	11423	11424	11426	11720

11721	11730	11732	11740	11750	12001	12020	12021
12041	16000	20550	28190	28630	28660	82962	87070
87102							

242.130 Procedure Codes Payable for Laboratory and X-Ray Services 8-1-04

The following procedure codes may be billed for laboratory and X-ray services. Section 214.300 contains information regarding the $500.00 benefit limit for laboratory and X-ray services established for individuals age 21 and over.

73592	73600	73610	73615	73620	73630	73650
73660	82962	87070	87101	87102	87106	87184

242.310 Completion of CMS-1500 Claim Form 8-1-04

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	Primary Care Physician (PCP) referral is required for Podiatrist Services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
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	Not applicable to Podiatrist Services.
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 CMS 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 242.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 242.200 for codes.
D. Procedures, Services or Supplies	.
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 242.100 through 242.130.
Modifier	Not applicable to Podiatrist Services claims.
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 Field 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. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the recipient, unless the recipient has an insurer that requires co-pay. In such a case, enter the sum of the insurer's payment and the recipient's co-pay. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 28 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#."

242.440 Bilaminate Graft or Skin Substitute Procedures 8-1-04

Arkansas Medicaid will reimburse physicians who furnish the manufactured viable bilaminate graft or skin substitute. The product is manually priced and requires paper claims using procedure code **J7340**, type of service code 1. The manufacturer's invoice and the operative report must be attached.

Application procedures of bilaminate skin substitute are payable to the physician using procedure codes **15342** and **15343.** These codes must be listed separately when filing claims.

Surgical preparation procedures using, procedure codes **15000** and **15001** may be reimbursed when performed at the same surgical setting. These codes must be listed separately in addition to the primary procedure and do not require PA.