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200.000 VENTILATOR EQUIPMENT GENERAL INFORMATION

201.000	Arkansas Medicaid Participation Requirements for Providers of Ventilator Equipment	11-1-09
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Ventilator equipment providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual to be eligible to participate in the Arkansas Medicaid Program.

The provider must have a registered respiratory therapist on staff that is licensed to practice in the State of Arkansas. A current copy of the respiratory therapist's license must accompany the provider application and Medicaid contract.

Providers who have agreements with Medicaid to provide other services to Medicaid beneficiaries must have a separate provider application and Medicaid contract to provide ventilator equipment. A separate provider number is assigned.

201.100 Ventilator Equipment in States Not Bordering Arkansas

3-1-11

- A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, providers must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. [View or print the provider enrollment and contract package \(Application Packet\).](#) [View or print Provider Enrollment Unit contact information.](#)

- B. Limited services providers remain enrolled for one year.
1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.
 2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
 3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

202.000 Documentation Requirements

11-1-09

Ventilator equipment providers are required to keep and properly maintain written records. Records must be developed and sufficient written documentation must be maintained to support each service for which billing is made.

- A. Physician's prescription of medical necessity for ventilator equipment stating prognosis, diagnosis and length of need for ventilator.
- B. Physician's prescription of changes in ventilator settings.
- C. Therapist's visit log documenting date and time, ventilator adjustments and patient's condition. Check and document machine calibrations.
- D. Documentation to reflect that the necessary training and orientation has been provided to the family and primary care givers.

203.000 The Ventilator Equipment Provider's Role in the Child Health Services (EPSDT) Program

10-13-03

The Arkansas Medical Assistance Program includes a Child Health Services (Early and Periodic Screening, Diagnosis and Treatment) (EPSDT) Program for eligible individuals under 21 years of age. The purpose of this program is to detect and treat health problems in their early stages.

Any enrolled Arkansas Medicaid provider rendering services not covered by the Arkansas Medicaid Program to a participant in the Child Health Services (EPSDT) Program who has been referred for services as a result of an EPSDT screen/referral will be reimbursed for the services rendered if the services are medically necessary and permitted under federal Medicaid regulations.

When a provider performs a Child Health Services (EPSDT) screen and/or refers the patient to another provider for services not covered by Arkansas Medicaid, the referring provider must give the beneficiary a prescription for the services. The prescription must indicate the services being prescribed and state the services are being prescribed due to a Child Health Services (EPSDT) screen.

210.000 PROGRAM COVERAGE

211.000 Introduction

10-13-03

Medicaid is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Reimbursement may be made for ventilator equipment within the Medicaid Program's limitations. These services are covered by the Medicaid Program under the prosthetic devices category.

212.000 Scope

10-13-03

Ventilator equipment in the beneficiary's place of residence may be covered only when determined to be medically necessary and prescribed by a physician.

"Place of residence" is defined as the beneficiary's own dwelling, an apartment, a relative's home or a nursing facility. Ventilator equipment is not covered in a boarding home or a residential care facility.

The prescription for ventilator equipment must be written on the Medical Equipment Request for Prior Authorization and Prescription (Form DMS-679). [View or print form DMS-679 and instructions for completion.](#)

The provider of ventilator equipment is responsible for ensuring credentialed individuals experienced in emergency airway management, CPR, respiratory care procedures and ventilator operation and maintenance are assigned to manage the ventilator patient. These individuals must be available 24 hours/day, 7 days/week.

213.000 Coverage of Ventilator Equipment

9-1-05

Ventilator equipment is covered for an eligible beneficiary who:

- A. Is medically dependent on a ventilator for life support at least 6 hours per day;
- B. Has been medically dependent for at least 20 consecutive days as an inpatient. The continuous stay may be in any one or more of the following facilities: hospital, nursing facility or intermediate care facility for the mentally retarded;
- C. But for the availability of the respiratory care services (ventilator equipment), would require respiratory care on an inpatient basis for which Medicaid would pay;
- D. Has adequate social support services to be cared for at home;
- E. Wishes to be cared for at home and

- F. Receives services under the direction of a pulmonary physician who is familiar with the technical and medical components of home ventilator support and has medically determined that in-home care is safe and feasible for the individual.

214.000 Medical Criteria and Guidelines for Coverage of Ventilator Equipment

214.100 Medical Criteria and Guidelines for Coverage of Volume Control Ventilator Equipment

8-1-09

The following medical criteria and guidelines are utilized in evaluation coverage of volume control ventilator equipment with invasive interface:

- A. Selection of patient
 - 1. Failure of aggressive weaning attempts is determined by a pulmonary physician.
 - 2. Maximal treatment of underlying disease, airway obstruction and/or complications as determined by a pulmonary physician.
 - 3. Stable medical condition with routine medical regimen established, e.g., oral meds, no IVs, stable ABGs.
- B. Specific factors to be assessed
 - 1. Medical
 - a. Adequate weaning trial
 - b. Stable ventilator status
 - c. Stable arterial blood gases
 - d. All reversible factors addressed, e.g., bronchospasm, increased lung fluids, infection, etc.
 - e. Renewals require continued care by physician with the last physical examination occurring within one year by the pulmonologist. Documentation of the pulmonary examination is required within twelve months of the beginning date of renewal.
 - f. The plan for weaning the pediatric patient with potentially reversible disease from ventilator support must be addressed and evaluated by the pulmonologist on a regular basis, at least annually.
 - 2. Family resources
 - a. Members
 - b. Primary care provider
 - c. Ability of family to provide care
 - d. Need for skilled nursing care
 - e. Motivation of patient and/or family
 - 3. Home environment
 - a. Adequate space
 - b. Electricity
 - c. Water
 - d. Availability of respiratory equipment
 - e. Building codes and/or limitations
 - f. Emergency communication system
 - 4. Nursing home environment

- a. Nursing facility
- b. Adequate personnel available
- c. Personnel trained in ventilator use and emergency care for ventilator patient

Beneficiaries under age 21 must have a current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening/referral. This requirement will be waived only for a request for a hospitalized child.

214.200 Medical Criteria and Guidelines for Coverage of Pressure Support Ventilator Equipment

8-1-09

The following medical criteria and guidelines are utilized in coverage of pressure support ventilator equipment with invasive interface:

- A. Selection of patient
 1. Infants, patients with weak respiratory muscles and those with chronic severe lung disease.
 2. Beneficiary is dependent on ventilator support more than six (6) hours per day
 3. Twenty (20) consecutive days as an inpatient prior to home ventilation
- B. Medical Necessity for the Pressure Support Ventilator
 1. Compromised airway or musculature and respiratory drive and a desire to breathe
 2. Compromised respiratory muscles from muscular dystrophies or increased resistance from airway anomalies or scoliosis conditions
 3. Other neurological disorders or thoracic disorders.
- C. Specific Factors to be assessed
 1. Medical
 - a. Adequate weaning trial
 - b. Stable ventilator status
 - c. Stable arterial blood gasses
 - d. All reversible factors addressed, e.g., bronchospasm, increased lung fluids, infection, etc.
 - e. Renewals require continued care by physician with the last physical examination occurring within one year by the pulmonologist. Documentation of the pulmonary examination is required within twelve (12) months of the beginning date of renewal.
 - f. The plan for weaning the pediatric patient with potentially reversible disease from ventilator support must be addressed and evaluated by the pulmonologist on a regular basis, at least annually.
 2. Family Resources
 - a. Members
 - b. Primary care provider
 - c. Ability of family to provide care
 - d. Need for skilled nursing care
 - e. Motivation of patient and/or family
 3. Home Environment
 - a. Adequate space
 - b. Electricity

- c. Water
- d. Availability of respiratory equipment
- e. Building codes and/or limitations
- f. Emergency communication system
- 4. Nursing Home Environment
 - a. Nursing facility
 - b. Adequate personnel available
 - c. Personnel trained in ventilator use and emergency care for ventilator patient

Beneficiaries under age 21 must have a current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening/referral. This requirement will be waived only for a request for a hospitalized child.

214.300 Guidelines for Coverage of Negative Pressure Ventilator Equipment 8-1-09

Coverage of negative pressure ventilator equipment is considered on a case-by-case basis. The request must be accompanied by supporting documentation from a qualified pulmonary physician.

Beneficiaries under age 21 must have a current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening/referral. This requirement will be waived only for a request for a hospitalized child.

NOTE: A negative pressure ventilator must not be billed for a volume control ventilator or a pressure support ventilator being used to administer respiratory assistance via a nasal and/or oral mask interface.

215.000 Reserved 8-1-09

216.000 Exclusions 10-13-03

Ventilator equipment will not be authorized for use by a beneficiary in a boarding home, residential care facility or any other type of institution not defined as the place of residence.

217.000 Rental of Used Equipment 10-13-03

Rental of "used equipment" is covered. If used equipment is provided, the supplier must offer a limited warranty that provides the following:

- A. Guarantee that the used equipment is in good working order and has no defects in workmanship or material.
- B. If the equipment fails within half the period of time specified by the manufacturer's warranty for new equipment, the supplier will pay for the replacement (including labor costs) of faulty parts or will replace the item of equipment with another.

218.000 Coverage of Private Duty Nursing Services for Ventilator-Dependent Beneficiaries 9-1-05

Private duty nursing services may be covered for Medicaid-eligible ventilator-dependent beneficiaries when determined medically necessary and prescribed by a physician. Prior authorization is required. The request for prior authorization must originate with the provider of private duty nursing services. See the Private Duty Nursing Program Manual for complete information and instructions.

219.000 Coverage of Respiratory Therapy Services 10-13-03

The Arkansas Medicaid Program covers respiratory care services for Ventilator-dependent eligible Medicaid beneficiaries under 21 years of age in the Child Health Services (EPSDT) Program. These services require prior authorization. The prior authorization request must specify the frequency of the therapist's visits as prescribed. Refer to Section 240.000 of this manual for the procedure codes and billing instructions.

220.000 PRIOR AUTHORIZATION

220.100 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

221.000 Prior Authorization (PA) 8-1-21

Reimbursement for ventilator equipment must have prior approval by DHS or its designated vendor. [View or print contact information to obtain instructions for submitting the request.](#)

222.000 Request for Prior Authorization 8-1-21

A request for prior authorization must originate with the provider of ventilator equipment. The provider is responsible for obtaining the required medical information and necessary prescription information needed for completion of form **DMS-679**. This form must be signed and dated by the physician. [View or print form DMS-679 and instructions for completion.](#)

Providers must specify the brand name/model of the ventilator on the prior authorization request.

The documentation submitted with the prior authorization request must support the medical necessity of the requested ventilator. If necessary additional information (i.e., original prescription, records from the hospitalization initiating the need for ventilator, etc.) shall be requested from the provider.

A prior authorization of ventilator equipment services does not guarantee payment.

Providers must note the date the ventilator is no longer in daily use.

222.100 Approvals of Prior Authorization 8-1-21

When a prior authorization (PA) request is approved, a prior authorization control number will be assigned and returned to the requesting provider.

Prior authorization approvals are authorized for a maximum of six (6) months (180 days) or for the life of the prescription, whichever is shorter. A new request must be made for services needed for a longer period of time.

The effective date of the PA will be the date the beneficiary begins using the equipment or the day following the last day of the previous prior authorization approval.

Within thirty (30) working days before the end of an authorization for ventilator equipment, the provider must obtain a new prescription and submit a new Medical Equipment Request for Prior Authorization and Prescription (form DMS-679) signed by the prescribing physician.

PA for ventilator equipment does not guarantee payment. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits. The provider must follow all applicable billing procedures.

222.200 Denial of Prior Authorization Requests 6-1-25

For a denied request, a letter containing case specific rationale that explains why the request was not approved will be mailed to both the requesting provider and to the Medicaid beneficiary.

222.300 Administrative Reconsideration and Appeals 6-1-25

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

222.400 Reserved 6-1-25

224.000 Reserved 8-1-09

230.000 REIMBURSEMENT

231.000 Method of Reimbursement 10-13-03

Reimbursement for ventilator equipment is based on the lower of the amount billed or the Title XIX maximum charge allowed.

Refer to Section 240.000 of this manual for billing instructions and procedure codes.

231.010 Fee Schedule 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov/> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

232.000 Rate Appeal Process 10-13-03

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

When the provider disagrees with the decision of the Assistant Director, Division of Medical Services, is unsatisfactory, the provider may appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider

association and a member of the Department of Human Services (DHS) management staff, who will serve as chairperson.

The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

240.000 BILLING PROCEDURES

241.000 Introduction to Billing 7-1-20

Ventilator equipment providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

242.000 CMS-1500 Billing Procedures 9-1-05

242.100 Ventilator Equipment and Supplies Procedure Codes 2-1-22

[View or print the procedure codes for Ventilator services.](#)

Procedure codes must be billed either electronically or on paper with the modifiers indicated.

Prior authorization requirements are shown under the heading PA.

¹Code may only be billed for a ventilator patient in his or her home. The code is not covered for a ventilator patient in a nursing facility.

²Bill only for beneficiaries under age 21.

***Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.**

***(...)**This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

242.200 National Place of Service (POS) Codes 7-1-07

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
Patient's Home	12
Skilled Nursing Facility	31

242.300 Billing Instructions – Paper Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](#)

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](#)

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

242.310 Completion of CMS-1500 Claim Form

2-1-22

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED SEX	Reserved for NUCC use. Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH SEX	Not required. Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	<p>Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.</p> <p>Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.</p>
15. OTHER DATE	<p>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</p> <p>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</p> <p>454 Initial Treatment</p> <p>304 Latest Visit or Consultation</p> <p>453 Acute Manifestation of a Chronic Condition</p> <p>439 Accident</p> <p>455 Last X-Ray</p> <p>471 Prescription</p> <p>090 Report Start (Assumed Care Date)</p> <p>091 Report End (Relinquished Care Date)</p> <p>444 First Visit or Consultation</p>
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary care physician (PCP) referral is not required for ventilator equipment services. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers
20. OUTSIDE LAB?	Not required.

Field Name and Number	Instructions for Completion
\$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>
22. RESUBMISSION CODE ORIGINAL REF. NO.	<p>Reserved for future use.</p> <p>Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.</p>
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Section 242.100 .
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do not include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.
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.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

242.400 Special Billing Procedures**10-13-03**

Each claim should reflect a "from" and "through" date of service. The claim should not be filed until the "through" date of service has elapsed. Claims may be submitted on either a weekly or monthly basis.

Two separate claims should be filed when one prior authorization expires and another prior authorization begins.