SECTION II - VISUAL CARE

CONTENTS

200.000 VISUAL CARE GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Visual Care Providers 12-1-06

Visual Care Services Program providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. Provider must be licensed by the State Board of Optometry to practice in his or her state. A current copy of the optometrist's license must be submitted with the provider application for participation.

B. Provider must be enrolled in the Title XVIII (Medicare) Program.

201.100 Group Providers of Visual Care Services 3-1-06

Group providers of visual care services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If an optometrist is a member of a group, each individual optometrist and the group must both enroll according to the following criteria:

A. Each individual optometrist within the group must enroll following the criteria established in Section 201.000.

B. All group providers are "pay to" providers only. The service must be performed and billed by a licensed and enrolled optometrist within the group.

201.110 Visual Care Providers in Arkansas and Bordering States 9-1-14

Visual Care Program providers in Arkansas and the bordering states of Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas will be enrolled as routine services providers.

Routine Services Providers

A. Provider will be enrolled in the program as a regular provider of routine services.

B. Reimbursement will be available for all visual care services covered in the Arkansas Medicaid Program.

C. Claims must be filed according to Section 240.000 of this manual. This includes assignment of ICD and HCPCS codes for all services rendered.

201.120 Visual Care Providers 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 beneficiary and have a claim or claims to file with Arkansas Medicaid.

A non-bordering state provider 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.

201.200 Services to Beneficiaries with Refraction 12-1-06

Visual care providers who accept a Medicaid beneficiary for an eye examination with refraction must follow these guidelines:

A. The provider will advise the beneficiary, prior to performing the exam, that he or she will not provide the glasses.

B. The beneficiary will be given the choice to select a provider who will provide both services.

C. If the beneficiary elects to have the examination, a written prescription for the glasses will be given or offered to the beneficiary post-examination.

D. The prescriber cannot withhold the prescription pending Medicaid payment for the refraction.

E. If the beneficiary is not satisfied with the frame selection or services provided, the provider will offer the beneficiary "freedom of choice" and give the beneficiary the prescription for glasses.

202.000 Visual Care Records Providers Are Required to Keep 1-1-16

Visual care providers are required to keep the following records and, upon request, must immediately furnish the records to authorized representatives of the Division of Medical Services, the state Medicaid Fraud Control Unit, representatives of the Department of Human Services and the Centers for Medicare and Medicaid Services:

A. History and visual care examination on initial visit.

B. Chief complaint on each visit.

C. Tests and results.

D. Diagnosis.

E. Treatment, including prescriptions.

F. Signature or initials of visual care provider after each visit.

G. Copies of hospital and/or emergency room records that are available to disclose services.

1. All records must be kept for five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish these records upon request may result in sanctions being imposed.

2. All documentation must be immediately made available to representatives of the Division of Medical Services at the time of an audit by the Office of Medicaid Inspector General. All documentation must be available at the provider's place of business. When a recoupment is necessary, no more than thirty (30) days will be allowed after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30 days allowed after recoupment.

3. Visual Care providers furnishing any Medicaid-covered good or service for which a prescription is required by law, by Medicaid rule, or both, must have a copy of the prescription for such good or service. The Visual Care provider must obtain a copy of the prescription within five (5) business days of the date the prescription is written.

4. The Visual Care provider must maintain a copy of each relevant prescription in the Medicaid beneficiary's records and follow all prescriptions and care plans.

203.000 Monitoring Performance of the Medicaid Optical Equipment Supplier 12-1-06

The Arkansas Medicaid Program uses a single optical laboratory selected through a competitive bid process to furnish eyeglasses for eligible Medicaid beneficiaries. The Medicaid Program's Medical Assistance Unit depends on visual care providers to assist in monitoring the performance of the contractor both in quality of product and timeliness of delivery. The following procedures must be followed:

A. The Medical Assistance Unit welcomes positive and negative comments regarding the optical laboratory's performance. All comments regarding the optical laboratory's performance must be made on the Vendor Performance Report. **View or print the Vendor Performance Report.** The provider will complete the Vendor Performance Report at any time a beneficiary verbally expresses dissatisfaction with their eyeglasses.

B. Vendor Performance Reports should be mailed to the Division of Medical Services, Medical Assistance Unit. **View or print the Division of Medical Services, Medical Assistance Unit contact information**.

C. The Medical Assistance Unit, upon receipt of the Vendor Performance Report, will log and investigate the complaint.

D. A copy of the report is kept on file and may be a factor in awarding future contracts.

To assist the Medical Assistance Unit in investigating your report, the following guidelines are suggested when submitting a Vendor Performance Report:

A. Agency and address - enter your name, address and phone number

B. Vendor and address - enter name and address of optical laboratory

C. Include the date the patient was examined and the date the claim and prescription were submitted

D. Indicate the date the eyewear was delivered

E. Describe specific problems, e.g., poor quality (explain in detail), failure to deliver in a timely manner, unauthorized frame substitution, etc.

F. Give name of the Medicaid beneficiary and ID number

G. If your staff has previously contacted the optical lab about a problem, note the date of contact, the name of the person who made the contact and the name of the persons contacted. Include any pertinent information related to the contact.

Copies of the Vendor Performance Report may be obtained by calling the Division of Medical Services, Medical Assistance Unit. **View or print the Division of Medical Services, Medical Assistance Unit contact information**.

204.000 The Visual Care Provider's Role in the Child Health Services (EPSDT) Program 1-15-11

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

If you are a Child Health Services (EPSDT) provider, please refer to the Child Health Services (EPSDT) provider manual for additional information.

Visual care providers interested in enrolling in the Child Health Services (EPSDT) Program should contact the Child Health Services Office. **View or print contact information for the Child Health Services Office.**

Visual care providers must bill Child Health Services (EPSDT) on the CMS-1500 claim form using the proper Child Health Services (EPSDT) procedure codes found in the Child Health Services (EPSDT) provider manual. See the EPSDT provider manual for information regarding EPSDT screenings. Ancillary charges, such as lab and X-ray, associated with Child Health Services (EPSDT) should also be listed on the CMS-1500. **View a CMS-1500 sample claim form.**

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 will be reimbursed for the services rendered if the services are medically necessary and permitted under federal Medicaid regulations.

Any Arkansas Medicaid provider may bill for non-covered services if the services are provided to a participant in the Child Health Services (EPSDT) Program who has been referred due to an EPSDT screen. The services must be medically necessary and permitted under federal Medicaid regulations.

When a provider performs a Child Health Services (EPSDT) screen and refers the patient to another provider for services **not covered** by Arkansas Medicaid, the referring provider must give the beneficiary a prescription for the non-covered services. The prescription must indicate the services being prescribed and state the services are being prescribed due to an EPSDT screen. **In order for the non-covered service to be eligible for Medicaid payment, the referral** documentation must be available for review. A provider who performs a Child Health Services (EPSDT) screen may also provide services resulting from the screen, if appropriate.

The prescription for services must be dated by the referring provider. The prescription for the non-covered service is acceptable if services were prescribed and the prescription is dated within the applicable periodicity schedule, not to exceed a maximum of 12 months.

210.000 PROGRAM COVERAGE

211.000 Introduction 12-1-06

The Arkansas Medicaid Program covers visual care services of Medicaid beneficiaries within restrictions set in federal and state guidelines. The following paragraphs are a general summary of the program coverage. Detailed coverage, prior authorization, reference information and other requirements may be found in those specific sections within this manual.

212.000 Contact Lens 9-1-08

The Visual Care Program makes contact lenses available to eligible beneficiaries under the following guidelines:

A. All requests for contact lenses require prior authorization by the Medical Assistance Unit. (Refer to Section 220.000 of this manual for prior authorization procedures).

B. Contact lenses are covered if either of the following conditions is exhibited by the patient:

1. Medically necessary
2. Cataract (aphakia) patients

C. The following types of contact lenses are provided:

1. Soft lens
2. Hard lens
3. Toric lens to correct astigmatism
4. Monocular lens
5. Lenses for cataract patients
6. Gas Permeable
7. Keratoconus lens
8. Planned replacement lens
9. Disposable lens

D. Bifocal lenses are not covered.

E. Upon completion of the visual analysis, the provider will forward a letter containing the following information to the Division of Medical Services, Medical Assistance Unit. **View or print form DMS-0101.**

1. Patient's name, date of birth and Medicaid ID number
2. Date of service
3. Patient's complaint
4. Diagnosis and pathology
5. Visual acuities without correction, with present correction and with best correction
6. Power of patient's most recent prior prescription
7. Medical justification for prescribing contacts
8. Type of contacts requested, lens specifications, K reading, hard or soft conventional daily-wear contacts, disposable or planned replacement contacts
9. Provider name, address and Medicaid provider number

F. The visual analysis is reimbursable even if the contact lenses are not authorized. All other services should be billed as a package deal and should include the following services:

1. Prescription services
2. Supply and fitting of contact lens

3. Contact lens care kit, including sterilizer

4. Up to four follow-up visits to achieve maximum wearing time up to a period of six months. The patient will be responsible for payment of all other office visits after the four initial visits or six months, whichever comes first.

G. A patient receiving contact lenses should have a pair of conventional glasses. If the current prescription of the patient's glasses is adequate, Medicaid will not furnish another pair. When the patient does not have a pair of conventional glasses or the current prescription is inadequate, a new pair will be furnished. If a new pair is needed, the provider must complete and submit Form CMS-1500 with a request for contact lens invoice. **View a CMS-1500 sample form**. The prescribing doctor will be paid one time for prescribing and verifying the prescription. At the time of the contact lens request, the provider should furnish the power of the patient's old prescription, if available.

H. Neither insurance nor service contracts are provided by Medicaid. This is the beneficiary's responsibility.

I. If the patient cannot wear the lens, it is the responsibility of the provider to notify Medicaid and reimburse the program 50 percent of Medicaid's payment for the contact lens package deal. Refund checks will be made payable to DHS Accounts Receivable. **View or print the DHS Accounts Receivable contact information**. An explanation of refund should be enclosed with the check identifying the patient name, Medicaid number, date of service and date of Medicaid payment. Even if the patient cannot wear the lens, once the billing has been submitted, the service will count against the patient's benefit limit.

J. For beneficiaries age 21 and over, lens replacement will be covered for post-operative cataract (aphakia) patients only and will require prior authorization. For beneficiaries under age 21, lens replacement will be covered as needed. For these beneficiaries, prior authorization is required except for post-operative cataract (aphakia) patients. Medicaid will reimburse the lower of the amount billed or the Medicaid maximum allowable for each procedure. When billing, the provider should submit the charge for lens replacement only and should not include charges for professional service.

K. Refer to Section 240.000 of this manual for the procedure codes, description of services and billing instructions for contact lens.

L. Any questions regarding approval or denial of contact lens should be forwarded to the Division of Medical Services, Medical Assistance Unit, attention Visual Care Services. **View or print Division of Medical Services, Medical Assistance Unit contact information**.

213.000 Adult Program

213.100 Scope of the Adult Program 2-1-06

The primary purpose of this program is for the screening, examination, diagnosis and treatment of conditions of the eye for the prescribing and fitting of eyeglasses, contact lenses and low vision aids for eligible beneficiaries 21 years of age and over.

213.200 Coverage and Limitations of the Adult Program 1-1-23

A. One visual examination and one pair of glasses are available to eligible Medicaid clients every twelve (12) months.

1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program for repairs to be made.

2. All repairs will be made by the optical laboratory.

B. Lens replacement as medically necessary with prior authorization

C. Lens power for single vision must be a minimum of:

1. +1.00 OR -0.75 sphere
2. -0.75 axis 90 or 0.75 axis 180 cylinder or at any axis

D. Tinted lenses, photogray lenses or sunglasses are limited to post-operative cataract or albino patients

E. Bifocals for presbyopia must have a power of +1.00 and any changes in bifocals must be in increments of at least +0.50

F. Bifocal lenses are limited to:

1. D-28 and
2. Kryptok

G. For clients who are eligible for both Medicare and Medicaid, see Section I for coinsurance and deductible information.

H. Plastic or polycarbonate lenses only are covered under the Arkansas Medicaid Program.

I. Low vision aids are covered on a prior authorization basis.

J. Adult diabetics are eligible (with prior authorization) to receive a second pair of eyeglasses within the twelve (12) month period if their prescription changes more than one diopter.

K. One visual prosthetic device every twenty-four (24) months from the last date of service

L. Eye prosthesis and polishing services are covered with a prior authorization.

M. Trifocals are covered if medically necessary with a prior authorization.

N. Progressive lenses are covered if medically necessary with a prior authorization.

O. Contact lenses are covered if medically necessary with a prior authorization. Please refer to Section 212.000 for contact lens guidelines.

213.300 Exclusions in the Adult Program 1-1-23

A. The Medicaid Program will not reimburse for replacement glasses, with the exception of post-cataract patients, which will require prior authorization.

B. Lenses may not be purchased separately from the frames. If the client desires frames other than the frames approved by Medicaid, he or she will be responsible for the lenses also. Medicaid will reimburse the provider for the examination in these situations.

C. Medicaid will not pay the prescription service charges in situations where the patient buys the eyeglasses.

D. Medicaid does not cover charges incurred due to errors made by doctors or optical laboratories.

E. Tinted lenses for cosmetics purposes are not covered.

F. Glass lenses are NOT covered by Medicaid.

214.000 Under Age 21 Program

214.100 Scope of the Under Age 21 Program 12-1-06

The primary purpose of this program is for the screening, examination, diagnosis and treatment of conditions of the eye for the prescribing and fitting of eyeglasses, contact lenses and low vision aids for eligible beneficiaries under 21 years of age.

214.200 Coverage and Limitations of the Under Age 21 Program 1-1-23

A. One examination and one pair of glasses are available to eligible Medicaid beneficiaries every twelve (12) months.

1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program in order for repairs to be made.
2. If the glasses are lost or broken beyond repair within the twelve (12)-month benefit limit period, one additional pair will be available through the optical laboratory. After the first replacement pair, any additional pair will require prior authorization..
3. All replacements will be made by the optical laboratory and the doctor's office may make repairs only when necessary.
4. Only ARKids First-B beneficiaries will be assessed a ten-dollar ($10.00) co-pay. All co-pays will be applied to examination codes rather than to tests or procedures.

B. Prescriptive and acuity minimums must be met before glasses will be furnished. Glasses should be prescribed only if the following conditions apply:

1. The strength of the prescribed lens (for the poorer eye) should be a minimum of -.75D + 1.00D spherical or a minimum of .75 cylindrical or the unaided visual acuity of the poorer eye should be worse than 20/30 at a distance.
2. Reading glasses may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a prior approval basis.

C. Plastic or polycarbonate lenses only are covered under the Arkansas Medicaid Program.

D. When the prescription has met the prescriptive and acuity minimum qualifications, Medicaid will purchase eyeglasses through a negotiated contract with an optical laboratory.

E. The eyeglasses will be forwarded to the doctor's office where he or she will be required to verify the prescription and fit or adjust them to the patient's needs.

F. Eye prosthesis and polishing services require a prior authorization.

G. Contact lenses are covered if medically necessary with a prior authorization. Please refer to Section 212.000 for contact lens guidelines.

H. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses.

1. Ptosis (droopy lid)
2. Congenital cataracts
3. Exotropia or vertical tropia
4. Children between the ages of twelve (12) and twenty-one (21) exhibiting exotropia

I. Prior authorized orthoptic and/or pleoptic training may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under.

1. The initial prior authorization request must include objective and subjective measurements and tests used to indicate diagnosis.
2. The initial prior authorization approved for this treatment will consist of sixteen (16) treatments in a twelve (12)-month period with no more than one treatment per seven (7) calendar days.
3. An extension of benefits may be requested for medical necessity.
4. Requests for extension of benefits must include the initial objective and subjective measures with diagnosis along with subjective and objective measures after the initial sixteen (16) treatments are completed to show progress and the need for, or benefit of, further treatment.
5. For a list of diagnoses that are covered for orthoptic and/or pleoptic training **(View ICD Codes.)**.

J. Prior authorized sensorimotor examination may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

1. Benefit limit of one (1) sensorimotor examination in a twelve (12) month period.
2. An extension of benefits may be requested for medical necessity.
3. For a list of diagnoses that are covered for sensorimotor examination **(View ICD Codes.)**.

K. Prior authorized developmental testing may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

1. Benefit limit of one (1) developmental testing in a twelve (12) month period.
2. An extension of benefits may be requested for medical necessity.
3. For a list of diagnoses that are covered for developmental testing **(View ICD Codes)**.

View or print the procedure codes for Vision services.

214.300 Exclusions in the Under Age 21 Program 12-1-06

A. Tinted or plastic lenses for cosmetic purposes

B. Frames other than the ones on contract

C. Contact lenses for cosmetic purposes

D. Contact lenses or eyeglasses obtained by means other than Medicaid

E. Glass lenses

215.000 Eyeglasses Covered by Medicaid 11-1-12

Brand	Frame	Gender	Size	Colors
Europa	ALT-07	Men’s	52 and 54	Brown, Gold and Grey
	Kerry	Unisex	48 and 50	Bronze, Black, Chrome
	Kip	Women's	48	Black and Crystal

Brand	Frame	Gender	Size	Colors
	MM-01	Children’s	38,40 and 42	Brown, Blue, Violet and Pink
	MM-02	Children’s	39, 41 and 43	Bronze, Blue, Gunmetal and Wine
	MM-03	Unisex	46, 48 and 50	Bronze, Black, Gunmetal and Light Copper
	MM-04	Unisex	44, 46 and 48	Brown, Blue, Violet and Red
	MM-05	Women's	45, 47 and 49	Brown, Black, Gunmetal and Blue
	NF-3	Unisex	44 and 46	Matte Black and Matte Silver
	L-Cable	Children's	36,38 and 40	Brown, Gold and Black
	NF-2	Unisex	45 and 47	Matte Black and Matte Blue
	MM-06	Men's	50, 52 and 54	Brown, Black, Gunmetal and Gold
Kenmark	Andrea	Women's	49	Rose, Brown and Wine
	Shannon	Women's	46 and 48	Sand, Black and Lavender
	Sharon	Women's	49	Black Crystal and Brown
	Blaire	Women's	50 and 52	Golden Rose, Nutmeg and Dove
	Gypsy	Women’s	55 and 57	Demi, Black and Lavender
	Sam	Men's	49 and 51	Brown, Gunmetal and Black
	Gracy	Women’s	52 and 54	Brown, Bleu and Rose
	Henry	Men's	52, 54, 56 and 58	Gold, Gold/Demi Amber and Gunmetal/Tortoise
	Chet	Men's	54 and 56	Brown and Gunmetal
	Aimee	Women’s	54 and 56	Brown, Purple and Rose
	Gwen	Women's	51 and 53	Beige, Blush and Mist
	Debbie	Women's	52	Tortoise and Black
	Jim	Men’s	53, 55 and 59	Brown, Gunmetal and Gold
	Bryant	Men’s	49 and 51	Black, Brown and Gunmetal
	Leya	Women’s	45 and 47	Brown, Grape, Black and Plum
United	Destiny	Unisex	47	Coffee, C2 Matte Black and C3 Matte Silver
	Steve	Men's	49 and 51	C1 Brown, and C2 Dark Gray
	Stella	Women's	51	C1 Light Brown C2 Lilac and C3 Matte Silver
	Candy	Unisex	45	C1 Shiny Brown and C2 Matte Black
Modern	Sporty	Kids	44 and 46	Black/Crystal, Blue and Brown

Brand	Frame	Gender	Size	Colors
	Gift	Women's	47 and 49	Black/Crystal, Brown/Crystal and Purple/Brown
	Dazzle	Women's	49, 51 and 53	Brown, Gold And Rose
	Judi	Women's	50 and 53	Black/Crystal, Tortoise and Wine/Gray
	Dynamite	Girl's	42, 45 and 47	Antique Brown and Black Silver
	Ralph	Men's	52, 54 and 56	Black, Brown and Gray
	Ninja	Unisex	44 and 46	Blue, Brown and Lilac
Zimco	Attitudes #3	Women's	50	Brown/Crystal and Black
	Retro#1	Women's	48	Gold, Gunmetal Blue and Matte Brown
Hart	Hart-9756	Women's	48	Brown, Gold and Gunmetal Silver
	3766	Women's	52	Brown and Lilac
	Hart-8112	Unisex	48	Matte Black, Matte Burgundy and Matte Coffee
	Reality-Hart	Women's	51	Onyx-Brown and Onyx-Burgundy
	3714	Women's	52	Black-Burgundy and Tortoise
	Hart-3712	Men's	52	Black-Brown and Gunmetal
	7206	Girl's	52	Brown and Graphite
	Hart-9751	Women's	48 and 50	Brown, Silver and Lilac
	Hart-9509	Boy's	38, 41 and 44	Gold Brown, Satin Blue and Shiny Brown
MiraFlex	Mini Baby	Children	Various	Various Colors
	Baby Lux	Children	Various	Various Colors
	New Baby 2	Children	Various	Various Colors
LBI	Woman Day	Women's	55	Gold, Rose and Gray
	LBI--915	Women's	53	Gold/Silver, Silver/Gold and Brown/Gold

216.000 Medical Procedures Billable by Optometrists 12-1-06

Optometrists are allowed to bill for certain procedures for office medical services and special services previously payable only to physicians.

The office medical services provided by an optometrist will be limited to twelve visits per state fiscal year for individuals age 21 and over. The benefit limit will be used in conjunction with four other programs. These programs are physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services. Beneficiaries will be allowed twelve visits per state fiscal year for office medical services furnished by an optometrist, medical services furnished by a dentist, physicians' services, rural health clinic services, certified nurse-midwife services or a combination of the five. Extensions beyond the twelve-visit limit may

be provided if medically necessary. Office medical services for beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited. Procedure codes, description of services and special billing instructions are located in Section 240.000 of this manual.

All beneficiaries of vision and medical eye care may have direct access to optometrists as primary eye care providers, independent of the primary care provider (e.g., physician, Federally Qualified Health Center (FQHC), etc.).

216.100 Extension of Benefits for Office Medical Services Provided by an Optometrist 10-13-03

Extensions of benefits beyond the twelve-visit limit for individuals age 21 and over may be provided, if medically necessary, for office medical services provided by an optometrist and in conjunction with four other programs. Those programs are physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services.

216.200 Procedure for Obtaining Extension of Benefits for Medical Services Provided by an Optometrist 8-1-21

A. Requests for extension of benefits for medical services provided by an optometrist must be submitted to DHS or its designated vendor. **View or print contact information to obtain instructions for submitting the request.** Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.

Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. *Do not* send a claim.

B. A request for extension of benefits must be received within ninety (90) calendar days of the date of benefits-exhausted denial. Requests received after the 90-day deadline will not be considered.

216.210 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for clinical services (physician's visits) outpatient services (hospital outpatient visits), diagnostic laboratory services (laboratory tests), and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain instructions for submitting the request.

1. Requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory,

and Radiology/Other Services" form (Form DMS-671). View or print Form DMS-671.

2. **Instructions for accurate competition of Form DMS-671 (including indication of required attachments) accompany the Form. All forms are listed and accessible in Section V of each provider manual.**

216.220 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1 Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records must:
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, and emergency room records for dates of service in chronological order;
   d. Include related diabetic and blood pressure flow sheets;
   e. Include current medication list for date of service;
   f. Include the obstetrical record related to the current pregnancy; and
   g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.
2. Diagnostic laboratory and radiology/other reports must include:
   a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests.

216.230 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.

216.240 Reserved 6-1-25

216.300 Prescription Drugs 8-1-21

PRESCRIPTION DRUG INFORMATION

Act 186 of 1997 authorizes optometrists to prescribe and administer both oral and topical drugs for the diagnosis and treatment only of conditions of the eye, lids, adnexa or visual system, except for those drugs listed in Schedules I and II of the Uniform Controlled Substance Act. They can also prescribe and administer epinephrine, Benadryl® or other comparable medication for the emergency treatment of anaphylaxis or anaphylactic reactions.

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective vendors is located on the DHS or designated Pharmacy vendor website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

For prescription drug prior authorization concerns or the latest information regarding prescription drug coverage, providers may visit the Prescription Drug PA Help Desk.

For questions regarding the Evidence-Based Prescription Drug Program or to request an override for non-preferred drugs, prescribers may contact the DHS Contracted Pharmacy Vendor Help Desk.

216.301 Tamper Resistant Prescription Applications 2-6-17

Section 7002(b), which amends section 1903(i) of the Social Security Act (the Act) (42 U.S.C. section 1936b(i)) by adding new paragraph (23), states that payment shall not be made for ". . . amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." This provision becomes effective on October 1, 2007. The tamper-resistant pad requirement of section 7002(b) applies to all outpatient drugs, including over-the-counter drugs in States that reimburse for prescriptions for such items. Section 1927(k)(3) of the Act provides exceptions to section 1927(k)(2) for drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and other specified institutional and clinical settings. Such drugs in these settings (to the extent that they are not separately reimbursed) are exceptions to section 1927(k)(2), and, therefore, are not subject to the tamper-resistant pad requirement of section 7002(b). Section 7002(b) is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

See the CMS website for technical information:

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/TRP.html

Regardless of whether Medicaid is the primary or secondary payer of the prescription being filled, this rule applies to all non-electronic Medicaid-covered outpatient drugs except:

1. Emergency fills of non-controlled or controlled dangerous substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic or compliant written prescription within 72 hours after the date on which the prescription was filled;

2. Drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities and other federally-specified institutional and clinical settings so long as those drugs are not billed separately to Medicaid, for example, those billed by an individual pharmacy provider.

For purposes of this rule, "electronic prescriptions" include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber.

217.000 Electronic Signatures 10-8-10

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

220.000 PRIOR AUTHORIZATION

221.000 How to Obtain Prior Authorization 7-1-17

To obtain prior authorization to provide services not ordinarily covered, the provider must submit in writing a brief, yet descriptive, account of the services requested and, if possible, the procedure code to be used when billing. All supportive information available should be submitted.

Send all requests for prior authorization to the Division of Medical Services, Medical Assistance Unit. **View or print Division of Medical Services, Medical Assistance Unit contact information**.

All requests for prior authorization will be reviewed by the visual care consultants. All or part of the services requested may be approved. Approval or denial of the services requested will be given in writing. In no event will prior authorization be given over the telephone.

The approval of the request for prior authorization will be signed by the visual care consultants or authorized personnel and assigned a prior authorization control number. The prior authorization control number must be indicated on the claim.

Prior Authorization (PA) requests should be submitted and approved PRIOR to the delivery of any requested service that requires prior authorization. PA requests received retrospectively (after the date of service of the requested service), will be evaluated for medical necessity and if approved will allow payment for related claims (subject to timely filing rules) performed prior to submission of the PA request. PLEASE NOTE: A provider who performs a service that requires a prior authorization before receiving PA approval is at risk for non-payment for the service in the event that the retrospectively submitted PA request is denied.

221.100 Extension of Benefits Review Process 8-1-21

Extension of Benefits must be submitted to DHS or its designated vendor for review. **View or print contact information to obtain a step-by-step outline for the extension process.**

222.000 Duration of Authorization 3-1-06

Medical assistance prior authorizations are valid for 180 days from date of approval, provided the patient remains eligible for services. Prior authorization does not guarantee payment unless the patient remains eligible.

The doctor's office will be responsible for verifying eligibility for the dates in which services are provided. The patient is responsible for telling the doctor that he or she is a Medicaid beneficiary when making the first appointment.

The doctor should always keep a copy of the services authorized with the prior authorization control number and a copy of each claim submitted. If the treatment has not been completed in this period of time, send a new request for authorization for the portion of the plan not completed. A new prior authorization control number may be issued under prevailing policies.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement 10-13-03

The methodology used by the Arkansas Medicaid Program to determine reimbursement rates for visual care providers is a fee schedule. Under the fee schedule methodology, reimbursement is based on the lesser of the billed charge or the Medicaid maximum allowable for each procedure. The maximum allowable for a procedure is the same for all visual care providers.

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 9-1-08

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.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services, which 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 chairman.

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

Visual care providers use the CMS-1500 claim form or 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 Reserved

242.100 Visual Care Procedure Codes

242.110 Visual Procedure Codes 2-1-22

The following services are covered under the Arkansas Medicaid Program. "W/PA" means that a service requires prior authorization.

View or print the procedure codes for Vision services.

DIAGNOSTIC AND ANCILLARY SERVICES
CONTACT LENS SERVICES
LOW VISION SERVICES
SUPPLEMENTAL PROCEDURES
MISCELLANEOUS SERVICES
CONTACT LENS REPLACEMENT
EYE PROSTHESIS

242.120 Co-pays for Prescription of Services 2-1-22

Co-pays apply to the following examination codes:

View or print the procedure codes for Vision services.

Co-pays do not apply to codes for the fitting of spectacles.

242.310 Reserved

242.400 Special Billing Procedures

242.410 Billing for Medicare/Medicaid Dually-Eligible Beneficiaries 12-1-06

If Medicare denies a claim for services provided to a beneficiary eligible for both Medicare and Medicaid, the claim will not cross over to Medicaid automatically. Therefore, the CMS-1500 claim form should be submitted to the Arkansas Medicaid fiscal agent along with the Explanation of Medicare Benefits (EOMB) explaining the reason for Medicare's denial.

NOTE: A copy of the Medicare EOMB must be attached to the claim and must match the dates of service on the claim form.

Medicare/Medicaid crossover claims are discussed in Section III of this manual.

242.420 Billing Instructions for Contact Lenses 10-13-03

A. All requests for contact lenses require prior authorization. Mail the request for prior authorization to the Division of Medical Services, Medical Assistance Unit. **View or print Division of Medical Services, Medical Assistance Unit contact information**.

B. When Medical Assistance authorizes contact lens, Medical Assistance staff will complete a prior authorization form, MAP-8, and assign a prior authorization number. The MAP-8 will be mailed to the provider advising of the approval. The provider must use the prior authorization control number when billing for contact lens.

C. The visual examination is reimbursable even if the contact lenses are not authorized. The provider may bill for the visual exam electronically on the CMS-1500 format or submit the CMS-1500 form to the Claims Department. **View or print Claims Department contact information**.

D. The provider may bill for the fitting and supplying of contact lenses. A copy of the contact lens invoice must be submitted with claim form CMS-1500. The Medicaid Program will reimburse the Medicaid allowable for contact lenses as a package deal, which may include:

1. Prescription services.
2. Supply and fitting of contact lenses.
3. Contact lens care kit and sterilizer.
4. Four (4) follow-up visits.
5. All items specified with the procedure codes. See Section 242.100 for procedure code list.

Mail form CMS-1500 for contact lenses directly to the Claims Department or file electronically on the CMS-1500 format. **View a CMS-1500 sample form**. **View or print Claims Department contact information**.

E. If the request for contact lenses is denied, a letter will be forwarded to the provider indicating the reason for denial.

F. If the doctor's prescription does not fall within the "Coverage and Limitations" outlined in Section 213.200, the claim will require prior authorization based on a manual review by the visual consultant of the Medicaid Medical Assistance Unit. In these cases, the doctor should complete the claim form, including the prescription form provided by the optical contractor, retain a copy of each for his or her file and forward the originals to the Division of Medical Services, Medical Assistance Unit. **View or print Division of Medical Services, Medical Assistance Unit contact information**.

The visual consultant will review the claim. The result of this review will be one of the following:

1. If the consultant approves the prescription, he or she will so note on the claim. The Medical Assistance staff will then forward the prescription form to the optical lab for processing. The original claim form will be forwarded immediately to the Arkansas Medicaid fiscal agent for the processing required to pay the doctor for examination and prescription services.
2. If the consultant denies the prescription, he or she will so note on the claim and route it to the Arkansas Medicaid fiscal agent for processing. The resulting RA should reflect payment for the examination service and denial of the prescription service.

NOTE: The optical lab will not process claim work orders for prescriptions outside the limits outlined in Section 213.200 unless the approval of the Medicaid visual consultant is noted.

Providers MUST ensure that information provided for prescription services is accurate and neatly entered in the required blocks.

242.430 Special Processing Procedures 8-1-21

The CMS-1500 claim form must be used by the ophthalmologists or optometrists when billing the Medicaid Program for non-prescription services. Submit the completed claim form to the Arkansas Medicaid fiscal agent.

If prescription services are required and are within the allowable limits outlined in Section 213.200, the provider must complete the prescription form provided by the optical contractor. Visual Care providers who submit claims electronically must submit a copy of the eligibility verification for the date on which the service is being provided along with the prescription form to the optical contractor for processing. The printout will provide verification of the beneficiary's eligibility, last visual exam date and last optical prescription date. (A photocopy of the beneficiary's plastic identification card will not be accepted by the optical contractor.) The prescription form and the eligibility verification can be sent to the optical contractor. **View or print the DHS Designated Optical Contractor contact information.**

If the copy of the eligibility on the date of service is not verified, and/or the benefit has been exhausted, the optical contractor will not fill the prescription and will return the claim to the physician.

242.440 ICD Diagnosis Codes 9-1-14

The primary diagnosis describing the reason for treatment must be entered on the claim with its ICD code. The secondary diagnosis is optional. Refer to the latest edition of the ICD Expert for Physicians publication for the appropriate diagnosis code.

243.000 CMS-1500 Billing Procedures

243.100 Visual Care Procedure Codes

243.120 CPT Codes Payable in the Visual Care Program 2-1-22

The following CPT codes are payable in the Visual Care Program. Optometrists may bill procedure code for treatment of dry eye syndrome.

View or print the procedure codes for Vision services.

*Procedure codes with one asterisk require prior authorization when the place of service is an inpatient hospital.

**Procedure code requires prior authorization and is limited to beneficiaries under age 21 years.

***Procedure code is manually priced and requires prior authorization.

Gross visual field testing is a part of general ophthalmologic services and is not billed separately. *See the CPT manual for definitions, examples of levels of service and complete procedure code descriptions.*

243.130 Hospital Discharge Day Management 2-1-22

Procedure code, hospital discharge day management, may not be billed by providers on the same date of service as initial or subsequent hospital care, procedure. Initial hospital care and subsequent hospital care may not be billed on the day of discharge.

View or print the procedure codes for Vision services.

243.140 Billing Instructions for Balanced Lens for Aphakia 2-1-22

Visual Care providers must bill procedure code (unspecified procedure) when providing balanced lenses to aphakia patients who are eligible for both Medicare and Medicaid. Medicaid providers must bill for this procedure using the CMS-1500 claim form. A copy of the lab invoice and the Medicare EOMB that reflects the denial must be attached to the claim.

View or print the procedure codes for Vision services.

243.150 Office Medical Services 2-1-22

The office medical services provided by an optometrist are limited to twelve (12) visits per state fiscal year (July 1 through June 30) for beneficiaries age 21 and older. The benefit limit will be used in conjunction with four other programs: physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services. Beneficiaries will be allowed twelve visits per state fiscal year for office medical services furnished by an optometrist, medical services furnished by a dentist, physicians' services, rural health clinic services and certified nurse-midwife services or a combination of the five. Extensions beyond the twelve-visit limit may be provided if medically necessary. Office medical services for beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Office medical services covered in the Visual Care Program are limited to the following procedure codes:

View or print the procedure codes for Vision services.

243.200 National Place of Service 7-1-07

Electronic and paper claims now require the same national place of service codes.

Place of Service (POS)	POS Codes
Inpatient hospital	21
Outpatient hospital	22
Doctor's office	11
Patient's home	12
Other location	99

243.300 Billing Instructions – CMS-1500 – 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.

243.310 Completion of CMS-1500 Claim Form 9-1-14

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.
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	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
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?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	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	Not required.
SEX	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.
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)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
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 visual care 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.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. 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.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. 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.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. 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 243.200 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 Sections 243.100 through 243.150.
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 beneficiary 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 NO.	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 or ARKids First-B 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.

243.400 Special Billing Procedures 2-1-22

Prosthetic providers that bill procedure codes electronically must use an **NU** modifier. Prosthetic providers billing either of the above procedure codes on paper must also use an **NU** modifier.

View or print the procedure codes for Vision services.