SECTION II - DEVELOPMENTAL REHABILITATION SERVICES

CONTENTS

200.000 DEVELOPMENTAL REHABILITATION SERVICES GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Developmental Rehabilitation Services 12-1-14

Developmental Rehabilitation Services 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. Providers must be certified as DDS First Connections Program participants by the Arkansas Division of Developmental Disabilities Services (DDS) to provide early intervention services.

B. Verification of current certification from DDS must accompany the provider application and the Medicaid contract.

201.100 Providers of Developmental Rehabilitation Services in Arkansas and Bordering States 10-13-03

Only providers of developmental rehabilitation services in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as **routine services providers** if they meet all Arkansas Medicaid participation requirements outlined above.

Routine services providers may furnish and claim reimbursement for developmental rehabilitation services covered by Arkansas Medicaid. Services are subject to benefit limitations and coverage restrictions set forth in this manual. Claims must be filed according to Section 260.000 of this manual.

202.000 Required Documentation 12-1-14

A. Providers of developmental rehabilitation services must establish and maintain records for each client.

B. Client records must support the levels of service billed to Medicaid.

C. Upon request, providers must furnish records to authorized representatives of the Arkansas Division of Medical Services, state Medicaid Fraud Unit, Office of Medicaid Inspector General (OMIG) and representatives of the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS).

1. Medicaid providers must make available all required records for audit and inspection by the Department of Human Services, or their authorized representatives, during normal business hours.
2. All records must be kept for a period of 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 medical records upon request may result in sanctions being imposed. (See Section I of this manual.)

D. All documentation must be made available to representatives of the Division of Medical Services and OMIG at the time of an audit. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.

E. Providers of developmental rehabilitation services are required to maintain copies of the following documentation in each child's file.

1. A written prescription and referral for DDS First Connections early intervention services signed by the child's primary care physician (PCP).
2. DDS First Connection eligibility verification.
3. Program Participation Authorization Form signed by the child's parent(s) or legal guardian(s).
4. A current (within a year) Individual Family Service Plan (IFSP) developed by an interdisciplinary team of professionals, the assigned service coordinator and the parent(s) or guardian(s).
5. The provider of a service must maintain documentation of the service provided as required by IDEA, Part C. This includes, but is not limited to: the specific service; the length, duration, frequency, intensity and method of the service; the date, times, activities and location where activities were conducted; outcomes or objectives worked on; progress made and recommendations (if appropriate).

6. Evaluations that meet the requirements of the DDS First Connections Program.

202.100 Electronic Signatures 10-8-10

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

210.000 PROGRAM COVERAGE

211.000 Introduction 3-15-12

The Medical Assistance (Medicaid) Program is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. All Medicaid benefits are based upon medical necessity. See the Glossary of this manual for the definition of "medical necessity."

212.000 Scope 12-1-14

Part C of the Individuals with Disabilities Education Act (IDEA) requires each state to provide mandated early intervention services. The Arkansas Department of Human Services (DHS) Division of Developmental Disabilities Services (DDS) is the lead agency for the Part C early intervention program in Arkansas. DDS First Connections is the name of the early intervention program.

Arkansas Medicaid's Developmental Rehabilitation Services Program provides coverage for the following DDS First Connections early intervention services that are medically necessary for Medicaid eligible beneficiaries under three years of age:

A. Developmental testing.

B. Therapeutic activities.

Developmental rehabilitation services require a primary care physician (PCP) referral.

213.000 Exclusions 12-1-14

The following services are excluded from coverage in this program.

A. Services that are not included in the Individualized Family Service Plan (IFSP).

B. Services furnished that are not within the scope of practice of the professional performing them or supervising the activity.

C. Services for individuals who are not Medicaid eligible.

D. Services provided in the Developmental Day Treatment Clinic Services (DDTCS) Medicaid Program.

E. Services provided in the Child Health Management Services (CHMS) Medicaid Program.

F. Services furnished that are not in compliance with the policies and procedures established by the DDS First Connections Program.

G. Services that are not provided in the natural environment as defined by the DDS First Connections Program.

Evaluations that are completed prior to the referral being made to the DDS First Connections Service Coordinator are excluded from coverage in this program.

214.000 Coverage 3-15-12

Coverage of developmental rehabilitation services is limited to two basic services for Medicaid eligible beneficiaries who meet the eligibility requirements. Refer to Section 214.100 for beneficiary eligibility criteria and Sections 214.200 through 214.220 for information on the services covered.

214.100 Beneficiary Eligibility 3-15-12

Beneficiaries eligible for these services must meet the following criteria:

A. The beneficiary must be Medicaid eligible and be under three years of age.

B. The beneficiary must have an Individualized Family Service Plan (IFSP) developed by a multidisciplinary team that meets the requirements of Part C of IDEA.

C. The beneficiary must have been diagnosed by a multidisciplinary team as having a delay of 25% or more in one or more areas of development (physical, cognitive, communication, social or emotional and adaptive).

OR

The beneficiary must have a diagnosed physical or mental condition that has a high probability of developmental delay. These diagnosed conditions may include but are not limited to:

1. Down's syndrome and other chromosomal abnormalities associated with mental retardation;
2. Congenital syndromes and conditions associated with delays in development such as fetal alcohol syndrome, intra-uterine drug exposure, prenatal rubella, severe macro and microcephaly;
3. Metabolic disorders;
4. Intra-cranial hemorrhage;
5. Malignancy or congenital anomaly of brain or spinal cord;
6. Spina bifida;
7. Seizure disorder, asphyxia, respiratory distress syndrome, neurological disorder, sensory impairments and
8. Maternal Acquired Immune Deficiency Syndrome.

214.200 Developmental Rehabilitation Services 12-1-14

Developmental rehabilitation services are early intervention services. This program covers two basic services: developmental testing and therapeutic activities. The DDS certified provider must ensure that an individual providing developmental testing services and therapeutic activities services meets the qualifications as outlined in Part C of IDEA and the DDS First Connections services guidelines.

Developmental rehabilitation services must be provided in the natural environment as defined by the DDS First Connections Program. Natural environments include: in the beneficiary's home, in the community (e.g., day care center) or in a clinical setting (with justification approved by the DDS First Connections Program).

Refer to Section 260.000 of this manual for billing instructions and procedure codes for services covered in this program.

214.210 Developmental Testing 10-13-03

Developmental testing is a battery of diagnostic tests for the purpose of determining a child's developmental status and need for early intervention services. This may include, but is not limited to, psychological and behavioral developmental profiles. The profiles are required to determine a person's eligibility for services and the development of the Individualized Family Service Plan (IFSP).

Developmental testing includes two instruments and a narrative report with interpretation.

Developmental testing is not covered through Developmental Rehabilitation Services if developmental testing has been provided and covered through a DDTCS program or a CHMS program within the last six months.

214.220 Therapeutic Activities 10-13-03

Therapeutic activities are services that provide direct instruction to a child, or both the parent or caregiver and the child, to promote the child's acquisition of skills in a variety of developmental areas.

A. Therapeutic activities must be based on an identified need as documented in the IFSP and must be the direct result of the level of delay(s) determined by the inter-disciplinary assessment.

B. Therapeutic activities **may not** be provided on the same day a Developmental Day Treatment Clinic Services (DDTCS) core service is provided, or on the same day that services are provided in a Child Health Management Services (CHMS) pediatric day program/intervention setting.

C. Therapeutic activities must include direct one-on-one instruction to the child, or to the child and parent or caregiver.

215.000 Benefit Limits 3-15-12

Benefit limits are the limits on the *quantity* of covered services Medicaid eligible beneficiaries may receive.

A. Developmental testing is limited to a maximum of four (4) one-hour units of service per calendar year.

B. Therapeutic activities are limited to a maximum of four (4) 15-minute units of service per week.

215.100 Extension of Benefits 12-1-14

Providers may request benefit extensions for **medically necessary** services by submitting the appropriate DDS First Connections forms for a benefit extension along with supporting documentation to the DDS First Connections Infant & Toddler Program Developmental Disabilities Services. **View or print DDS First Connections contact information**.

DDS First Connections Infant & Toddler Program staff is responsible for approval or denial of benefit extension requests. The requesting provider will be notified of approval or denial of the request. The approval notification will list the procedure codes approved for benefit extension, the approved dates or date-of-service range and the number of units of service authorized.

Providers are to file the claims electronically, entering the assigned control number in the Prior Authorization (PA) number field of the CMS-1500 claim format. Subsequent benefit extension requests will be necessary only when the extension expires or when a beneficiary's need for

services unexpectedly exceeds the amount or number of services granted under the benefit extension.

Providers may obtain the appropriate forms for requesting benefit extensions from the DDS First Connections Service Coordinator or from the DDS First Connections Program in the DDS central office as listed above.

Refer to Section 262.100 of this manual for a listing of the procedure codes.

240.000 PRIOR AUTHORIZATION

241.000 Prior Authorization (PA) Request Procedures 12-1-14

A. Developmental rehabilitation services procedures require prior authorization. The DDS First Connections Program Prior Authorization Unit staff is responsible for the review of and approval or denial of all prior authorization requests.

B. The DDS certified initial or ongoing service coordinator must submit all requests for prior authorization of Developmental Rehabilitation Services to the DDS First Connections Program. **View or print the DDS First Connections contact information**.

C. Each request for prior authorization must be submitted through the DDS First Connections Comprehensive Data System (CDS).

D. For prior authorization approval, the documentation submitted must substantiate the following:

1. Medical necessity for the service requested.
2. Eligibility for the DDS First Connections Program.
3. Needed service(s) determined by a multi-disciplinary team.
4. IFSP completed within the last year.

E. A PA request is processed by the DDS First Connections program staff within 15 working days of the receipt of request.

F. DDS First Connections staff will verify information submitted. A prior authorization (PA) control number will be assigned and the PA number will be entered into the Medicaid system.

G. Notification of the prior authorization approval will be sent to the service provider through the CDS system.

H. The PA control number must be entered on the CMS-1500 claim format when filing claims for reimbursement. Refer to Section 260.000 of this manual for billing instructions and procedure codes.

I. If a PA request is denied, the beneficiary may request a fair hearing. (Refer to Section 242.000)

241.100 Quality Assurance 12-1-14

The DDS First Connections Program staff will review all PA requests. The Individual Family Service Plan (IFSP) will be reviewed and the parent or legal guardian will be contacted to assess successful outcomes for the child and family.

242.000 Appeal Process 12-1-14

When coverage of services or a prior authorization request for services is denied, the beneficiary may request a fair hearing of the denial of services from DDS First Connections Appeals.

The appeal request must be in writing and received by DDS First Connections Appeals within thirty (30) days of the date of the denial notification.

Submit appeal requests to DDS First Connections Appeals. **View or print DDS First Connections Appeals contact information.**

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 10-13-03

The reimbursement methodology for developmental rehabilitation services is a "fee schedule" methodology. Under the fee schedule methodology, reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowed for each procedure. The maximum allowable fee for a procedure is the same for all Developmental Rehabilitation Services Program providers.

252.000 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.

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

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 7-1-07

Developmental Rehabilitation Services Program 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 beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 CMS-1500 Billing Procedures

262.100 Procedure Codes 10-13-03

The following is a listing of Developmental Rehabilitation Services Program procedure codes. It is imperative to use the Medicaid code listed for the services provided.

Procedure Codes	
96111	97530

262.200 National Place of Service Codes 12-1-14

Electronic and paper claims require the same National Place of Service Code.

Place of Service	Place of Service Codes
Office	11
Home*	12
Clinic	49
Day Care Center or Other Natural Environment**	99

* Home (12) is defined as a location where the beneficiary receives care in a private residence. This code is appropriate when services are delivered in the child's home, a relative's home or a caregiver's home.

** Other Natural Environment (99) settings are community settings as defined by DDS First Connections.

262.300 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.

262.310 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.

Field Name and Number		Instructions for Completion
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.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	

Field Name and Number		Instructions for Completion
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	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
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	Reserved for future use.
ORIGINAL REF. NO.	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. Some 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.
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	One CPT or HCPCS procedure code for each detail.
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.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. 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.

262.400 Special Billing Procedures 10-13-03

Not applicable to this program.