SECTION II – SCHOOL-BASED MENTAL HEALTH SERVICES

CONTENTS

200.000 SCHOOL-BASED MENTAL HEALTH SERVICES GENERAL INFORMATION

201.000 Introduction 10-13-03

In order to ensure quality and continuity of care, school districts and/or Education Services Cooperatives (ESC) that are providers of School-Based Mental Health Services, approved to receive Medicaid reimbursement for services provided to the under age 21 Medicaid population, must ensure that contractors and personnel engaged as licensed school-based mental health practitioners meet specific qualifications in order for school districts and ESC providers to bill Medicaid for their services.

202.000 Arkansas Medicaid Participation Requirements for a School District or Education Services Cooperative (ESC) to Provide School-Based Mental Health Services 10-13-03

School-Based Mental Health 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. Arkansas Medicaid will enroll as providers only school districts and ESCs that are located within the State of Arkansas.

B. The Arkansas Department of Education (ADE) will ensure that a school district or ESC interested in becoming a Medicaid provider of school-based mental health services meets Medicaid provider requirements. Notification of approval by the Arkansas Department of Education must be presented to the Arkansas Division of Medical Services at the time application for enrollment is made. Subsequent decisions by ADE must be provided when issued.

202.100 Requirements for Certification of Provider Staff or Contracted Professionals Who Provide School-Based Mental Health Services 7-1-17

School-Based Mental Health Services provider employees and contractors will provide services only in those areas in which they are licensed or credentialed.

School-Based Mental Health Services provider employees and contractors will be under the supervision and jurisdiction of the school district and/or ESC and will provide services twelve months of each year.

School district and Educational Services Cooperative (ESC) mental health provider employee and contractor requirements are as follows:

A. Licensed Certified Social Worker (LCSW)

1. The LCSW must possess a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education (CSWE).
2. The LCSW must be state licensed and certified to practice as a licensed certified social worker in the State of Arkansas and in good standing with the Arkansas Social Work Licensing Board.
3. The LCSW must provide to the school district or ESC proof of two (2) years post-licensure experience treating children and adolescents with mental illness.
4. The LCSW shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

NOTE: A licensed certified social worker employed or contracted with the school district or ESC may not be enrolled in the Targeted Case Management (TCM) Program. He or she must choose only one of these programs in which to participate.

B. Licensed Master Social Worker (LMSW)

1. The LMSW must have a master's degree from an accredited social work program in an accredited institution approved by the Council on Social Work Education (CSWE).
2. The LMSW must be state licensed and certified to practice as a licensed master social worker in the State of Arkansas and in good standing with the Arkansas Social Work Licensing Board.
3. The LMSW must work under the supervision of an LCSW.
4. The LMSW shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.
5. The LMSW shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

NOTE: A licensed certified social worker employed or contracted with the school district or ESC may not be enrolled in the Targeted Case Management (TCM) Program. He or she must choose only one of these programs in which to participate.

C. Licensed Professional Counselor (LPC)

1. The LPC must have received a graduate (master's) degree that is primarily professional counseling in content from a regionally accredited institution of higher education. The LPC must have accumulated at least 48 graduate semester hours to meet the academic and training content standard established by the Arkansas Board of Examiners in Counseling.
2. The LPC has three (3) years of supervised full-time experience in professional counseling acceptable to the Arkansas Board of Examiners in Counseling. One (1) year of experience may be gained for each 30 graduate semester hours earned beyond the master's degree provided that the hours are clearly related to the field of counseling and are acceptable to the Board. In no case may the applicant have less than one (1) year of supervised professional experience.
3. The LPC must be licensed as a licensed professional counselor and be in good standing with the Arkansas Board of Examiners in Counseling.
4. The LPC must meet all licensure requirements as set forth in Arkansas Code Annotated § 17-27-301 for licensed Professional Counselors (LPC).
5. The LPC must provide proof to the school district or ESC of two (2) years post-licensure experience treating children and adolescents with mental illness.
6. The LPC shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

D. Licensed Associate Counselor (LAC)

1. The LAC must be licensed as a licensed associate counselor and in good standing with the Arkansas Board of Examiners in Counseling.
2. The LAC must meet all licensure requirements as held forth in Arkansas Code Annotated § 17-27-302.
3. The LAC may practice only under direct supervision of an LPC.
4. The plan for supervision of the LAC must be approved by the Board of Examiners in Counseling prior to any actual performance of counseling on the part of the LAC.

5. The LAC must provide proof to the school district or ESC of two (2) years post-licensure experience treating children and adolescents with mental illness.

6. The LAC shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

7. The LAC shall provide to the school district or ESC a copy of his or her supervision plan including the name and license number of his or her supervising LPC before the LAC provides any service for which he or she is required to be under the supervision of a LPC.

E. Licensed School Psychology Specialist (LSPS)

1. The LSPS must possess a minimum of 60 graduate semester hours sixth year/specialist program with an appropriate graduate degree from a North Central Accreditation for Teacher Education (NCATE) accredited institution of higher learning or one authorized by the Arkansas Department of Education.

2. The LSPS must hold a valid license from the Arkansas State Board of Education and be licensed as a school psychology specialist.

3. The LSPS must have completed an internship that consists of one academic year or its equivalent with a minimum of 1200 clock hours of supervised experience, at least 600 of which must be in a school setting.

4. The LSPS shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

F. Licensed Psychological Examiner (LPE)

1. The LPE must have two (2) academic years of graduate training in psychology, including a master's degree from an accredited educational institution recognized by the Arkansas Board of Examiners in Psychology as maintaining satisfactory standards or, in lieu thereof, such training and experience as the Board shall consider equivalent.

2. The LPE must be licensed as a licensed psychological examiner and be in good standing with the Arkansas Board of Examiners in Psychology.

3. The LPE shall provide to the school district or ESC the name and licensure number of his or her supervising psychologist before the LPE provides any service for which he or she is required to be under the supervision of a psychologist licensed by the Arkansas Board of Examiners in Psychology.

4. The LPE shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

G. Psychologist

1. The psychologist must have at least two (2) years of experience in psychology of a type considered by the Board to be qualifying in nature with at least one (1) of those years being postdoctoral work.

2. The psychologist must be licensed as a psychologist by the Arkansas Board of Examiners in Psychology.

3. The psychologist shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

202.110 School-Based Mental Health Services When School is not in Session or a Child is not in School 10-13-03

School-based mental health services providers (school districts and ESCs) will provide services twelve months of each year, either directly or by arrangement with other appropriately licensed personnel.

Examples of periods of time a child is not in school but the school district or ESC is required to provide services are:

A. Summer school break;

B. Holidays;

C. Nights and weekends;

D. When a child is out of school due to disciplinary action or

E. Other times a child may be out of school but the school district or ESC is responsible for providing services to the child.

202.120 Liability Insurance 10-13-03

Each practitioner must be covered by liability insurance. The school district or ESC may have a W-4 relationship of employment with an individual practitioner, contract with an individual practitioner or contract with an organization that employs individual practitioners. The requirement regarding liability insurance must be met in one of the following ways:

A. When school-based mental health services practitioners are employed by the local school district, the school district's liability insurance covers the practitioner.

B. When the school district enters into a professional services contract with an individual who is in private practice, the individual will be responsible for carrying liability insurance.

C. When the district contracts with an organization, such as a Community Mental Health Center, which employs mental health practitioners, the organization employing the practitioner is responsible for carrying liability insurance.

210.000 PROGRAM COVERAGE

211.000 Introduction 10-13-03

Medicaid (Arkansas Medical Assistance Program) is designed to assist eligible beneficiaries in obtaining medical care within the guidelines specified in Section I of the manual. Reimbursement will be made for allowed services rendered by a Medicaid-enrolled school-based provider within the Medicaid Program limitations as outlined in this manual.

211.100 Continuity of Care and/or Services 10-13-03

In accordance with existing ADE policy, public education agencies are required to work cooperatively with other providers of services to children and youth. Likewise, providers of mental health services other than public education agencies are also required by state policy to work collaboratively to coordinate the delivery of mental health services with other sources of similar services and care and to make appropriate disclosure consistent with privacy and confidentiality rights of the treatment plan to all parties involved with mental health services. The school counselor will be informed as to the need for services.

211.200 Non-Refusal Requirement 10-13-03

The school-based mental health services provider may not refuse services to a Medicaid-eligible beneficiary under age 21 in a school setting unless, based upon the primary mental health diagnosis, the provider does not possess the services or program to adequately treat the beneficiary's mental health needs.

211.300 Primary Care Physician (PCP) Referral 6-1-22

Each beneficiary who receives School-Based Mental Health Services can receive a limited amount of services. Once those limits are reached, a Primary Care Physician (PCP) referral or Patient-Centered Medical Home (PCMH) approval will be necessary to continue treatment. This referral or approval must be retained in the beneficiary's medical record.

A beneficiary can receive ten (10) School-Based Mental Health Services before a PCP/PCMH referral is necessary. No services will be allowed to be provided without appropriate PCP/PCMH referral. The PCP/PCMH referral must be kept in the beneficiary's medical record.

The Patient-Centered Medical Home (PCMH) will be responsible for coordinating care with a beneficiary's PCP or physician for School-Based Mental Health Services. Medical responsibility for beneficiaries receiving School-Based Mental Health Services shall be vested in a physician licensed in Arkansas.

The PCP referral or PCMH authorization for School-Based Mental Health Services will serve as the prescription for those services.

See Section I of this manual for the PCP procedures. A PCP referral is generally obtained prior to providing service to Medicaid-eligible children. However, a PCP is given the option of providing a referral after a service is provided. If a PCP chooses to make a referral after a service has been provided, the referral must be received by the SBMH provider no later than 45 calendar days after the date of service. The PCP has no obligation to give a retroactive referral.

The SBMH provider may not file a claim and will not be reimbursed for any services provided that require a PCP referral unless the referral is received.

211.310 When a Child is Ineligible for Medicaid at Time of Service 7-1-05

A. When a child who is not eligible for Medicaid receives an outpatient mental health service, an application for Medicaid eligibility may be filed by the child or his or her representative.

B. If the application for Medicaid coverage is approved, a PCP referral is not required for the period prior to the Medicaid authorization date. This period is considered **retroactive** eligibility and does not require a referral.

C. A PCP referral is required no later than forty-five calendar days after the authorization date. If the PCP referral is not obtained within forty-five calendar days of the Medicaid authorization date, reimbursement will begin, if all other requirements are met, the date the PCP referral is received. To verify the authorization date, a provider may call the Arkansas Medicaid fiscal agent or the local DHS Office.

However, a PCP is given the option of providing a referral after a service is provided. If a PCP chooses to make a referral after a service has been provided, the referral must be received by the SBMH provider no later 45 calendar days after the date of authorization. The PCP has no obligation to give a retroactive referral.

The SBMH provider may not file a claim and will not be reimbursed for any services provided that require a PCP referral unless the referral is received.

View or print PAC contact information. View or print DHS contact information.

211.320 Renewal of PCP Referral 10-13-03

If a beneficiary continues to require outpatient mental health services for six months or more, the PCP referral must be renewed every six months.

212.000 Scope 7-1-17

The School-Based Mental Health Services program consists of a range of mental health diagnostic, therapeutic, rehabilitative or palliative services provided by the employees and

contractors described in Section 202.100 of this manual to Medicaid-eligible beneficiaries (including ARKids B) under age twenty-one (21) suffering from psychiatric conditions as described in the current allowable American Psychiatric Association Diagnostic and Statistical Manual (DSM).

Medicaid-covered school-based mental health services may be provided only when:

A. Referred, in writing or verbally, by a Medicaid-enrolled physician. See Section 212.100 for details.

B. Provided to Medicaid recipients under age 21.

C. Provided to outpatients.

D. Provided by School-Based Mental Health Services provider employees or contractors.

E. A comprehensive assessment indicates the need for services (see Section 212.200 for details).

F. Included in a treatment plan.

212.100 Physician Referral 4-1-07

The Medicaid beneficiary must be referred verbally or in writing for school-based mental health services by a Medicaid-enrolled physician. The referral must establish that services are medically necessary. **The referral must be renewed every six (6) months.** The written referral or documentation of the verbal referral must include:

A. The name of the referring Medicaid-enrolled physician,

B. The referring Medicaid-enrolled physician's provider identification number and

C. The date of the referral.

212.200 Comprehensive Assessment 10-13-03

Documentation of the comprehensive assessment shall include at a minimum:

A. Complete demographic information;

B. Presenting problem(s);

C. History of present problem(s);

D. Psychiatric history;

E. Substance abuse history;

F. Medical and Developmental history;

G. Family and social history;

H. Mental status examination and

I. Clinical impression and diagnosis.

212.300 Treatment Plan Requirements 10-13-03

An individualized, written treatment plan must be developed and included in the patient medical record for each beneficiary receiving mental health services. The treatment plan must include at a minimum:

A. Demographic data;

B. Presenting problem;

C. History of problem;

D. Social history;

E. Defined goals and objectives with documented input of beneficiary. The input of family, where applicable, must also be documented and

F. Date(s) of treatment plan review, with updates to occur no less than every 90 days.

A student's IEP, Behavior Intervention and Support Plan or family services plan shall be considered to meet the definition of the individualized treatment plan only when containing the information specified above.

212.400 Place of Service 10-13-03

School-Based Mental Health Services are reimbursable by Arkansas Medicaid only when provided in the following locations:

A. School: School can be defined for purposes of these services to include an area on- or off-site based on accessibility for the child.

B. Home: When the home is considered to be an educational setting for a child who is enrolled in the public school system. (The home is not considered a place of service when the parent elects to home school the child.)

213.000 Exclusions 7-1-17

The following are non-covered School-Based Mental Health Services:

A. Services provided in a supervised living or residential treatment facility.

B. Educational services.

C. Telephone contacts with the patient or telephone contacts with the collateral in regard to the beneficiary.

D. Services to individuals with developmental disabilities that are non-psychiatric in nature, except for testing purposes.

E. Inpatient Hospital Services.
"Inpatient" means a patient who has been admitted to a medical institution on recommendation of a physician or dentist and is receiving room, board and professional services in the institution on a continuous 24-hour-a-day basis, or who is expected by the institution to receive room, board and professional services for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

F. Inpatient Psychiatric Services.
See E. above for definition of inpatient.

G. A School-Based Mental Health Services provider will not be reimbursed for the same procedure code for a service provided on the same date of service as services provided by a Counseling Level Outpatient Behavioral Health Services Provider or Outpatient Behavioral Health Services Provider certified by the Division of Behavioral Health Services.

214.000 Covered Services 4-1-18

Outpatient Services

Fifteen-minute units, unless otherwise stated.

School-Based Mental Health Services must be billed on a per-unit basis, as reflected in a daily total, per beneficiary, per service.

One (1) unit =	8–24 minutes
Two (2) units =	25–39 minutes
Three (3) units =	40–49 minutes
Four (4) units =	50–60 minutes

Time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day. Providers may accumulatively bill for a single date of service, per beneficiary, per Outpatient Behavioral Health service. Providers are not allowed to accumulatively bill for spanning dates of service.

All billing must reflect a daily total, per Outpatient Behavioral Health service, based on the established procedure codes. No rounding is allowed.

The sum of the days' time, in minutes, per service will determine how many units are allowed to be billed. That number must not be exceeded. The total number of minutes per service must be compared to the following grid, which determines the number of units allowed.

One (1) unit =	8–24 minutes
Two (2) units =	25–39 minutes
Three (3) units =	40–49 minutes
Four (4) units =	50–60 minutes

In a single-claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary. There is no "carryover" of time from one day to another or from one beneficiary to another.

Documentation in the beneficiary's record must reflect exactly how the number of units is determined.

No more than four (4) units may be billed for a single hour per beneficiary or provider of the service.

Refer to Section 272.100 of this manual for descriptions of procedure codes that are reimbursable by Arkansas Medicaid for School-Based Mental Health providers.

215.000 Diagnosis and Clinical Impression 9-1-14

Diagnosis and clinical impression shall be required in the terminology of ICD for billing purposes.

216.000 Record Keeping Requirements 10-13-03

All medical records that support the provision of medical services billed to Medicaid shall be completed promptly, filed and retained by the school district or ESC in which the child attends school. The records must be available for audit. Specific record keeping requirements are listed below:

A. The school district or ESC must keep all required documentation and records for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.

B. The school district or ESC must furnish requested records and documentation to authorized representatives of the Arkansas Division of Medical Services and the Arkansas Attorney General's Office Medicaid Fraud Unit, as well as to representatives, authorized agents or officials of the United States Department of Health and Human Services. Failure to furnish records upon request may result in sanctions being imposed.

C. All documentation must be made available to representatives of the Arkansas Division of Medical Services (DMS) at the time of an audit by the Arkansas Medicaid Field Audit Unit.

1. All documentation must be available at the provider's place of business.

2. If an audit determines that recoupment is necessary, there will be no more than thirty (30) days allowed after the date of the recoupment notice in which additional documentation will be accepted.

See Section 217.000 of this manual for a complete listing of required documentation.

217.000 Documentation 4-1-07

The documentation must be maintained in the student's medical record.

The school district or ESC must properly maintain written records for each child receiving school-based mental health services that include, at a minimum, the following:

A. A referral from a Medicaid-enrolled physician must be obtained and filed in the medical record of each child receiving school-based mental health services. The referral may be verbal or written and must contain the physician's name and provider identification number and the date of the referral. If the referral is verbal, the school district or ESC must document the referral in the child's medical record by stating the name of the physician and the date of the verbal referral. The referral must be renewed every six (6) months.

B. Comprehensive assessment. See Section 212.200 for details.

C. Written treatment plan which meets the requirements of Section 212.300.

D. Provider of services signature and title.

E. Beneficiary of service(s).

F. Date of service(s).

G. Place the service(s) were provided.

H. Actual time of services (beginning and ending time of each service).

I. Length of time over which a service was provided.

J. Specific service(s) rendered (type of activity provided).

K. Progress notes for each service provided, which include information on patient response to treatment rendered.

NOTE: Each progress note should relate to treatment plan goals and objectives and describe the student's progress toward established goals. Progress notes may be kept in narrative form or on logs, if all required components are present.

L. Discharge plan, to include input of the beneficiary, the beneficiary's family, or both as appropriate.

217.100 Electronic Signatures 10-8-10

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

218.000 Beneficiary Appeal Process 10-13-03

When an adverse decision is received, the beneficiary may request a fair hearing of the denial decision.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter explaining the denial of services. Appeal requests must be submitted to the Department of Human Services, Appeals and Hearings Section. **View or print the Appeals and Hearings Section contact information**.

219.000 Utilization Review 7-1-17

The Utilization Review Section of the Arkansas Medicaid Program has the responsibility for assuring quality medical care for its beneficiaries along with protecting the integrity of both state and federal funds supporting the Medical Assistance Program.

219.100 Record Reviews 4-1-18

The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) has contracted with an independent contractor to perform on-site inspections of care (IOC) and retrospective reviews of outpatient mental health services provided by School-Based Mental Health Services providers. **View or print current contractor contact information**. The reviews are conducted by licensed mental health professionals and are based on applicable federal and state laws, rules and professionally recognized standards of care.

219.200 Utilization Review Section 10-13-03

If a claim is rejected due to the same service being billed by more than one provider on the same date, the provider whose claim was rejected may contact the Utilization Review (UR) Section of the Division of Medical Services to request a review for medical necessity. If medical necessity is established the UR Section will authorize payment of the claim.

Division of Medical Services Utilization Review Section may be contacted in writing. **View or print the Utilization Review Section contact information.**

228.130 Retrospective Reviews 7-1-17

The Division of Medical Services (DMS) of the Arkansas Department of Human Services has contracted with a Quality Improvement Organization (QIO) or QIO-like organization to perform retrospective (post-payment) reviews of outpatient mental health services provided by Outpatient Behavioral Health providers. **View or print current contractor contact information.**

The reviews will be conducted by licensed mental health professionals who will examine the medical record for compliance with federal and state laws and regulations.

228.131 Purpose of a Review 7-1-17

The purpose of a review is to:

A. Ensure that services are delivered in accordance with the treatment plan and conform to generally accepted professional standards.

B. Evaluate the medical necessity of services provided to Medicaid beneficiaries.

C. Evaluate the clinical documentation to determine if it is sufficient to support the services billed during the requested period of authorized services.

D. Safeguard the Arkansas Medicaid program against unnecessary or inappropriate use of services and excess payments in compliance with 42 CFR § 456.3(a).

229.000 Medicaid Beneficiary Appeal Process 7-1-17

If an adverse decision is received, the beneficiary may request a fair hearing of the denial decision.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter explaining the denial of services.

229.200 Recoupment Process 7-1-17

The Division of Medical Services (DMS), Utilization Review Section (UR) is required to initiate the recoupment process for all claims that the current contractor has denied because the records submitted do not support the claim of medical necessity.

Arkansas Medicaid will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the recoupment is initiated.

260.000 REIMBURSEMENT

261.000 Method of Reimbursement 10-13-03

Reimbursement is based on the lesser of the billed amount or the Title XIX maximum allowable for each procedure.

261.010 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.

262.000 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 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.

270.000 BILLING PROCEDURES

271.000 Introduction to Billing 7-1-20

School-based mental health providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim should contain charges for only one (1) beneficiary.

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

272.000 CMS-1500 Billing Procedures

272.100 School-Based Mental Health Services Procedure Codes 9-1-13

The following is a list of covered services available in the School-Based Mental Health Services Program. Practitioners enrolled as school-based mental health services provider personnel may provide the services on this list according to their scope of practice as identified by the licensure requirements.

272.110 Mental Health Diagnosis 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature and appropriate treatment of a mental illness or related disorder as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to, a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (Plan of Care). Services must be congruent with the age and abilities of the beneficiary, client-centered and	• Date of service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s) including duration, intensity and response(s) to prior treatment • Culturally- and age-appropriate psychosocial

<table>
<tr><td>strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.</td><td colspan="2">history and assessment
• Mental status/clinical observations and impressions
• Current functioning plus strengths and needs in specified life domains
• DSM diagnostic impressions to include all axes
• Treatment recommendations
• Goals and objectives to be placed in Plan of Care
• Staff signature/credentials/date of signature</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.).</td><td>Encounter</td><td>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children and Youth</td><td colspan="2">Outpatient Behavioral Health Services Providers cannot bill on same date of service
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<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face</td><td colspan="2">School-Based Mental Health</td></tr>
<tr><td>ALLOWABLE PERFORMING PROVIDER</td><td colspan="2">PLACE OF SERVICE</td></tr>
<tr><td>• Licensed Certified Social Worker (LCSW)
• Licensed Master Social Worker (LMSW)
• Licensed Professional Counselor (LPC)
• Licensed Associate Counselor (LAC)
• Licensed School Psychology Specialist (LSPS)
• Licensed Psychological Examiner (LPE)
• Psychologist
* School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.</td><td colspan="2">03</td></tr>
</table>

272.120 Psychological Evaluation 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Psychological evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology, e.g. MMPI, Rorschach®, and WAIS®. Psychological testing is billed per hour both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary. Medical necessity for this service is met when: • the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions; • history and symptomatology are not readily attributable to a particular psychiatric diagnosis; or • questions to be answered by the evaluation could not be resolved by a psychiatric/diagnostic interview, observation in therapy or an assessment for level of care at a mental health facility.	• Date of service • Start and stop times of actual encounter with beneficiary • Start and stop times of scoring, interpretation and report preparation • Place of service • Identifying information • Rationale for referral • Presenting problem(s) • Culturally- and age-appropriate psychosocial history and assessment • Mental status/clinical observations and impressions • Psychological tests used, results, and interpretations, as indicated • DSM diagnostic impressions to include all axes • Treatment recommendations and findings related to rationale for service and guided by test results • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Licensed Psychological Examiner (LPE)	03

• Psychologist	

272.130 Interpretation of Diagnosis 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for SBMH services.	Interpretation or explanation of results of psychiatric or other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face to face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the goals and objectives placed in Plan of Care • Participant(s) response and feedback • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary, the beneficiary and the parent(s) or guardian(s) or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS)	03	

• Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	

272.140 Marital/Family Behavioral Health Counseling with Beneficiary Present 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for SBMH services.	Family psychotherapy with patient present (conjoint psychotherapy)	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Marital/Family Behavioral Health Counseling with Beneficiary Present is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used, that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant release of Information, completed, signed and dated	
NOTES	**UNIT**	**BENEFIT LIMITS**

Natural supports may be included in these sessions if justified in service documentation. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

272.150 Crisis Intervention **2-1-22**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.	Crisis intervention service, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)	• Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to

	current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services. The provider of this service MUST complete a Mental Health Diagnosis (90791) within 7 days of provision of this service. If the beneficiary needs more time to be stabilized, this must be noted in the beneficiary's medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 72
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for SBMH services.	psychotherapy, 30 min psychotherapy, 45 min psychotherapy, 60 min	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based with an emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.	• Date of service • Start and stop times of face-to-face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the master treatment plan, diagnosis or medication(s) • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service.	30 minutes 45 minutes 60 minutes View or print the procedure codes for SBMH services.	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12 units
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	A provider may only bill one individual counseling/psychotherapy code per day per beneficiary. A provider cannot bill any other individual counseling/psychotherapy code on the same date of service for the same beneficiary.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**	

• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03

272.170 Group Outpatient – Group Therapy 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for SBMH services.	A direct service contact between a group of patients and school-based mental health services provider personnel for the purposes of treatment and remediation of psychiatric condition.	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Group Behavioral Health Counseling is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis • Focus of group • Brief mental status and observations • Rationale for group counseling must coincide with master treatment plan • Beneficiary's response to the group counseling that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next group session, including any homework assignments • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This does NOT include psychosocial groups. Beneficiaries eligible for Group Outpatient – Group Psychotherapy must demonstrate the ability to benefit from experiences shared by	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1

others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of beneficiaries aged 18 and over, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 12. For groups of beneficiaries under 18 years of age, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 10. A beneficiary must be 4 years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e., 16 year olds and 4 year olds must not be treated in the same group). Providers may bill for services only at times during which beneficiaries participate in group activities.		YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 12 units Rehabilitative/Intensive Level Beneficiary: 104 units
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill one Group Behavioral Health Counseling / Community Group Psychotherapy encounter per day. For Counseling Level Beneficiaries, there are 12 total group behavioral health counseling visits allowed per year unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid. For Rehabilitative/Intensive Level Beneficiaries, there are 104 total group behavioral health counseling visits allowed per year unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72	

272.200 National Place of Service Code 7-1-07

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

National Place of Service	National POS Code
Public School	03

272.300 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 Arkansas Medicaid fiscal agent 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.

272.310 Completion of the 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	

Field Name and Number	Instructions for Completion
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If beneficiary 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. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9a and d are required. Name of the insured individual's employer and/or school.
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.

Field Name and Number	Instructions for Completion
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, 9c 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.
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	Enter the name of the referring physician. 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.

Field Name and Number	Instructions for Completion
19. Local Educational Agency (LEA) Number	Insert LEA number.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
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. 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 272.200 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	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 co-payment.
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.

272.400 Special Billing Procedures 10-13-03

Not applicable to this program.