TOC not required

292.310 Completion of the CMS-1500 Claim Form

~~12-15-14~~10-1-21

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.

Field Name and Number			Instructions for Completion
	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:		
	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.

Field Name and Number	Instructions for Completion
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	Primary Care Physician (PCP) referral is required for most Physician/Independent Lab/CRNA/Radiation Therapy Center services provided by non-PCPs. Enter the referring physician's name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 292.200 for codes.
C. EMG	Check “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. For anesthesia, when billed with modifier(s) P1, P2, P3, P4, or P5, hours and minutes must be entered in the shaded portion of that detail in field 24D.

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	For paper claims, including Anesthesia on paper claims, enter ~~T~~the units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail. For electronic claims submission, for Anesthesia services, enter total minutes.
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.

292.440 Anesthesia Services

~~7-1-2010~~-1-21

Anesthesia procedure codes (**00100** through **01999**) must be billed in anesthesia time. Anesthesia modifiers **P1** through **P5** listed under Anesthesia Guidelines in the CPT must be used. When appropriate, anesthesia procedure codes that have a base of four (4) or fewer are eligible to be billed with a second modifier, **"22,"** referencing surgical field avoidance.

Reimbursement for use and administration of local or topical anesthesia is included in the primary surgeon's reimbursement for the surgery that requires such anesthesia. No modifiers or time may be billed with these procedures.

A. Electronic Claims

For electronic claims for Anesthesia services (procedure codes 00100 through 01999), total minutes should be billed in the units field.~~Electronic claims submission may be used unless attachments are required.~~

B. Paper Claims

If paper billing is required, enter the procedure code, time, and units as shown in Section 292.447. Enter again the number of units (each fifteen (15) minutes of anesthesia equals one (1) time unit) in Field 24G. (See cutaway section of a completed claim in Section 292.447.)

C. The following CPT procedure codes require attachments or documentation~~for hysterectomies and abortions must be billed on CMS-1500 paper claims because they require attachments or documentation~~.

Procedure Code	Description	Documentation Required

Procedure Code	Description	Documentation Required
00800	Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified	Operative Report~~On females only, required to name each procedure done by surgeon in "Procedures, Services, or Supplies" column. Example - 1. colon resection 2. lysis of adhesions 3. appendectomy~~
00840	Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; not otherwise specified	Operative Report~~On females only, required to name each procedure done by surgeon in "Procedures, Services, or Supplies" column. This code may not be used to bill Arkansas Medicaid for any hysterectomy anesthesia.~~
00840 Modifier UI	Anesthesia for Abdominal Hysterectomy	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00840 Modifier U2	Anesthesia for Laparoscopic Hysterectomy	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00840 Modifier U3	Anesthesia for Supra-cervical Hysterectomy, any method	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00846	Radical hysterectomy	Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00848	Pelvic exenteration	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00922	Anesthesia for procedures on male genitalia (including open urethral procedures); seminal vessels	Operative Report
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified	Operative Report~~Required to name each procedure done by surgeon in "Procedures, Services or Supplies" column.~~

Procedure Code	Description	Documentation Required
00944	Vaginal hysterectomy	Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
01962	Anesthesia for urgent hysterectomy following delivery	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
01963	Anesthesia for cesarean hysterectomy without labor analgesia/anesthesia care	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
01965	Anesthesia for incomplete or missed abortion procedure	Procedure requires the following ICD diagnosis code (**View ICD Codes.**). Any other diagnosis billed with this procedure code requires paper billing and documentation to justify the procedure
01966	Anesthesia for induced abortions. Use for billing anesthesia services for all elective, induced abortions, including abortions performed for rape or incest.	Operative Report Certification Statement for Abortion (DMS-2698). (See Sections 251.220, 261.000, 261.100, 261.200, and 261.260 of this manual.) **View or print form DMS-2698 and instructions for completion.**
01999	Unlisted anesthesia procedure(s)	Procedure Report

*****Other documentation may be requested upon review.**

D. Anesthesiologist/anesthetists may bill procedure code **00170** for any inpatient or outpatient dental surgery using place of service code "~~24~~11," "**21**," "**22**", or "~~11~~24," as appropriate. This code does not require Prior Approval for anesthesia claims.

E. A maximum of seventeen (17) units of anesthesia are allowed for a vaginal delivery or Cesarean Section. Refer to Anesthesia Guidelines of the CPT book for procedure codes related to vaginal or Cesarean Section deliveries. Only one (1) anesthesia service is billable for Arkansas Medicaid as the anesthesia for a delivery. The anesthesia service ultimately provided should contain all charges for the anesthesia. No add-on codes are payable.

292.446 Time Units

~~7-1-07~~10-1-21

Time units will be added to the Base Value and the Anesthesia Modifier for all cases at the rate of 1.0 Unit for each 15 minutes or any fraction thereof. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

Enter the time units in Field 24G for paper claims. If filing electronically, the value submitted in this field should be the total anesthesia in minutes.

Anesthesia stand-by should be billed as detention time using procedure code **99360.** One unit equals 30 minutes. A maximum of one unit per date of service may be billed.