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**200.000 HEARING SERVICES GENERAL INFORMATION****201.000 Arkansas Medicaid Participation Requirements for Hearing Aid Dealers 10-15-09**

Hearing aid dealers 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. Hearing aid dealers, physicians and audiologists in Arkansas must be licensed as Hearing Aid dealers.
- B. Audiologists licensed in Arkansas may provide both audiology service and the dispensing of hearing aids with their audiologist license.
- C. Hearing aid dealers, physicians and audiologists outside of Arkansas must be licensed by their states as hearing aid dealers.

A current copy of the applicable license must be submitted with the Medicaid provider application packet.

### 202.000 Participation Requirements for Individual Audiologists 10-15-09

Audiologists 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. Audiologists must be licensed in their states as audiologists. Audiologists with an Arkansas license may also dispense hearing aids as per Arkansas Act 1171 of 1991. A copy of the current state license must accompany the provider application and Medicaid contract.

**NOTE: An audiologist licensed outside the state of Arkansas who has a Hearing Aid Dealer license and an Audiology license must enroll under both programs. A provider application packet must be completed for each program, and two (2) separate Medicaid provider numbers will be assigned.**

### 202.100 Group Providers of Audiology Services in Arkansas and Bordering States 10-15-09

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

If an audiologist is a member of a group, each individual audiologist and the group must both enroll in the Arkansas Medicaid Program.

- A. Each individual audiologist within the group must enroll following the criteria established in Section 202.000.
- B. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled licensed audiologist within the group.

**NOTE: An audiologist licensed outside the state of Arkansas who has a Hearing Aid Dealer License and an Audiology License must enroll under both programs. A provider application packet must be completed for each program, and two (2) separate Medicaid provider numbers will be assigned.**

### 202.110 School Districts and Education Service Cooperatives 10-15-11

If a school district or an education service cooperative (ESC) contracts with an individual qualified audiologist, the participation criteria for group providers of audiology services apply. (Refer to Section 202.100.)

If a school district or ESC employs a qualified audiologist, the following participation criteria apply:

- A. The school district or ESC must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653), a certification letter from the Arkansas Department of Education (ADE) and a Request for Taxpayer Identification Number and Certification (form W-9) with the Arkansas Medicaid Program. [View or print a provider application \(form DMS-652\), Medicaid contract \(form DMS-653\) and Request for Taxpayer Identification Number and Certification \(form W-9\).](#) The Local Education Agency (LEA) number must be used as the license number for the school district or ESC.
- B. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

- C. The school district or ESC must maintain a copy of each employed audiologist's current state license.
- D. A Medicaid-enrolled audiologist who exclusively performs services as an employee of a school district or ESC must complete and submit form DMS-7782 ([view or print form DMS-7782](#)) on an annual basis so that the audiologist's individual enrollment with Arkansas Medicaid remains active.

**202.200 Enrollment in the Title XVIII (Medicare Program)**

9-1-09

For beneficiaries who are eligible for Medicare and Medicaid, see Section I of this manual for additional coinsurance and deductible information. See Section III for instructions on filing joint Medicare/Medicaid claims.

**203.000 Providers in Arkansas and Bordering States**

9-1-06

Hearing Services providers in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) will be enrolled as routine services providers.

Routine Services Provider

- A. Provider is enrolled in the program as a regular provider of routine services.
- B. Reimbursement will be available for all hearing services covered in the Arkansas Medicaid Program.
- C. Paper claims must be filed according to Section 240.000 of this manual. Information regarding electronic claim filing is available in Section III of this manual.

**203.100 Providers in States Not Bordering Arkansas**

3-1-11

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

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

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

**204.000 The Hearing Services Provider's Role in the Child Health Services (EPSDT) Program**

1-15-11

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

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

Hearing Services providers interested in the Child Health Services (EPSDT) Program should contact the Child Health Services (EPSDT) Office. [View or print the Child Health Services Office \(EPSDT\) contact information.](#)

Hearing Services providers must bill Child Health Services (EPSDT) on the CMS-1500 claim form when billing on paper. If billing electronically, use the professional claim format. Current billing information must be obtained from the Child Health Services (EPSDT) provider manual. See the EPSDT provider manual for information regarding EPSDT screenings. Ancillary charges, such as lab and X-ray, associated with Child Health Services (EPSDT) should be listed on the claim. [View a sample CMS-1500 form.](#)

Any enrolled Arkansas Medicaid provider who provides services that are not covered by the Arkansas Medicaid Program to a participant in the Child Health Services (EPSDT) Program who has been referred for services as a result of an EPSDT screen will be reimbursed for the services provided they are medically necessary and permitted under Federal Medicaid regulations.

When a provider performs a Child Health Services (EPSDT) screen and refers the patient to another provider for services not covered by Arkansas Medicaid, the referring provider must give the beneficiary a prescription for the services. The prescription must indicate that the services being prescribed are due to a Child Health Services (EPSDT) screen. The beneficiary must present this prescription to the provider. The beneficiary may take this prescription to the provider of his or her choice. The prescription for services must then be retained in the beneficiary's medical record for audit purposes by the provider who provides the services. If the beneficiary is then referred to another provider, the same procedure must be followed. A provider who performs a Child Health Services (EPSDT) screen may also provide services resulting from the screen, if appropriate.

**In order for the non-covered service to be eligible for Medicaid payment, the referral documentation must be available for review.**

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

**205.000**      **Record Keeping Requirements**      **10-15-09**

Documentation and provider participation requirements are detailed within Section 140.000, Provider Participation, of this manual.

**206.000**      **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**      **9-1-09**

The Arkansas Medicaid Program is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual.

**212.000 Coverage 9-1-09**

Arkansas Medicaid covers hearing services for eligible Medicaid beneficiaries under age 21 in the Child Health Services (EPSDT) Program when prescribed by a physician.

**213.000 Scope 10-15-11**

The Utilization Review Section of the Division of Medical Services is responsible for authorizing hearing aid services for eligible Medicaid beneficiaries under age 21. Services are provided as a result of a referral from the beneficiary's primary care physician (PCP). If the beneficiary is exempt from the PCP process, then the attending physician must make the referral. Licensed audiologists may provide vestibular testing, aural rehabilitation and aural habilitation services.

A school district or education service cooperative (ESC) may provide audiology services in accordance with a student's Individual Education Program (IEP). A PCP referral is required each time a new IEP is written for the student. When the student is exempt from PCP referral requirements, the student's attending physician must make the referral for audiology services. The referral can encompass the 9-month school year unless the PCP or attending physician specifies otherwise. The school district or ESC must use a Referral Form for Audiology Services – School-Based Setting (form DMS-7783) to obtain the referral and must maintain the completed referral form in the student's medical record. ([View or print form DMS-7783.](#)) Certain procedure codes are not payable to school districts and education service cooperatives. (Refer to Sections 242.100 and 242.110 of this manual for more information about non-payable codes.)

Prior to providing hearing aid services to an eligible Medicaid beneficiary, a medical clearance must be obtained from a physician. This clearance must indicate if there are any medical or surgical indications contrary to fitting the beneficiary with a hearing aid. An audiological exam must be made by a certified audiologist or a physician. Arkansas Medicaid will not reimburse for a hearing test performed by a State-licensed hearing aid dispenser unless the hearing aid dispenser is also a licensed physician or licensed audiologist. The hearing evaluation must include the audiologist's or physician's recommendations regarding the brand name and model of the hearing aid to be dispensed and the name of the Medicaid dealer the patient has chosen to provide the hearing aid. The cost of the hearing aid should be provided if available. The medical clearance and hearing evaluation and a copy of the audiogram must be forwarded to the Division of Medical Services Utilization Review (UR) Section and must reach the UR Section within 6 months from the date the above evaluations were performed. [View or print the Division of Medical Services Utilization Review Section contact information.](#) After reviewing the medical clearance from the physician and the audiological evaluation from the audiologist or the physician, a letter of authorization is sent from the Utilization Review Section to the Medicaid provider dispensing the hearing aid.

Fitting and servicing the hearing aid is performed by a licensed dispenser. The dealer must submit his or her claim for payment to the Arkansas Medicaid fiscal agent with the charges and serial numbers of the aid dispensed. Please refer to Section 240.000 of this manual for billing instructions and procedure codes regarding hearing aids.

The beneficiary is entitled to three follow-up visits to the dealer who dispensed the aid for the purpose of learning proper operation and care of the aid. The Medicaid Program does not reimburse the provider an additional amount for these three visits.

**214.000 Limitations and/or Exclusions 10-15-11**

There is a one-year warranty period during which all necessary adjustments, parts and replacements to the transmitter and receiver are provided at no cost to the beneficiary or to the Medicaid Program. At the expiration of the warranty period, the dealer will be reimbursed at the lesser of 75% of charges billed to private patients or the Title XIX maximum charge allowed for necessary repairs and replacements.

Repairs and replacements to the transmitter or receiver of hearing aids not purchased through the Medicaid Program may be authorized in the same manner as aids purchased through the Program. Medicaid will make no reimbursement for this equipment during the one-year warranty period.

Replacements are not covered under the Medicaid Program one-year warranty period. Reimbursement is made by Medicaid at 68% of charges billed to private pay patients.

In cases of equipment abuse, no payment will be made by the Medicaid Program. The beneficiary (or parent or guardian) is encouraged to purchase hearing aid insurance from the dealer to cover the cost of repairs or replacements.

The Arkansas Medicaid Program does not cover assistive listening devices that are prescribed solely for social or educational development.

#### 214.100 Extension of Benefits

9-1-09

The hearing services provider may request an extension of benefits by sending a letter to the Utilization Review Unit requesting prior authorization for additional services. The request must be accompanied by the Medicaid beneficiary's medical record. [View or print the Utilization Review Section contact information.](#)

Providers are encouraged to use Form DMS-686, Amplification/Assistive Technology Recommendation Form, to request hearing aid services that require approval. Providers are not required to use DMS-686. However, all the information contained in DMS-686 must be submitted in writing to the reviewer. [View or print form DMS-686.](#)

### 220.000 PRIOR AUTHORIZATION

10-13-03

Prior authorization (PA) is not applicable to Hearing Services provided by in-state providers, with the exception of repairs. Refer to Section 213.000 for policy regarding medical necessity and the prior authorization process.

Refer to Section 203.000 of this manual for information regarding prior authorization of hearing services provided by providers in non-bordering states.

#### 221.000 Prior Authorization for Repairs

7-1-07

Unlike other hearing services, repairs made to hearing aids must be assigned a prior authorization control number prior to Medicaid reimbursement. This PA control number is assigned by the Division of Medical Services Utilization Review Section. Claims may be submitted electronically the day after the PA number is assigned.

Prior to repairing the hearing aid equipment, the provider must submit Form DMS-679 to the Division of Medical Services Hearing Aid Consultant to request prior approval. [View or print the Division of Medical Services Hearing Aid Consultant contact information.](#)

[View or print Request for Prior Authorization and Prescription Form DMS-679 and instructions for completion.](#)

The request for prior authorization will be reviewed by the Utilization Review Section. If necessary, Utilization Review may request additional information.

If the request is approved, a Prior Authorization Control Number will be assigned. The PA number will be indicated on the copy of the Request for Prior Authorization and Prescription Form that is returned to the provider, with a copy sent to the beneficiary. Denied requests will be returned to the provider, with a copy sent to the beneficiary, and will include the reason for denial. Information on the Fair Hearing process will also be included. See Section 190.000, et al, for information regarding administrative appeals.

Prior Authorization does not guarantee payment. Payment is contingent on beneficiary and provider eligibility at the time of service and upon the correct submission of the claim.

**NOTE: The Prior Authorization Control Number in Item 10 of the Request for Prior Authorization and Prescription form must be entered on the CMS-1500 claim form filed for payment of these services. If the claim is submitted electronically, the claim can be submitted the day after the PA number is issued.**

Beneficiaries in the Arkansas Medicaid Program receive plastic I.D. cards with their picture and a hologram in the background. Children under 5 years old will not have a picture on the I.D. cards. Eligibility can be verified electronically using the I.D. card. Reimbursement of services is contingent on beneficiary and provider eligibility, and the filing of a complete, correct claim.

## 230.000 REIMBURSEMENT

### 231.000 Method of Reimbursement 10-13-03

Reimbursement for hearing aids is based on 68% of retail price.

Maintenance and repairs are reimbursed according to the lesser of the amount billed, not to exceed a maximum \$100.00 per repair and/or maintenance.

Audiologist reimbursement is based on the lesser of the amount billed or the Title XIX maximum charge allowed. The Title XIX (Medicaid) maximum is 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1994.

### 231.010 Fee Schedule 12-1-12

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

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

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

### 232.000 Rate Appeal Process 10-13-03

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

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

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

## 240.000 BILLING PROCEDURES

### 241.000 Introduction to Billing 7-1-20

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

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

### 242.000 CMS-1500 Billing Procedures

#### 242.100 Audiology Procedure Codes 2-1-22

Use the following procedure codes for audiological function tests.

[View or print the procedure codes for Hearing \(Audiology\) services.](#)

† Non-payable to a school district or ESC

\*\*(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

Use the following procedure code for hearing screenings for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

#### 242.110 Hearing Aid Procedure Codes 2-1-22

Use the following procedure codes for hearing aid equipment for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

[View or print the procedure codes for Hearing \(Audiology\) services.](#)

Medicaid covers up to 2 hearing aids per beneficiary each six-months. Hearing aid procedure codes may be billed electronically or on a paper claim form.

\*Repairs require prior authorization

\*\*Accessories

† Non-payable to a school district or ESC

#### 242.200 National Place of Service Codes 10-15-11

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

Place of Service	Place of Service Codes
Inpatient Hospital	21
Doctor's Office	11
Ambulatory Surgical Center	24
Public School	03

**242.300 Billing Instructions – Paper Only**

11-1-17

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

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

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

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

**242.310 Completion of CMS-1500 Claim Form**

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	

Field Name and Number	Instructions for Completion
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 SEX	Reserved for NUCC use. 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?  PLACE (State)	Required when an auto accident is related to the services. Check YES or NO.  If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at <a href="http://www.nucc.org">www.nucc.org</a> 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.

Field Name and Number	Instructions for Completion
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, 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.
15. OTHER DATE	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.
15. OTHER DATE	The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:
15. OTHER DATE	454 Initial Treatment
15. OTHER DATE	304 Latest Visit or Consultation
15. OTHER DATE	453 Acute Manifestation of a Chronic Condition
15. OTHER DATE	439 Accident
15. OTHER DATE	455 Last X-Ray
15. OTHER DATE	471 Prescription
15. OTHER DATE	090 Report Start (Assumed Care Date)
15. OTHER DATE	091 Report End (Relinquished Care Date)
15. OTHER 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 Hearing Services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.

Field Name and Number	Instructions for Completion
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. LOCAL EDUCATION AGENCY (LEA) NUMBER	Insert LEA number.
20. OUTSIDE LAB? \$ CHARGES	Not required. Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>
22. RESUBMISSION CODE ORIGINAL REF. NO.	<p>Reserved for future use.</p> <p>Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.</p>
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> <li>1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month.</li> <li>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.</li> </ol>
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	

Field Name and Number	Instructions for Completion
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 242.100 through 242.110.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT 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 <b>not</b> 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.

#### 242.400 Special Billing Procedures

2-1-22

Requests for payment of hearing aids, accessories and repairs must be completed on Form CMS-1500 prior to being submitted to the Utilization Review Section.

The following documentation must accompany each request for a hearing aid:

- A. Medical Clearance (within the last six (6) months, by an orologist or ENT specialist)
- B. Audiogram (by certified audiologist) and Evaluation

All hearing aid providers must use code (Hearing Aid Repair and Service) when billing for hearing aid repairs.

[View or print the procedure codes for Hearing \(Audiology\) services.](#)

Code will require authorization prior to payment. All prior authorization requests must be submitted to the Hearing Aid Consultant, Division of Medical Services. [View or print the Division of Medical Services Hearing Aid Consultant contact information.](#)

Use code when billing for hearing aid accessories.