ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

NOTICE OF RULE MAKING

TO: **Health Care Providers – All Providers**

DATE: **November 1, 2017**

SUBJECT: **Removal of Processing Hold on Paper Claims**

General Information

With the implementation of the new Medicaid Management Information System (MMIS), submitted paper claims will no longer be held for processing for all provider types. On or after November 1, 2017, paper claims will be processed as they are received.

If you have questions regarding this notice, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rulemaking and remittance advice (RA) messages are available for download from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle 10/4

Dawn Stehle
Director

TOC not required

262.300 Billing Instructions – Paper Only 11-1-171-1-16

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

Bill Medicaid for ARChoices 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.

TOC not required

242.300 **Paper Billing Procedures** ~~11-1-17~~ ~~1-07~~

~~Although electronic billing has virtually eliminated the need for paper claims, some notable exceptions are claims that require an original signature, signed consent, approval letters, operative reports, etc. Arkansas Medicaid pays most adjudicated paper claims once each month; but claims that are submitted on paper only because they require attachments are paid in less than 30 days.~~

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell UB-04 forms. **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements, and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding UB-04. **View or print NUBC contact information.**

The committee develops, maintains, and distributes to its subscribers the UB-04 Data Element Specifications Manual and periodic updates. The NUBC is also a vendor of UB-04 claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Data Element Specifications Manual (UB-04 Manual), a UB-04 claim form.

Please forward the original of the completed form to the Claims Department. **View or print the Claims Department contact information.** One copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

TOC not required

230.400 Billing Instructions - Paper Only 11-1-17~~10-1-12~~

~~DHS' fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

Bill Medicaid for professional services with form CMS-1500. View a sample form CMS-1500.

Carefully follow these instructions to help the 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 fiscal agent's claims department. View or print fiscal agent 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.**

TOC not required

242.300 **Billing Instructions – Paper Claims Only** 11-1-17~~7-1-07~~

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

262.300 **Billing Instructions – Paper Only** ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.**

TOC not required

272.300 Billing Instructions ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.**

272.533 Injections, Therapeutic and/or Diagnostic Agents 511-1-17

A. Providers billing the Arkansas Medicaid Program for covered injections should bill the appropriate CPT or HCPCS procedure code for the specific injection administered. The procedure codes and their descriptions may be found in the Current Procedure Terminology (CPT) and in the Healthcare Common Procedural Coding System Level II (HCPCS) coding books.

Injection administration code, T1502 is payable for beneficiaries of all ages. **T1502** may be used for billing the administration of subcutaneous and/or intramuscular injections only. This procedure code cannot be billed when the medication is administered "ORALLY." No fee is billable for drugs administered orally.

T1502 cannot be billed separately for Influenza Virus vaccines or Vaccines for Children (VFC) vaccines.

T1502 cannot be billed to administer any medication given for family planning purposes. No other fee is billable when the provider decides not to supply family planning injectable medications.

T1502 cannot be billed when the drug administered is not FDA approved.

See the table below when billing T1502:

Procedure Code	Modifier	Eligibility Category
T1502	EP	ARKids-A (Ages 0-20)
T1502	SL	ARKids-B
T1502		Ages 19 and above

Most of the covered drugs can be billed electronically. However, any covered drug marked with an asterisk (*) must be billed on paper with the name of the drug and dosage listed in the "Procedures, Services, or Supplies" column, Field 24D, of the

CMS-1500 claim form. View a CMS-1500 sample form. If requested, additional documentation may be required to justify medical necessity. Reimbursement for manually priced drugs is based on a percentage of the average wholesale price.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See Section 272.531 for further information.

Administration of therapeutic agents is payable only if provided in a physician's office, place of service code "11." These procedures are not payable to the certified nurse-midwife if performed in any other setting. Therapeutic injections should only be provided by certified nurse-midwives experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim form. Reimbursement for supplies is included in the administration fee. An administration fee is not allowed when drugs are given orally.

Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379 and 96401 through 96549 for therapeutic and chemotherapy administration procedure codes.

B. For consideration of payable unlisted CPT/HCPCS drug procedure codes:

1. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.
2. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.
3. All other billing requirements must be met in order for payment to be approved.

C. **Immunizations**

Physicians may bill for immunization procedures on the CMS-1500 claim form. View a CMS-1500 sample form.

Coverage criteria for all immunizations and vaccines are listed in Part F of this section.

Influenza virus vaccine through the Vaccines for Children (VFC) program is determined by the age of the beneficiary and which vaccine is used.

The administration fee for all vaccines is included in the reimbursement fee for the vaccine CPT procedure code.

D. **Vaccines for Children (VFC)**

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. Arkansas Medicaid established new procedure codes for billing the administration of VFC immunizations for children under the age of 19 years of age. To enroll in the VFC Program, contact the Arkansas Department of Health. Providers may also obtain the vaccines to administer from the Arkansas Division of Health. View or print Arkansas Department of Health contact information.

Medicaid policy regarding immunizations for adults remains unchanged by the VFC Program.

Vaccines available through the VFC Program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines,

providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ.** ARKids First-B beneficiaries are not eligible for the VFC Program; however vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids First-B SCHIP vaccines. **View or print the Department of Health contact information.**

When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **SL** must be used for billing. Any additional billing and coverage protocols are listed under the specific procedure code in the tables in this section of this manual. See Part F of this section.

E. Billing of Multi-Use and Single-Use Vials

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

1. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
2. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
    a. **Single-Use Vials:** If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
    b. **Multi-Use Vials** are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
    c. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
    d. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-564** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 272.531 for additional information regarding National Drug Code (NDC) billing.

F. Tables of Payable Procedure Codes

The tables of payable procedure codes are designed with eight columns of information.

1. The **first** column of the list contains the CPT or HCPCS procedure codes.
2. The **second** column indicates any modifiers that must be used in conjunction with the procedure code when billed, either electronically or on paper.

3. The **third** column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years(y) or months (m).
4. The **fourth** column indicates specific ICD primary diagnosis restrictions.
5. The **fifth** column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
6. The **sixth** column indicates whether a procedure is subject to medical review before payment.
7. The **seventh** column indicates a procedure code requires a prior authorization before the service is provided. (See Section 240.000 for prior authorization.)

G **Process for Obtaining a Prior Authorization (PA) Number from Arkansas Foundation for Medical Care (AFMC)**

In collaboration with AFMC, DMS is changing the process for acquiring prior approval for drug procedure codes from a prior approval letter to a PA number. Instead of attaching a prior approval letter to a paper claim, providers will now list the PA number on the claim. This will mean that effective for claims submitted on and after August 26, 2016, drug procedure codes requiring PA should be billed with the PA number listed on the claim form. These drugs may be billed electronically or on a paper claim. Additionally, these procedure codes requiring a PA will no longer require manual review during the processing of the claim.

As part of the transition, AFMC will send a letter to all providers who have approval letters spanning timeframes within the last 365 days at the time of the effective date of this policy. The letter will contain a PA number and the total remaining number of the approved units that can be billed. Any providers who have questions regarding PA numbers and/or the transition process outlined above can contact AFMC at the following:

Toll Free: 1-877-350-2362, ext. 8741 or (501) 212-8741

A PA must be requested before treatment is initiated for any drug, therapeutic agent or treatment that indicates a PA is required in a provider manual or an official Division of Medical Services correspondence.

The PA requests should be completed using the approved AFMC PA request form and must be submitted by mail, fax or https://afmc.org.reviewpoint/ (View or print PA form.)

A decision letter will be returned to the provider by fax or *e-mail* within five (5) business days.

If approved, the Prior Authorization number must be appended to all applicable claims, within the scope of the approval and may be billed electronically or on a paper claim with additional documentation when necessary. ~~Claims billed on paper will be subject to a 30 day hold of the adjudicated payment.~~

Denials will be subject to reconsideration if received by AFMC with additional documentation within fifteen (15) business days of date of denial letter.

A reconsideration decision will be returned within five (5) business days of receipt of the reconsideration request.

H. **Contact Information for Obtaining Prior Authorization**

When obtaining a Prior Authorization from the Arkansas Foundation for Medical Care, please send your request to the following:

In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax – General	(479) 649-0799
Fax – Physician Drug Reviews Only (PDR)	(501) 212-8663
Web portal	**https://afmc.org.reviewpoint/**
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	5111 Rogers Avenue, Suite 476 Fort Smith, AR 72903
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

I. All family planning procedures require an FP modifier and a primary family planning diagnosis on the claim.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)
See Section 240 000-240.200 for prior authorization procedures.
List 003/103 diagnosis codes include: (View ICD Codes. This link is only active on page 51 of this document.) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0290	No	No	No	003/103	No	No	No
J0360	No	No	No	003/103	No	No	No
J0461	No	No	No	003/103	No	No	No
J0500	No	No	No	003/103	No	No	No
J0520	No	No	No	003/103	No	No	No
J0558	No	No	No	003/103	No	No	No
J0561	No	No	No	003/103	No	No	No
J0610	No	No	No	003/103	No	No	No
J0670	No	No	No	003/103	No	No	No
J0690	No	No	No	003/103	No	No	No
J0694	No	No	No	003/103	No	No	No
J0695	No	18y & up	No	No	No	No	No
J0696	No	No	No	003/103	No	No	No
J0697	No	No	No	003/103	No	No	No
J0698	No	No	No	003/103	No	No	No
J0702	No	No	Yes	003/103	No	No	No
NOTE: Procedure code J0702 is covered for a valid diagnosis code from range (View ICD codes.) for complications of pregnancy or List 003 for all ages.							
J0710	No	No	No	003/103	No	No	No
J0970	No	No	No	003/103	No	No	No
J1000	No	No	No	003/103	No	No	No
J1050	FP	10y & up	No	No	No	No	No
J1100	No	No	Yes	003/103	No	No	No
NOTE: Procedure code J1100 is covered for a valid diagnosis code from range (View ICD codes.) for complications of pregnancy or List 003 for all ages.							
J1200	No	No	No	003/103	No	No	No
J1240	No	No	No	003/103	No	No	No
J1320	No	No	No	003/103	No	No	No
J1330	No	No	No	003/103	No	No	No
J1380	No	No	No	003/103	No	No	No
J1410	No	No	No	003/103	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)
See Section 240.000-240.200 for prior authorization procedures.
List 003/103 diagnosis codes include: (View ICD Codes. This link is only active on page 51 of this document.) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1435	No	No	No	003/103	No	No	No
J1580	No	No	No	003/103	No	No	No
J1626	No	No	No	003/103	No	No	No
J1670	No	No	No	003/103	No	No	No
J1750	No	No	No	No	No	No	No
J1815	No	No	No	003/103	No	No	No
J1840	No	No	No	003/103	No	No	No
J1850	No	No	No	003/103	No	No	No
J1890	No	No	No	003/103	No	No	No
J1940	No	No	No	003/103	No	No	No
J1980	No	No	No	003/103	No	No	No
J2001	No	No	No	003/103	No	No	No
J2400	No	No	No	003/103	No	No	No
J2510	No	No	No	003/103	No	No	No
J2540	No	No	No	003/103	No	No	No
J2547	No	18y & up	View ICD Codes	No	No	No	No
J2590	No	No	No	003/103	No	No	No
J2650	No	No	No	003/103	No	No	No
J2675	No	No	No	003/103	No	No	No
J2700	No	No	No	003/103	No	No	No
J2916	No	No	No	No	No	No	No
J3070	No	No	No	003/103	No	No	No
J3250	No	No	No	003/103	No	No	No
J3260	No	No	No	003/103	No	No	No
J3301	No	No	No	003/103	No	No	No
J3302	No	No	No	003/103	No	No	No
J3303	No	No	No	003/103	No	No	No
J3370	No	No	No	003/103	No	No	No
J3410	No	No	No	003/103	No	No	No
J7297	FP	12y – 65y	No	No	No	No	No
J7298 Females Only	FP	12y – 65y	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)
See Section 240.000-240.200 for prior authorization procedures.
List 003/103 diagnosis codes include: (View ICD Codes. This link is only active on page 51 of this document.) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7300	FP	No	No	No	No	No	No
J7301	FP	No	No	No	No	No	No
J7302	FP	No	No	No	No	No	No
J7303	FP	No	No	No	No	No	No
90371	No	No	No	No	No	No	No
90656	No	19y & up	No	No	No	No	No
NOTE: See subsections A through G of this section for additional instructions.							
90658	No	19y & up	No	No	No	No	No
NOTE: See subsections A through G of this section for additional instructions.							
90673	No	19y-49y	No	No	No	No	No
90703	No	No	No	No	No	No	No
90707	No	19y-20y	No	No	No	No	No
90732	No	2y & up	No	No	No	No	No
NOTE: Patients age 21 years and older who receive the injection must be considered by the provider as high risk. All beneficiaries over age 65 may be considered high risk.							
90743	No	0-18y	No	No	No	No	No
90744	No	0-18y	No	No	No	No	No
90746	No	19y & up	No	No	No	No	No
90748	No	19y-20y	No	No	No	No	No
90749*	No	No	No	No	No	No	No
NOTE: Claim forms for procedure code 90749 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.							

TOC not required

262.300 Billing Instructions – Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

262.200 **Billing Instructions - Paper Only** ~~3-1-10~~11-1-17

~~DHS' fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

Bill Medicaid for professional services with form CMS-1500. View a sample form CMS-1500.

Carefully follow these instructions to help the 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 fiscal agent's claims department. View or print fiscal agent 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.

TOC not required

262.300 Billing Instructions – Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

263.300 Billing Instructions – CMS-1500 – Paper Claims Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

262.300 Billing Instructions – Paper Only ~~7-1-07~~11-1-17

~~Although electronic billing has virtually eliminated the need for paper claims, some notable exceptions are claims that require an original signature, signed consent, approval letters, operative reports, etc. Arkansas Medicaid pays most adjudicated paper claims once each month; but claims that are submitted on paper only because they require attachments are paid in less than 30 days.~~

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell UB-04 forms. **View a sample CMS-1450 (UB-04) claim form.**

Arkansas Medicaid program claims must be completed in accordance with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding UB-04. **View or print NUBC contact information.**

The committee develops, maintains, and distributes to its subscribers the UB-04 Data Element Specifications Manual and periodic updates. The NUBC is also a vendor of UB-04 claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Data Element Specifications Manual (UB-04 Manual), a UB-04 claim form.

Please forward the original of the completed form to the Claims Department. **View or print the Claims Department contact information.** One copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received

TOC not required

262.300 **Billing Instructions – Paper Only** ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.**

TOC not required

264.000 Billing Instructions – Paper Only ~~7~~11-1-~~07~~17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

242.300 Billing Instructions – Paper Only ~~1-15-11~~ 1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.~~

To bill for a Child Health Services (EPSDT) screening service, use the CMS-1500 claim form. The numbered items correspond to numbered fields on the claim form. See Section 242.310 for paper billing instructions. **View or print a sample CMS-1500 form.**

Each screening should be billed separately, providing the appropriate information for each of the screening components.

With the exception of codes **99201-99215** (office medical services), **99341-99353** (home medical services) and **99221-99223**, **99431**, **99231-99233** and **99238** (hospital inpatient medical services), specific procedures may be used at the provider's discretion as long as the federally-mandated components (refer to Section 215.000) have been included in the screening package.

Medical services such as immunizations and laboratory procedures may also be billed on the CMS-1500 when provided in conjunction with a Child Health Services (EPSDT) screening, as well as other treatment services provided.

Claims for Child Health Services (EPSDT) dental services are to be billed on the ADA claim form. For dental screening to be paid, the ADA claim form must be completed and the box marked "child" in Field 2 must be checked.

Claims for Child Health Services (EPSDT) visual services are to be billed on the DMS-26-V claim form, Field 9. If services were provided as a result of a Child Health Services (EPSDT) screen referral, check the "Yes" box on the DMS-26-V claim form. **View or print a DMS-26-V sample form.**

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 applicable information is omitted. Claims should be typed whenever possible.

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.

TOC not required

262.300 Billing Instructions – Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

242.300 Billing Instructions – Paper Only ~~7~~1-1-~~07~~17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.**

TOC not required

242.300 Billing Instructions – Paper Only ~~7-1-07~~11-1-17

~~Although electronic billing has virtually eliminated the need for paper claims, some notable exceptions are claims that require an original signature, signed consent, approval letters, operative reports, etc. Arkansas Medicaid pays most adjudicated paper claims once each month; but claims that are submitted on paper only because they require attachments are paid in less than 30 days.~~

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) **View or print NUBC contact information.**

The committee develops, maintains and distributes to its subscribers the UB-04 Data Specifications Manual and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Data Specifications Manual (UB-04 Manual), a CMS-1450 (UB-04) claim form.

Please forward the original of the completed form to the Claims Department. **View or print the Claims Department contact information.** One copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

TOC not required

250.200 Paper Claim Processing and Remittance ~~12-1-07~~11-1-17

~~A. Electronic billing has virtually eliminated the need for paper claims, so Arkansas Medicaid remits only once each month, reimbursement for adjudicated paper claims that could have been submitted electronically.~~

AB. However, there may be occasional instances when submitting a paper claim is necessary, for instance, to include a letter or an attachment to resolve a timely filing or eligibility issue.

BC. Claims that are submitted on paper solely because they require attachments or special handling are usually paid in less than 30 days after adjudication.

TOC not required

272.000 **Inpatient and Outpatient Hospital CMS-1450 (UB-04) Billing Procedures** ~~7~~11-1-07~~17~~

~~Although electronic billing has virtually eliminated the need for paper claims, some notable exceptions are claims that require an original signature, signed consent, approval letters, operative reports, etc. Arkansas Medicaid pays most adjudicated paper claims once each month; but claims that are submitted on paper only because they require attachments are paid in less than 30 days.~~

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements, and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) **View or print NUBC contact information.**

The committee develops, maintains, and distributes to its subscribers the Official UB-04 Data Specifications Manual (UB-04 Manual) and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Manual, a CMS-1450 (UB-04) claim form.

Please forward the original of the completed form to the Claims Department. **View or print the Claims Department contact information.** One copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

TOC not required

242.300 **Billing Instructions – Paper Only** ~~7~~11-1-~~07~~17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

262.300 Billing Instructions—Paper Only ~~7~~11-1-0~~1~~7

~~Although electronic billing has virtually eliminated the need for paper claims, some notable exceptions are claims that require an original signature, signed consent, approval letters, operative reports, etc. Arkansas Medicaid pays most adjudicated paper claims once each month. However, claims submitted on paper only because they require attachments are paid in less than 30 days.~~

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements, and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) **View or print NUBC contact information.**

The committee develops, maintains, and distributes to its subscribers the UB-04 Data Element Specifications Manual and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

In conjunction with the UB-04 Data Element Specifications Manual (UB-04 Manual), Section 262.310 contains Arkansas Medicaid's instructions for completing a CMS-1450 (UB-04) claim form.

The original of the completed form may be forwarded to the Claims Department. **View or print the Claims Department contact information.** One copy of the claim form should be retained for your records.

NOTE: **A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.**

TOC not required

262.300 Billing Instructions – Paper Only ~~7-1-07~~11-1-17

~~Although electronic billing has virtually eliminated the need for paper claims, some notable exceptions are claims that require an original signature, signed consent, approval letters, operative reports, etc. Arkansas Medicaid pays most adjudicated paper claims once each month; but claims that are submitted on paper only because they require attachments are paid in less than 30 days after adjudication.~~

The numbered items in the following instructions correspond to the numbered fields on form CMS-1500. 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.

TOC not required

262.300 Billing Instructions – Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

252.300 **Billing Instructions – Paper Claims Only** ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

Bill Medicaid for nurse practitioner 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.

TOC not required

256.500 Billing Instructions – Paper Only ~~7-1-17~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.~~

To bill for Outpatient Behavioral Health services, use the CMS-1500 form. The numbered items correspond to numbered fields on the claim form. View a CMS-1500 sample form.

When completing the CMS-1500, accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to the Arkansas Medicaid fiscal agent. View or print Claims contact information.

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

TOC not required

242.300 Billing Instructions—Paper Claims Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

NOTE: What was formerly type of service code "S" is now requiring the LEA number of the school district in Field 19 of the CMS-1500.

TOC not required

262.400 Billing Instructions—Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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

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

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information**

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

262.300 Billing Instructions—Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

292.300 Billing Instructions—Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

242.300 Billing Instructions—Paper Only ~~7~~11-1-~~07~~17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.**

TOC not required

242.300 Billing Instructions – Paper Only ~~7~~11-1-0~~7~~17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.**

TOC not required

242.300 **Billing Instructions - Paper Only** ~~7~~11-1-0~~7~~17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

242.400 Billing Instructions - Paper Only ~~7-1-07~~11-1-17

~~Although electronic billing has virtually eliminated the need for paper claims, some notable exceptions are claims that require an original signature, signed consent, approval letters, operative reports, etc. Arkansas Medicaid pays most adjudicated paper claims once each month; but claims that are submitted on paper only because they require attachments are paid in less than 30 days.~~

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and NUBC is the official source of information regarding form CMS-1450 (the UB-04 claim form). **View or print NUBC contact information.**

The committee develops, maintains, and distributes to its subscribers the Official UB-04 Data Specifications Manual (UB-04 Manual) and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Manual, a CMS-1450 (UB-04) claim form.

Please forward the original of the completed form to the Claims Department. **View or print the Claims Department contact information.** One copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

TOC not required

262.300 Billing Instructions—Paper Only ~~7-1-07~~11-1-17

~~Although electronic billing has virtually eliminated the need for paper claims, some notable exceptions are claims that require an original signature, signed consent, approval letters, operative reports, etc. Arkansas Medicaid pays most adjudicated paper claims once each month; but claims that are submitted on paper only because they require attachments are paid in less than 30 days.~~

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements, and regulations for claim form CMS-1450.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) **View or print NUBC contact information.**

The committee develops, maintains, and distributes to its subscribers the UB-04 Data Element Specifications Manual and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Data Element Specifications Manual (UB-04 Manual), a CMS-1450 (UB-04) claim form.

Forward the original of the completed form to the DXC Technology Claims Department. **View or print the DXC Technology Claims Department contact information.** One copy of the claim form should be retained for your records.

NOTE: **A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.**

TOC not required

252.300 Billing Instructions - Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.~~

To bill for RSPMI services, use the CMS-1500 form The numbered items correspond to numbered fields on the claim form. View a CMS-1500 sample form.

When completing the CMS-1500, accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to the Arkansas Medicaid fiscal agent. View or print Claims contact information.

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

TOC not required

252.300 Billing Instructions—Paper Claims ~~7-1-07~~11-117

~~Although electronic billing has virtually eliminated the need for paper claims, some notable exceptions are claims that require an original signature, signed consent, approval letters, operative reports, etc. Arkansas Medicaid pays most adjudicated paper claims once each month; but claims that are submitted on paper, only because they require attachments, are paid in less than 30 days.~~

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) **View or print NUBC contact information.**

The committee develops, maintains and distributes to its subscribers the Official UB-04 Data Specifications Manual (UB-04 Manual) and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Manual, a CMS-1450 (UB-04) claim form.

Please forward the original of the completed form to the Claims Department. One copy of the claim form should be retained for your records. **View or print Claims Department contact information.**

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

TOC not required

252.300 Billing Instructions - Paper Only

~~7-1-11~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.~~

To bill for SAT services, use the CMS-1500 form. The numbered items correspond to numbered fields on the claim form. **View a CMS-1500 sample form.**

When completing the CMS-1500, accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to. **View or print Claims contact information.**

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

TOC not required

272.300 Billing Instructions—Paper Only

~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

TOC not required

262.300 Billing Instructions—Paper Claims Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent Packard Enterprise offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.**

TOC not required

262.300 **Billing Instructions - Paper Only** ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

252.300 Ambulance Transportation Billing Instructions—Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

292.300 DDTCS Transportation Billing Instructions—Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.

242.300 Billing Instructions – Paper Only ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.**

TOC not required

243.300 **Billing Instructions – CMS-1500 – Paper Only** ~~7-1-07~~11-1-17

~~The Arkansas Medicaid fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.~~

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.