Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – Physician/Independent Lab/CRNA/Radiation Therapy Center**

DATE: **October 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #112**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	10-13-03	201.000	10-1-06
201.130	10-13-03	201.130	10-1-06
201.330	10-13-03	201.330	10-1-06
202.100	10-13-03	202.100	10-1-06
203.140	10-13-03	203.140	10-1-06
203.170	10-13-03	203.170	10-1-06
203.230	3-15-05	203.230	10-1-06
211.000 – 212.000	10-13-03	211.000 – 212.000	10-1-06
221.000	10-13-03	221.000	10-1-06
223.000	2-1-06	223.000	10-1-06
225.100 – 226.000	Varying dates	225.100 – 226.000	10-1-06
241.000	10-13-03	241.000	10-1-06
243.100	2-1-06	243.100	10-1-06
243.300 – 243.500	10-13-03	243.300 – 243.500	10-1-06
244.000 – 244.200	2-1-06	244.000 – 244.002	10-1-06
250.500	10-13-03	250.500	10-1-06
251.230	10-13-03	251.230	10-1-06
251.250	10-13-03	—	—
251.304	3-15-05	251.304	10-1-06
253.000	2-1-06	253.000	10-1-06
257.000 – 258.000	Varying dates	257.000 – 258.000	10-1-06
261.000	8-1-04	261.000	10-1-06
261.110 – 261.120	10-13-03	261.110 – 261.130	10-1-06
261.210 – 261.232	Varying dates	261.210 – 261.231	10-1-06
261.250	10-13-03	261.250	10-1-06
262.000	2-1-06	262.000	10-1-06

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
292.000 – 292.110	Varying dates	292.000 – 292.110	10-1-06
292.410	8-1-04	292.410	10-1-06
292.430 – 292.440	Varying dates	292.430 – 292.440	10-1-06
292.443	2-1-06	292.443	10-1-06
292.480	10-13-03	292.480	10-1-06
292.550 – 292.551	2-1-06	292.550 – 292.553	10-1-06
—	—	292.561	10-1-06
292.591 – 292.599	Varying dates	292.591 – 292.595	10-1-06
292.600	10-13-03	292.600	10-1-06
292.602	10-13-03	292.602	10-1-06
292.620	10-13-03	292.620	10-1-06
292.671 – 292.675	Varying dates	292.671 – 292.675	10-1-06
292.730	10-13-03	292.730	10-1-06
292.742	10-13-03	292.742	10-1-06
292.760	10-13-03	292.760	10-1-06
292.801	10-13-03	292.801	10-1-06
292.812	10-13-03	292.812	10-1-06
292.827	3-15-05	292.827	10-1-06
292.870	2-1-06	292.870	10-1-06
292.900	2-1-06	292.900	10-1-06

Explanation of Updates

Throughout this update the agency name has been changed to Department of Health and Human Services. Arkansas Department of Health has been changed to Division of Health.

Section 201.000 is included in this update because introductory statements have been added for clarification.

Sections 201.130 and 201.330 have been revised to include participation policy for providers in states that do not border Arkansas.

Section 202.100 has been revised to clarify documentation requirements applicable to all Medicaid providers.

Section 203.140 has been revised to change the name of the Family Planning Waiver to the Women's Health Waiver.

Section 203.170 is included because of minor wording change for clarity.

Section 203.230 has been revised to clarify the process of obtaining prior authorization of drugs prescribed for beneficiaries of long-term-care services.

Section 211.000 has been revised to delete obsolete information.

Section 212.000 has been revised to correct grammatical error and to change a section number reference.

Section 221.000 has been revised to correct grammatical errors and change the word Norplant to the HCPCS procedure code description.

Section 223.000 has been revised to change a section reference number.

Section 225.100 is included for minor wording change for clarification.

Section 226.000 has been revised to include physician visits in the outpatient hospital for pregnancy as services exempt from extension of benefits requirements.

Section 241.000 has been revised to change a section number reference.

Section 243.100 has been revised to change the name of the Family Planning Demonstration Waiver to the Women's Health Demonstration Waiver.

Section 243.300 has been revised to correct grammatical errors.

Section 243.400 has been revised to correct grammatical errors.

Section 243.500 has been revised to include information about coverage of Essure as a contraceptive. This also includes minor wording changes and change reference to the Family Planning Waiver to the Women's Health Waiver.

Section 244.000 is included because of a change in section number reference.

Section 244.001 is a new section that includes coverage information previously located in section 292.595.

Section 244.002 is a new section that includes coverage information for verteporfin (Visudyne).

Section 244.100 has been revised to change the section title and make minor wording changes. Prior approval information has been added and section number references have been corrected

Section 244.200 has been revised to correct a section number reference.

Section 250.500 has been revised to make minor wording change.

Section 251.230 has been revised to include information about other devices that are covered for use with the cochlear implant device. A section number reference has been changed.

Section 251.250 has been deleted from the manual.

Section 251.304 has been revised to delete obsolete information.

Section 253.000 has been revised to remove the prior authorization requirement for the *application* procedure for bilaminate graft or skin substitute.

Section 257.000 has been revised to include prior authorization and additional prescription benefits for tobacco cessation products.

Section 258.000 has been included in this update to change "extension of benefits" to "extension of treatment period."

Section 261.000 has been revised to make changes in section number references.

Section 262.110 has been revised to change the word recipients to beneficiaries.

Section 261.120 has been revised to delete the statement that "prior authorization is required for application procedures." No prior authorization is required for the application procedures. A section number reference has been changed.

Section 261.130 is a new section number that includes information previously located in section 261.220. Cochlear implants, external sound processor and related devices are prior authorized by AFMC and not DMS Utilization Review.

Section 261.210 has been revised to correct a grammatical error.

Section 261.220 has been revised. Information previously located in this section has been relocated to section 261.130. Section 261.220 now includes information formerly included in section 261.230.

Section 261.230 has been revised to include reconsideration process for prior approvals to be consistent with the current policy.

Section 261.231 has been renumbered to section 261.230. Section 261.232 has been renumbered to section 261.231. Section 261.232 has been deleted.

Section 261.250 is included because of a minor wording change and to add maximum daily units to procedure codes included in this section.

Section 262.000 has been revised to delete procedure codes that no longer payable or no longer require prior authorization and to include procedure codes that require prior authorization.

Sections 292.000 through 292.110 have been revised by removing unnecessary wording and by adding new CPT procedure codes that are non-covered by Medicaid. Codes that have been deleted from the CPT book have been deleted from this list.

Section 292.410 has been revised. Effective for dates of service on and after March 1, 2006, procedure code **01964** was made non-payable. The revision includes procedure code **01966** as a replacement procedure code for this service.

Section 292.430 has been revised to correct grammatical errors.

Section 292.440 has been revised to include procedure code **01966** in place of procedure code **01964**, effective for dates of service on and after March 1, 2006.

Section 292.443 has been revised. Effective for dates of service on and after March 1, 2006, procedure codes **90780** and **90781** are no longer payable. The revision includes addition of replacement procedure codes **99143** through **99150**.

Section 292.480 is included to clarify billing instructions for procedure code **V2630**.

Section 292.550 has been revised to include currently covered family planning procedure codes payable for beneficiaries in full coverage aid categories. Family planning services recently added have been included. Procedure code **S0612** has been deleted from this section and is non-payable as a family planning service effective for dates of service on and after June 28, 2006.

Section 292.552 is a new section added to include current family planning services that are payable for beneficiaries of the Women's Health Waiver, limited aid category 69.

Section 292.553 is a new section that includes laboratory procedure codes that are payable as family planning services. The information in this section was previously located in section 292.551. Newly covered laboratory procedure codes **87491** and **87591** effective for dates of service on and after February 1, 2006 are included in this section.

Section 292.561 is a new section added to the manual to include genetic testing procedure codes currently covered by Medicaid.

Section 292.591 has been revised to include new procedure codes made payable effective for dates of service on and after March 1, 2006. Procedure codes no longer payable have been deleted from this section. Some procedure codes have been relocated to section 292.592.

Section 292.592 has been revised to include new procedure codes Procedure codes that are no longer payable and procedure codes that are included elsewhere in this manual have been deleted from this list. The list includes clarification of special coverage conditions for certain procedure codes. Information previously included in sections 292.593 and 292.594 are now included in this section.

Section 292.593 has been revised to include Vaccines for Children Information previously found in section 292.597.

Section 292.594 has been revised to include information previously found in section 292.598.

Section 292.595 has been revised to include information previously included in section 292.599. Information previously included in 292.595 has been relocated to sections 244.002 and 292.592.

Section 292.596 has been deleted from the manual. The information in this section is now located in section 292.592.

Sections 292.597, 292.598 and 292.599 have been deleted from the manual..

Section 292.600 has been revised to delete unnecessary information.

Section 292.602 has been revised to delete unnecessary information and includes special billing requirements for certain laboratory and radiology services effective for dates of service on and after March 1, 2006.

Section 292.620 has been revised to remove an obsolete local code.

Section 292.671 has been revised to clarify global or all-inclusive rates.

Section 292.672 has been revised to clarify itemized billing for laboratory services.

Section 292.673 has been revised to include correct procedure codes.

Section 292.674 has been revised to delete obsolete local procedure code.

Section 292.675 has been revised to include correct modifiers for use when billing obstetrical care without delivery.

Section 292.730 has been revised to include a clarifying statement in regard to procedures that are billed as technical or professional components.

Section 292.742 has been revised to remove information no longer applicable.

Section 292.760 has been revised to delete obsolete local codes and correct list of codes.

Section 292.801 has been revised to include procedure code **L8614** for the cochlear device. Procedure codes for other devices that may be necessary for use with the cochlear implant device have been added to the manual. Those codes are **L8615**, **L8616**, **L8617** and **L8618**.

Section 292.812 has been revised by deleting obsolete local procedure codes.

Section 292.827 has been revised to correct a typographical error.

Section 292.870 has been revised to correct to correct an error. The application procedure for bilaminate graft or skin substitute does not require prior authorization.

Section 292.900 has been revised to clarify the prior authorization procedure for tobacco cessation products.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789.

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

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

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

TOC required due to deletions and title changes

201.000 Arkansas Medicaid Participation Requirements 10-1-06

To participate in the Arkansas Medicaid Program, providers must adhere to all applicable professional standards of care and conduct. The following sections provide participation requirements for each provider type whose services are included in this manual.

201.130 Providers of Physician Services in States Not Bordering Arkansas 10-1-06

A. Providers in states not bordering Arkansas may enroll as closed-end providers after they have furnished services to an Arkansas Medicaid beneficiary and have a claim to file with Arkansas Medicaid. **View or print Provider Enrollment Unit contact information.**

A non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, **www.medicaid.state.ar.us/InternetSolution/Provider/Provider.aspx**, and then submit the application and claim to the Medicaid Provider Enrollment Unit.

B. Closed-end providers remain enrolled for one year.

1. If a closed-end provider treats another Arkansas Medicaid beneficiary during the provider's year of enrollment and bills Medicaid, the enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
2. During the enrollment period the provider may file any subsequent claims directly to EDS.
3. Closed-end providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.330 Providers of CRNA Services in States Not Bordering Arkansas 10-1-06

A. Providers in states not bordering Arkansas may enroll as closed-end providers after they have furnished services to an Arkansas Medicaid beneficiary and have a claim to file with Arkansas Medicaid. **View or print Provider Enrollment Unit contact information**.

A non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, **www.medicaid.state.ar.us/InternetSolution/Provider/Provider.aspx**, and then submit the application and claim to the Medicaid Provider Enrollment Unit.

B. Closed-end providers remain enrolled for one year.

1. If a closed-end provider treats another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
2. During the enrollment period the provider may file any subsequent claims directly to EDS.
3. Closed-end providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

202.100 Documentation Required of All Medicaid Providers 10-1-06

A. Providers must contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with its delivery of medical assistance to any Medicaid beneficiary.

B. Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the prescription, care plan or order within five (5) business days of the date it is signed. Providers also must maintain a copy of each prescription, care plan or order in the beneficiary's medical record and follow all prescriptions, care plans, and orders as required by law, by Medicaid rule, or both.

C. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary. When records are stored off-premise or are in active use, the provider may certify in writing that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

D. All records must be kept for a period of five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish medical records upon request will result in sanctions being imposed. (See Section I of this manual.)

203.140 Physician's Role in Family Planning Services 10-1-06

A. Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services.

1. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits.
2. Family planning services do not require PCP referral. PCPs electing not to provide some or all family planning services can use the information in this manual to counsel their Medicaid-eligible patients and help them locate family planning services.
    a. Refer to Sections 221.000 and 221.100 of this manual for family planning services benefit limitations.
    b. Refer to Sections 243.000 through 243.500 of this manual for service descriptions and coverage information.
    c. Refer to Section 292.550 of this manual for family planning services billing instructions and procedure codes.

B. Arkansas Medicaid also covers family planning services for women in two limited aid categories.

1. Pregnant Woman-Poverty Level (PW-PL, Aid Category 61) and
2. Women's Health Waiver (FP-W, Aid Category 69).
    a. Refer to Sections 221.100 and 243.000 through 243.500 for more information on coverage of family planning services for these eligibility categories.
    b. Refer to Section 292.676 for more information on services available to women in the PW-PL category.

203.170 Physician's Role in Hospital Services 10-1-06

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations.

B. The care and treatment of a patient must be under the direction of a licensed physician or dentist with hospital staff affiliation. Most inpatient admissions require a PCP referral. (Refer to Section I of this manual.)

C. Arkansas Foundation for Medical Care, Inc., (AFMC) is the Medicaid agency's Quality Improvement Organization (QIO).

1. AFMC reviews for the Medicaid Utilization Management Program, all inpatient hospital transfers and all inpatient stays longer than four days.
2. The QIO also performs post-payment reviews of hospital stays of any length for medical necessity determinations.

D. Hospital claims are also subject to review by the Medical Director for the Medicaid Program.

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
2. Practitioners and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
3. Practitioners and hospitals may not bill as outpatient services, inpatient services previously denied for lack of medical necessity.
4. Refer to Sections I and III of this manual for Medicare deductible and coinsurance information.

203.230 Physician's Role in the Pharmacy Program 10-1-06

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

A. Prescribers must refer to the Arkansas Medicaid Web site at **http://www.medicaid.state.ar.us/** to obtain the following information:

1. Multisource Drugs Listing/Generic Upper Limits.
2. Covered cough and cold preparations (see part C, 7 of this section).
3. Covered over-the-counter (OTC) products (see part C, 8 of this section).
4. Drugs requiring prior authorization (PA), the forms to be completed for PA requests and the procedures required of the prescriber to request prior authorization.
5. List of alternative drugs that do not require PA.
6. Information on MedWatch, the Food and Drug Administration (FDA) Safety Information and Adverse Event Reporting Program.

As additions or deletions by labelers are submitted to the state by Centers for Medicare and Medicaid Services (CMS), the Web site is updated.

B. The following procedures are to be followed when prescribing drugs for Medicaid beneficiaries.

1. In addition to the prescriber's normal procedure for prescribing drugs, the prescriber must include his or her Medicaid provider number on all prescriptions for Medicaid beneficiaries, whether or not the drug prescribed is a controlled substance. The prescriber's Medicaid provider number is essential for tracking and utilization review purposes.

   The requirement to include the prescriber's Medicaid provider number is a condition of participation in the Arkansas Medicaid Program. Administrative sanctions will be imposed for noncompliance. If prescription pads are not preprinted with the prescriber's name, it is essential that the physician's signature be legible.

2. When the prescriber determines that a particular brand is medically necessary, the prescriber must write "This Brand Medically Necessary" in his or her own handwriting on the face of the prescription. A rubber stamp is not acceptable. The statements "Do not substitute" or "Dispense as written" are not sufficient. For prescriptions ordered by telephone, a written prescription that includes the required statement must also be provided to the pharmacist.

C. Coverage Limitations

1. Medicaid beneficiaries aged 21 and older are limited to three (3) prescriptions per month, each filled for a maximum of one month's supply. Extensions of an individual's drug benefit up to six (6) prescriptions per month may be considered for reasons of medical necessity. The prescribing provider must request an extension.

2. A prescription may be filled for a maximum of one month's supply. A thirty-one-day supply is allowed.

3. Up to five refills within six months of the date the prescription is issued are covered if specified by the prescriber. Renewals or continuations of drug therapy beyond six months require another prescription.

4. Prescriptions for family planning items will not be counted toward the beneficiary's monthly three-prescription limit.

5. Medicaid beneficiaries under age 21 are not subject to the prescription benefit limit.

6. Long-term-care (LTC) certified Medicaid beneficiaries are not subject to the prescription benefit limit.

   LTC patients must receive prescribed drugs within a specific period of time after the prescriber's order. For prescribed drugs that require PA and are administered in oral dosage forms for which a 5-day supply may be calculated and dispensed, one 5-day supply of the drug may be provided to the LTC beneficiary upon receipt of the prescription and reimbursed by Arkansas Medicaid without receipt of PA.

   Within five (5) days of the prescription of a drug requiring prior authorization (PA) and for which no PA has been obtained, the pharmacist and the physician shall consult to determine if there is a therapeutically equivalent drug that does not require PA. The results of the consultation shall be documented in writing.

   If a non-PA, therapeutically equivalent drug exists, the physician will immediately write a substitute prescription for the non-PA drug.

7. Cough and cold preparations are not covered except for those listed on the Web site at www.medicaid.state.ar.us in the covered cough and cold products list. Coverage is restricted to Medicaid beneficiaries under age 21 and for certified long-term care beneficiaries. Any over-the-counter cough and cold products listed at the Web site are not covered for certified long-term care beneficiaries.

8. Over-the-counter (OTC) products are not covered except for those listed on the Web site at www.medicaid.state.ar.us in the covered over-the-counter products list. OTC products are not covered for certified long-term care beneficiaries.

9. When prescribing pharmaceuticals to Medicaid beneficiaries who are excluded from the beneficiary cost sharing coinsurance/copayment policy, the prescribing provider must write "Excluded from copay" on the face of the prescription. (Refer to Section 133.400 of this manual for more information.)

211.000 Introduction 10-1-06

A. The Arkansas Medicaid Program reimburses enrolled providers for the medical care of Medicaid beneficiaries.

B. Medicaid reimbursement is conditional upon providers' compliance with Program policy as stated in provider manuals, manual update transmittals and official Program correspondence.

C. All Medicaid benefits are based on medical necessity. Refer to the Glossary for a definition of medical necessity.

1. Service coverage will be denied and reimbursement recouped if a service is not medically necessary.
2. The finding of medical necessity may be made by the:
   a. Medical Director for the Medicaid Program, the
   b. Quality Improvement Organization (QIO)

212.000 Scope 10-1-06

A. Physician services are services provided within the scope of the practice of medicine or osteopathy, as defined by State law and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy (42 Code of Federal Regulations, Section 440.50).

B. Many physician services covered by the Arkansas Medicaid Program are restricted or limited.

1. Sections 220.000 through Section 227.000 describe limits on the quantity of covered services beneficiaries may receive.
2. Sections 240.000 through section 258.000 describe the circumstances under which certain services will be covered.

221.000 Family Planning Services 10-1-06

A. Medicaid covers one basic family planning examination and three periodic family planning visits per beneficiary, per state fiscal year (July 1 through June 30). Refer to Sections 243.000 through 243.500 of this manual for service descriptions and coverage information.

B. Prescriptions for family planning services are unlimited.

C. Levonorgestrel Implant System

1. The benefit limit for levonorgestrel Implant system (kit) and insertion is two each per five-year period per beneficiary.
2. The benefit limit for removal of the kit is only once per 5-year period, with or without reinsertion.

D. Extension of benefits is not available for family planning services.

E. Special billing instructions for all family planning services are in section 292.550 of this manual.

223.000 Injections 10-1-06

A. The Arkansas Medicaid Program applies benefit limits to some covered injections.

B. For information on coverage of injections, special billing instructions and procedure codes, refer to sections 292.590 through 292.595 of this manual.

225.100 Laboratory and X-Ray Services 10-1-06

The Medicaid Program's laboratory and X-ray services benefit limits apply to outpatient laboratory services, radiology services and machine tests (such as electrocardiograms).

A. Medicaid has established a maximum paid amount (benefit limitation) of $500 per state fiscal year (July 1 through June 30) for beneficiaries aged 21 and older, for outpatient laboratory and machine tests and outpatient radiology.

1. There is no lab and X-ray benefit limit for beneficiaries under age 21.
2. There is no benefit limit on professional components of laboratory, X-ray and machine tests for hospital inpatients.
3. There is no benefit limit on laboratory services related to family planning. See Section 292.550 for the family planning-related clinical laboratory procedures exempt from benefit limits.
4. There is no benefit limit on laboratory, X-ray and machine-test services performed as emergency services.

B. Extension-of-benefit requests are considered for medically necessary services.

1. The claims processing system automatically overrides benefit limitations for services supported by the following diagnoses:
   a. ICD-9 code ranges 140.0 through 208.91;
   b. ICD-9 code 042; or
   c. ICD-9 code range 584 through 586
2. Benefits may be extended for other conditions for documented reasons of medical necessity. Providers may request extensions of benefits according to instructions in Section 228.100 of this manual.

C. Magnetic resonance imaging (MRI) is exempt from the $500 outpatient laboratory and X-ray annual benefit limit.

1. Medical necessity for each MRI must be documented in the beneficiary's medical record.
2. Refer to Section 292.610 of this manual for billing instructions and Section 272.600 for reimbursement information.

D. Cardiac catheterization procedures are exempt from the $500 annual benefit limit for outpatient laboratory and X-ray. Medical necessity for each procedure must be documented in the beneficiary's medical record.

226.000 Physician Services Benefit Limit 10-1-06

A. Physician services in a physician's office, patient's home or nursing home for beneficiaries aged 21 or older are limited to 12 visits per state fiscal year (July 1 through June 30). Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not subject to this benefit limit.

The following services are counted toward the 12 visits per state fiscal year limit established for the Physician program:

1. Physician services in the office, patient's home or nursing facility.
2. Rural health clinic (RHC) encounters.
3. Medical services provided by a dentist.
4. Medical services furnished by an optometrist.
5. Certified nurse-midwife services.

B. Extensions of this benefit are considered when documentation verifies medical necessity. Refer to sections 229.100 through 229.120 of this manual for procedures for obtaining extension of benefits for physician services.

C. The Arkansas Medicaid Program exempts the following diagnoses from the extension of benefit requirements when the diagnosis is entered as the primary diagnosis:

1. Malignant Neoplasm ICD-9-CM code ranges 140.0 through 208.91
2. HIV/AIDS ICD-9 code 042
3. Renal Failure ICD-9 code range 584.5 through 586
4. Additionally, physician visits in the outpatient hospital are exempt from the extension of benefit requirements for pregnancy (ICD-9 code range 630 through 677, diagnosis codes V22.0 through V24.2 and V28.0 through V28.9

When a Medicaid beneficiary's primary diagnosis is one of those listed above and the beneficiary has exhausted the Medicaid established benefit for physician services, outpatient hospital services or laboratory and X-ray services, a request for extension of benefits is not required.

241.000 Ambulatory Infusion Device 10-1-06

Arkansas Medicaid covers an Ambulatory Infusion Device when it is provided by the physician and prior authorized by the Division of Medical Services. This device is covered only when services are provided to Medicaid beneficiaries receiving chemotherapy, pain management or antibiotic treatment in the home. Refer to Section 261.200 of this manual for prior authorization procedures and Section 292.430 for the procedure code and billing instructions.

243.100 Women's Health Demonstration Waiver 10-1-06

A. The Arkansas Medicaid program administers a Women's Health Demonstration Waiver. This waiver program extends Medicaid coverage of family planning services to women of childbearing age throughout Arkansas who meet the eligibility requirements for participation.

B. Women's Health Demonstration Waiver beneficiaries must be of childbearing age. The target population is women age 14 to age 44, but all women at risk of unintended pregnancy may apply for Women's Health Demonstration Waiver (FP-W) services.

C. The women in the FP-W category are eligible for limited Medicaid coverage of *family planning services only*. See section 292.552 for services covered. The PES eligibility transaction response identifies them as eligible in Aid Category 69 (FP-W).

243.300 Basic Family Planning Visit 10-1-06

Medicaid covers one basic family planning visit per beneficiary per Arkansas state fiscal year (July 1 through June 30). This basic visit comprises the following:

A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight and blood pressure

B. Counseling and education regarding

1. Breast self-exam
2. The full range of contraceptive methods available
3. HIV/STD prevention

C. Prescription for any contraceptives selected by the beneficiary

D. Laboratory services, including, as necessary

1. Pregnancy test
2. Hemoglobin and Hematocrit
3. Sickle cell screening
4. Urinalysis testing for albumin and glucose
5. Papanicolaou smear for cervical cancer
6. Testing for sexually transmitted diseases

243.400 Periodic Family Planning Visit 10-1-06

Medicaid covers three periodic family planning visits per beneficiary per state fiscal year (July 1 through June 30). The periodic visit includes follow-up medical history, weight, blood pressure and counseling regarding contraceptives and possible complications of contraceptives. The purpose of the periodic visits is to evaluate the patient's contraceptive program, renew or change the contraceptive prescription and to provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

243.500 Contraception 10-1-06

A. Prescription and Non-Prescription Contraceptives

1. Medicaid covers for birth control pills and other prescription contraceptives as a family planning prescription benefit.
2. Medicaid covers for non-prescription contraceptives as a family planning benefit, when a physician writes a prescription for them.

B. Evonorgestrel Implant System

1. Medicaid covers the Levonorgestrel (contraceptive) implant system, including implants and supplies
2. Alternatively, Medicaid reimburses physicians and clinics that supply the kit at the time of insertion.
3. Medicaid covers for insertion, removal and removal with reinsertion.

C. Intrauterine Device (IUD)

1. Medicaid pays for IUDs as a family planning prescription benefit.
2. Alternatively, Medicaid reimburses physicians that supply the IUD at the time of insertion.
3. Medicaid pays physicians for IUD insertion and removal.

D. Occlusion by Placement of Permanent Implants (Essure)

Medicaid covers the Essure implant system including the physician's services, implant and the supplies and follow-up procedures.

E. Medroxyprogesterone Acetate

Medicaid covers medroxyprogesterone acetate injections for birth control.

F. Sterilization

1. All adult (21 or older) female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures and medically necessary follow-ups as long as they remain Medicaid-eligible.
2. All adult (21 or older) male Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures and medically necessary follow-ups as long as they remain Medicaid-eligible.
3. Adult (21 or older) women in the Women's Health Waiver category, Aid Category 69, who are mentally competent, are eligible for sterilization procedures.
4. Refer to Section 251.290 of this manual for Medicaid policy regarding sterilization.

Refer to Section 292.550 of this manual for family planning procedure codes and billing instructions for family planning services.

244.000 Covered Drugs and Immunizations 10-1-06

The Arkansas Medicaid Program provides coverage of drugs for treatment purposes and for immunizations against many diseases. Most of these are administered by injection. Appropriate procedure codes may be found in the *CPT* and *HCPCS* books and in this manual. The following types of drugs are covered.

A. Chemotherapy and immunosuppressive drugs. (See sections 292.590 and 292.591.) No take-home drugs are covered.

B. Desensitization (allergy) injections for beneficiaries in the Child Health Services (EPSDT) program. (See section 292.420 of this manual for billing instructions.)

C. Immunizations, childhood and those covered for adults. (See sections 292.592 through 292.595 of this manual for special billing instructions.)

D. Other injections that are covered for specific diagnoses and/or conditions. See section 292.592. No take home drugs are covered.

244.001 Agalsidase Beta and Laronidase Injections 10-1-06

A. Arkansas Medicaid covers agalsidase beta injections. This procedure is covered for treatment of Fabry's disease, ICD-9-CM diagnosis code 272.7.

B. Arkansas Medicaid covers laronidase injections. This procedure is covered for treatment of mucopolysaccharidosis (MPS I), ICD-9-CM diagnosis code 277.5.

C. Arkansas Medicaid covers imiglucerase injections. This procedure **(J1785)** is covered for treatment of Type I Gaucher disease with complications, ICD-9-CM diagnosis code 272.7.

D. These injections may be provided in the outpatient hospital or emergency room. If the physician provides the service in the office, the following conditions apply.

1. The provider must have nursing staff available to monitor the patient's vital signs during the infusion.

2. The provider must be able to treat anaphylactic shock in the treatment area where the drugs are infused.

E. When the physician determines a Medicaid beneficiary needs the injection, he or she must obtain prior approval from the Medical Director of the Division of Medical Services before beginning therapy.

The prior approval request must include:

1. Documentation of an office visit that includes a physical examination specifically identified by its date and must note the diagnosis.
2. Medical history that includes an annotated list of previous treatment protocols administered and their results.
3. Statement of medical necessity, including method of diagnosis, from genetics physician.

F. See section 292.592 for procedure codes and billing instructions.

244.002 Verteporfin (Visudyne) 10-1-06

Medicaid covers verteporfin injections for all ages under the following conditions.

A. There must be documentation by eye exam of an ICD-9-CM diagnosis of:

1. Predominantly classic subfoveal choroidal neovascularization due to age-related macular degeneration (ICD-9-CM diagnosis code 362.50 or 362.52); **or**
2. Pathologic myopia (ICD-9-CM diagnosis code 360.21); **or**
3. Presumed ocular histoplasmosis (ICD-9-CM diagnosis code 115.02 or 115.12 or 115.92).

B. The lesion size determination should be included in the exam. Which eye will be treated with that administration should also be clearly documented, along with the current visual acuity. If previous treatments with other modalities have been attempted, these also must be documented.

C. See section 292.592 for procedure code and billing instructions.

244.100 Special Pharmacy, Therapeutic Agents and Treatments 10-1-06

Providers must obtain prior approval, in accordance with the following procedures, for special pharmacy, therapeutic agents and treatments.

A. Before treatment is begun, the Medical Director for the Division of Medical Services (DMS) must approve any drug, therapeutic agent or treatment not listed as covered in this provider manual or in official DMS correspondence.

This requirement also applies to any drug, therapeutic agent or treatment with special instructions regarding coverage in the provider manual or in official DMS correspondence.

B. The Medical Director's prior approval is necessary to ensure approval for medical necessity.

1. The provider must submit a history and physical examination with the treatment protocol before beginning the treatment.
2. The provider will be notified by mail of the DMS Medical Director's decision. No prior authorization number is assigned if the request is approved, but a prior approval letter is issued and must be attached to each claim. Any changes in treatment require resubmission and a new approval letter.

Send requests for prior approval of pharmacy and therapeutic agents to the attention of the Medical Director of the Division of Medical Services. **View or print the contact information for the Arkansas Division of Medical Services Medical Director.**

Refer to sections 292.591 – 292.595 for pharmacy and therapeutic agents for special billing procedures.

See sections 258.000 and 292.860 for coverage and billing procedures for hyperbaric oxygen therapy.

244.200 Radiopharmaceutical Therapy 10-1-06

Medicaid covers radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion.

Before beginning therapy the provider must submit the following documentation.

A. Patient history and physical report is required.

B. Drugs and therapeutic procedures previously administered must be included along with documentation that conventional therapy has failed.

C. This information must be sent to the attention of the Medical Director of the Division of Medical Services.

The provider will be notified by mail of the Medical Director's decision. If approval is received, the provider must file the claim for service with a copy of the approval letter and a copy of the invoices for the monoclonal antibody.

Refer to section 292.595 for special billing procedures.

250.500 Observation Status 10-1-06

When billing for services to a patient in "observation status," physicians must adhere to Arkansas Medicaid definitions of inpatient and outpatient. Observation status is an outpatient designation. Physicians must also follow the guidelines and definitions in **Physician's Current Procedural Terminology (CPT),** under "Hospital Observation Services" and "Evaluation and Management Services Guidelines."

A. Arkansas Medicaid uses the following criteria in determining inpatient and outpatient status:

1. If a patient is expected to remain in the hospital for less than 24 consecutive hours and this expectation is realized, the hospital and the physician should consider the patient an outpatient; i.e., the patient is an outpatient unless the physician has admitted them as an inpatient.
2. If the physician or hospital expects the patient to remain in the hospital for 24 hours or more, Medicaid deems the patient admitted at the time the patient's medical record indicates the existence of such an expectation, even though the physician has not yet formally admitted the patient.
3. Medicaid also deems a patient admitted to inpatient status at the time they have remained in the hospital for 24 consecutive hours, even if the physician or hospital had no prior expectation of a stay of that or greater duration.

B. Medical Necessity Requirements

1. Physician inpatient services must meet the Medicaid requirement of medical necessity. The Quality Improvement Organization (QIO) will deny payments for inpatient admissions and subsequent inpatient services when they determine that inpatient care was not necessary. Inpatient services are subject to QIO review for

medical necessity whether the physician admitted the patient, or whether Medicaid deemed the patient admitted according to the criteria above.

2. The attending physician must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent. Physician and hospital claims for hospital observation services are subject to post payment review to verify medical necessity.

C. Coverage Limitations

Medicaid pays physicians all-inclusive "global" fees for outpatient surgical procedures. Physicians may not bill Medicaid separately for hospital observation services preceding, or subsequent to, outpatient surgery.

Please note that an attending physician may bill Medicaid only once per day per patient for "Evaluation and Management Services" including physician non-emergency outpatient visit.

The following table gives examples of appropriate physician billing for several common hospital scenarios. The billing instructions under the headings, "PHYSICIAN MAY BILL...," do not necessarily include all services for which the physician may bill. For instance, they do not state that you may bill for interpretation of X-rays or diagnostic tests. The purpose of this table is to illustrate Arkansas Medicaid observation status policy and to give guidance for billing related evaluation and management services.

Patient is admitted to observation	**Patient Is**	**Physician may bill for Tuesday services:**	**Physician may bill for Wednesday services:**
Tuesday, 3:00 PM	Still in Observation Wednesday, 3:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM	Discharged Wednesday, 12:00 PM (noon)	Appropriate level of Initial Observation Care	Observation care discharge day management
Tuesday, 3:00 PM	Discharged Wednesday, 4:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM, after outpatient surgery	Discharged Wednesday, 10:00 AM	Outpatient surgery	No evaluation and management services
Tuesday, 3:00 PM, after exam in Emergency Department-emergency or non-emergency	Discharged Tuesday, 7:00 PM	Appropriate level of Initial Observation Care	Not Applicable; patient was discharged Tuesday

251.230 Cochlear Implant and External Sound Processor 10-1-06

The Arkansas Medicaid Program provides coverage for cochlear implantation and the external sound processor for beneficiaries under age 21 in the Child Health Services (EPSDT) Program. Also covered are headset, microphone, transmitting coil and transmitter cable. The cochlear implant device, implantation procedure, the sound processor and other necessary devices for use with the cochlear implant device require *prior authorization* from AFMC. Refer to Section 261.100 of this manual for prior authorization procedures.

251.304 Liver and Liver/Bowel Transplants 10-1-06

A. Medicaid covers liver transplants for beneficiaries of all ages.

B. Medicaid covers liver/bowel transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

C. Covered physician services related to the transplant include:

1. The surgical procedure to remove a partial liver from a living donor (when applicable).
2. Physician services for transplanting the liver into the receiver.
3. Postoperative care (including postoperative care for the living donor of a partial liver, when applicable).

D. Liver and liver/bowel transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published Medicare National Coverage Decisions and/or AFMC medical review. Refer to section 251.300 subpart C.

253.000 Bilaminate Graft or Skin Substitute 10-1-06

Arkansas Medicaid covers bilaminate graft or skin substitute, known as dermal and epidermal tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements. Prior authorization is required for the product but not the application procedure.

This product is designed to be used for treatment of non-infected partial and full-thickness skin ulcers due to venous insufficiency and for treatment of full-thickness neuropathic diabetic foot ulcers that extend through the dermis, but without tendon, muscle, capsule or bone exposure and which are located on the plantar, medial or lateral area of the foot (excluding the heel).

A. Indications and Documentation:

Coverage of this modality/product will be considered when all of the following conditions are satisfied and documented:

1. Partial or full-thickness skin ulcers due to venous insufficiency or full-thickness neuropathic diabetic foot ulcers,
2. Ulcers of greater than three (3) months duration and
3. Ulcers that have failed to respond to documented conservative measures of greater than two (2) months duration.
4. There must be measurements of the initial ulcer size, the size of the ulcer following cessation of conservative management and the size at the beginning of skin substitute treatment.
5. For neuropathic diabetic foot ulcers, appropriate steps to off-load pressure during treatment must be taken and documented in the patient's medical record.
6. In addition, the ulcer must be free of infection and underlying osteomyelitis and treatment of the underlying disease (e.g., peripheral vascular disease) must be provided and documented in conjunction with skin substitute treatment.

B. Diagnosis Restrictions:

Coverage of the bilaminate skin product and its application is restricted to the following ICD-9-CM codes:

454.0
454.2
250.8 (requires a fifth-digit subclassification)
707.10
707.13
707.14
707.15
940.0 through 949.5

257.000 Tobacco Cessation Products Counseling Services 10-1-06

Arkansas Medicaid covers generic Zyban (bupropion for tobacco cessation) and nicotine replacement therapy (NRT), either nicotine gum or nicotine patches through the Medicaid Prescription Drug Program.

A. Physician providers may participate by prescribing covered tobacco cessation products.

1. The reimbursement to the pharmacy provider for the products is available for up to 2 ninety-three day courses of treatment within a calendar year.
2. Beneficiaries who are pregnant are allowed up to four ninety-three day courses of treatment per calendar year.
3. One course of treatment is three consecutive months.

B. Counseling by the prescriber is required for to obtain initial prior authorization (PA) coverage of the products. Counseling consists of reviewing the Public Health Service (PHS) guideline-based checklist with the patient. The prescriber must retain the counseling checklist in the patient records for audit. A copy of the checklist is available on the Medicaid website at **www.medicaid.state.ar.us**.

Subsequent prior authorizations will require prescriber referral to an intensive tobacco cessation program, such as SOS Works. A referral form will also be available on the Medicaid website.

C. Counseling procedures do not count against the twelve visits per state fiscal year (STY), but they are limited to no more than two 15-minute units and two 30-minute units for a maximum allowable of 4 units per SFY.

D. Additional prescription benefits will be allowed per month for tobacco cessation products during the approved PA period and will not be counted against the monthly prescription benefit limit. One benefit will be allowed for generic Zyban if the physician believes that generic Zyban therapy is appropriate and one benefit for NRT, either nicotine gum or patches.

E. Refer to section 292.900 for procedure codes and billing instructions.

258.000 Hyperbaric Oxygen Therapy 10-1-06

Physicians may be reimbursed for attendance and supervision of hyperbaric oxygen therapy.

Hyperbaric oxygen therapy involves exposing the body to oxygen under pressure greater than one atmosphere. Such therapy is performed in specially constructed hyperbaric chambers holding one or more patients; although oxygen may be administered in addition to the hyperbaric treatment. Patients should be assessed for contraindications such as sinus disease or claustrophobia prior to therapy. In some diagnoses, hyperbarics is only an adjunct to standard surgical therapy. These indications are taken from “The Hyperbaric Oxygen Therapy Committee Report” (2003) of The Undersea and Hyperbaric Medical Society (Kensington, MD).

A. All hyperbaric therapy will require prior approval, except in emergency cases such as for air embolism or carbon monoxide poisoning. Prior approval will be for a certain number of treatments. A copy of the approval letter must be filed with each claim and the number in the series of treatments documented.

B. Further treatments will require reapplication for a prior approval. Documentation for prior approval should include, but not be limited to, a complete physician SOAP note, a physical exam and prior therapy treatment failures, including antibiotic therapies and surgical interventions.

1. It must include a clear description of the wound with each claim. Documentation of no measurable signs of healing for at least 30 consecutive days of wound care therapy prior to the start of HBO therapy should be included (for those diagnoses requiring this treatment plan).

2. If extension of treatment period is needed, the above documentation must be submitted and fully documented. Physician progress notes physical findings at each treatment and the effects of treatment wound description will be needed for an extension. Any questions may be addressed to the Medical Director at 501-682-9868.

3. Requests for prior approval may be mailed or faxed.

Mailing address:
ATTN: Medical Director
Division of Medical Services
Slot S412
Department of Health and Human Services
PO Box 1437
Little Rock, AR 72203-1437

Fax to
501-682-8013 or
501-683-4124
ATTN: Medical Director

C. The following tables provide explanation of diagnosis requirements and treatment number of treatments and treatment schedules.

Diagnosis	Description	Number of Treatments
6396, 67300, 9580,9991	Air or Gas Embolism	10
9930	Decompression Sickness	10
986	Carbon Monoxide Poisoning	5
0400, 0383	Clostridial Myositis and Myonecrosis (Gas Gangrene)	10
8690-8691, 8871, 8873, 8875, 8877, 8971, 8973, 8975, 8977, 9251-9299, 99690-99699	Crush injuries, compartment syndrome, other acute traumatic peripheral ischemias	See Table
25070-25073, 44023, 44024, 44381-4439, 4540, 4542, 70700-7079, 9895, 99859	Enhancement of healing in selected problem wounds; diabetic foot ulcers, pressure ulcers, venous stasis ulcers; only in severe and limb or life-threatening wounds that have not responded to other treatments, particularly if ischemia that cannot be corrected by vascular procedures is present	30
3240	Intracranial abscess, multiple abscesses, immune compromise, unresponsive	20

Diagnosis	Description	Number of Treatments
72886, 7854	Necrotizing Soft Tissue Infections, immune compromise	30
73000-73020	Refractory osteomyelitis after aggressive surgical debredement	40
52689, 73010-73019, 7854, 9092, 990	Delayed Radiation Injury	60
99652, 99660-99670, V423	Compromised skin grafts and flaps	20
9400-9495	Thermal burns > 20% TSBA +/or involvement of hands, face, feet or perineum that are deep, partial or full thickness injury	40

Hyperbaric Treatment Schedules ("Doses") of HBO_2				
ICD9 Code	**Injury Type**	**Number & Schedule of HBO_2 Treatments**	**Number of HBO_2 Treatments Before Peer Review (Days)**	**Comments**
9251-929.9	Crush Injuries according to Gustilo classification	TID[a] 2 days BID[b] 2 days Daily for 2 days	6	
9585	Compartment syndrome, impending stage fasciotomy not required	TID[a] for 1 day	1	If post-fasciotomy, *see* problem wound recommendations
9400-9495, 99652, 99666-99670, V423	Threatened flaps & grafts	Same as for crush injuries	6	
92951-929.9	Problem wounds after primary management	BID[b] for 7d; daily 7 days	14	Post-fasciotomy wounds, complications and residual wounds after primary management of crush injuries
73000-73020	Refractory osteomyelitis	Daily for 21 days	21 +	May require continuation of HBO_2 through 60 treatments, but reassessment and second stage peer review recommended

Hyperbaric Treatment Schedules ("Doses") of HBO_2				
ICD9 Code	**Injury Type**	**Number & Schedule of HBO_2 Treatments**	**Number of HBO_2 Treatments Before Peer Review (Days)**	**Comments**
				after 40 treatments

[a]Three times a day
[b]Twice a day

Refer to section 292.860 of this manual for billing instructions.

261.000 Obtaining Prior Authorization of Restricted Medical and Surgical Procedures 10-1-06

A. Certain medical and surgical procedures are not covered without prior authorization (PA). Most restricted procedures are prior authorized by the Arkansas Foundation for Medical Care, Inc. (AFMC). Refer to sections 261.100, 261.120 and 261.130 for instructions on requesting PA from AFMC.

B. The Division of Medical Services Utilization Review Section makes PA determinations for certain procedures. Refer to sections 261.200 through 261.260 for instructions on requesting PA from Utilization Review.

C. Refer to section 262.000 for a list of procedures requiring prior authorization.

261.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 10-1-06

A. Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain a prior authorization number **if the beneficiary is under age 21**.

B. The following post-procedural authorization process must be followed when obtaining an authorization number for the procedures in Section 262.000.

1. All requests for post-procedural authorizations for eligible beneficiaries are to be made to the Arkansas Foundation for Medical Care (AFMC) by telephone within 60 days of the date of service. The physician or the physician's office nurse must contact AFMC. **View or print AFMC contact information.** These calls will be tape recorded.
2. If the provider receives only the Medicaid identification number from the beneficiary and is unable to obtain the actual card to validate the eligibility dates, you may call the EDS Provider Assistance Center to obtain the dates of eligibility. **View or print the EDS Provider Assistance Center contact information.** AFMC must be provided the beneficiary and provider identifying criteria and all of the medical data necessary to justify the procedures. As medical information will be exchanged for this procedure, the physician or a nursing member of his/her staff must make these calls.
3. The provider will be issued a PA number at the time of the call if the procedure requested is approved. A follow-up letter will be mailed the same day to the physician.
4. Consulting physicians are responsible for calling AFMC to have their required and/or restricted procedures added to the PA file. They will be given the prior authorization

number at the time of the call on cases that are approved. A letter verifying the PA number will be sent to the consultant upon request. When calling, all patient identification information and medical information related to the necessity of the procedure needing authorization must be provided.

C. The Arkansas Medicaid Program continues to recommend providers obtain prior authorization for procedures requiring authorization in order to prevent risk of denial due to lack of medical necessity.

This policy applies only to those eligible Medicaid recipients under age 21. This policy does not alter policy currently applicable to retroactive-eligible beneficiaries.

261.120 Prior Authorization of Bilaminate Graft or Skin Substitute 10-1-06

Arkansas Medicaid requires prior authorization (PA) of the product for bilaminate graft or skin substitute. Prior authorization for the product (dermal and epidermal tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter) is issued in units. One unit equals one square centimeter. Application procedures do not require prior authorization.

To request prior authorization, providers must submit a request for prior authorization to Arkansas Foundation for Medical Care, Inc. (AFMC). The AFMC Request for Bilaminate Skin Substitutes form must be completed and submitted to AFMC with supportive documentation. **View or print the AFMC Request for Bilaminate Skin Substitutes form.** (Refer to section 253.000 for coverage criteria and section 292.870 for billing instructions.) Providers who will be using this product should copy the prior authorization request form for later use.

261.130 Prior Authorization of Cochlear Implant and External Sound Processor 10-1-06

A. Arkansas Medicaid provides coverage for cochlear implantation and for the external sound processor when provided to recipients under age 21 in the Child Health Services (EPSDT) Program. Prior authorization by AFMC is required.

B. A written request signed by the physician performing the procedure is required. The request must be accompanied by medical documentation to support medical necessity. See section 261.100 for prior authorization instructions.

261.210 Prior Authorization of Ambulatory Infusion Device 10-1-06

A. Arkansas Medicaid covers an ambulatory infusion device when it is provided by the physician and prior authorized. To obtain prior authorization, the physician providing the equipment must complete and sign Form DMS-679, Medical Equipment Request for Prior Authorization and Prescription. **View or print form DMS-679 and instructions for completion.** The original and first copy of the form must be submitted to the Division of Medical Services Utilization Review Section. **View or print the Division of Medical Services Utilization Review Section contact 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 DMS-679 returned to the provider. The PA control number in Item 10 of the DMS-679 must be entered on the claim form filed for Medicaid payment of these services.

B. Approvals are authorized for a maximum of six months (180 days). If services are needed for a longer period, a new request must be submitted.

C. The effective date of the prior authorization is the date the patient begins use of the equipment or the date following the expiration date of the previous prior authorization approval.

D. Denied requests are returned to the provider indicating the reason for denial.

261.220 Prior Approval of Transplant Procedures 10-1-06

A. The attending physician is responsible for obtaining prior approval for organ transplant evaluations and for organ transplants.

1. The attending physician must request from UR prior approval of a transplant evaluation, naming the facility at which the evaluation is to take place and the physician who will conduct the evaluation. **View or print the UR Section contact information.** This request must include the following:
   a. History and physical and supporting documentation
   b. Previous treatment
   c. Copy of the most recent hospitalization
   d. Name of proposed facility where patient will be referred for transplant
   e. Third-party insurance information, when applicable
2. UR reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.
3. The evaluation results are forwarded to UR with a request for the transplant procedure.
4. UR forwards the request and its supporting documentation to AFMC for a determination of approval or denial.
5. AFMC advises the requesting physician and the beneficiary of its decision.

B. The physician is responsible for distributing documentation of prior approval to the hospital and to the other participating providers, such as the anesthetist, assistant surgeon, etc.

261.230 Reconsideration for Denied Prior Approvals 10-1-06

A request for administrative reconsideration of a denied prior approval must be in writing and sent to AFMC within 35 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis. Reconsideration requests must be mailed or delivered by hand. Faxed or emailed requests will not be accepted.

261.231 Beneficiary Appeal Process for Denied Prior Approvals 10-1-06

When DMS or its designee (AFMC in this case) denies a request for prior approval of a transplant or transplant evaluation, the beneficiary may appeal the denial and request a fair hearing.

A. An appeal request must be in writing.

B. The appeal request must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the provider notification denial letter from the Utilization Review Section or AFMC. **View or print the Department of Human Services, Appeals and Hearings Section contact information.**

261.250 Prior Authorization process for Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) 10-1-06

The following CPT procedure codes are covered for Medicaid beneficiaries when prior authorized.

87901	A maximum of 2 units per 12 month period can be requested at one time
87903	A maximum of 1 unit per year can be requested at one time.
87904	This procedure is an add-on code. The appropriate number of units must be included with each prior authorization request.

Physicians ordering the test must obtain the prior authorization. For billing purposes, the physician must supply a copy of the prior authorization to the laboratory performing the test. The process for requesting prior authorization for these procedures is listed below.

A. A statement is required from the physician stating that the patient presented with virologic failure during HAART.

B. A copy of the results of tests, CPT procedure code 87536 – "HIV-1, quantification" or procedure code 87539 – "HIV-2, quantification," must be attached to the prior authorization requests. These tests must reflect that the patient has suboptimal suppression of viral loads (i.e.>1000 HIV RNA copies/ml.) after initiation of antiretroviral therapy.

C. Submit request for prior authorization for these procedure codes to the Utilization Review Section. **View or print the Division of Medical Services Utilization Review Section address.**

262.000 Procedures That Require Prior Authorization 10-1-06

The following procedure codes require prior authorization:

Procedure Codes							
J7320	J7340	L8614	L8615	L8616	L8617	L8618	L8619
S0512	S2213	V5014	00170	01966	11960	11970	11971
15400	15831	19318	19324	19325	19328	19330	19340
19342	19350	19355	19357	19361	19364	19366	19367
19368	19369	19370	19371	19380	20974	20975	21076
21077	21079	21080	21081	21082	21083	21084	21085
21086	21087	21088	21089	21120	21121	21122	21123
21125	21127	21137	21138	21139	21141	21142	21143
21145	21146	21147	21150	21151	21154	21155	21159
21160	21172	21175	21179	21180	21181	21182	21183
21184	21188	21193	21194	21195	21196	21198	21199
21208	21209	21244	21245	21246	21247	21248	21249
21255	21256	27412	27415	29866	29867	29868	30220
30400	30410	30420	30430	30435	30450	30460	30462

Procedure Codes							
32851	32852	32853	32854	33140	33282	33284	33945
36470	36471	37785	37788	38240	38241	38242	42820
42821	42825	42826	42842	42844	42845	42860	42870
43257	43644	43645	43842	43845	43846	43847	43848
43850	43855	43860	43865	47135	48155	48160	48554
48556	50320	50340	50360	50365	50370	50380	51925
54360	54400	54415	54416	54417	55400	57335	58150
58152	58180	58260	58262	58263	58267	58270	58280
58290	58291	58292	58293	58294	58345	58550	58552
58553	58554	58672	58673	58750	58752	59135	59840
59841	59850	59851	59852	59855	59856	59857	59866
60512	61850	61860	61862	61870	61875	61880	61885
61886	61888	63650	63655	63660	63685	63688	64555
64573	64585	64809	64818	65710	65730	65750	65755
67900	69300	69310	69320	69714	69715	69717	69718
69930	87901	87903	87904	92081	92100	92326	92393
93980	93981						

Procedure Code	Modifier	Description
E0779	RR	Ambulatory infusion device
D0140	EP	EPSDT interperiodic dental screen
J7330		Autologous cultured chondrocytes, implant
L8619	EP	External sound processor
S0512		Daily wear specialty contact lens, per lens
V2501	UA	Supplying and fitting Keratoconus lens (hard or gas permeable) - 1 lens
V2501	U1	Supplying and fitting of monocular lens (soft lens) - 1 lens
Z1930		Non-emergency hysterectomy following c-section
92002	UB	Low vision services – evaluation

292.000 CMS-1500 Billing Procedures 10-1-06

292.100 Procedure Codes 10-1-06

292.110 Non-covered CPT Procedure Codes 10-1-06

The following is a list of CPT procedure codes that are non-covered by the Arkansas Medicaid Program to providers of Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Some procedure codes are non-payable, but the service is payable under another procedure code. Refer to Special Billing Procedures, sections 292.000 through 292.860.

Procedure Codes							
01953	01968	09169	11900	11901	11920	11921	11922
11950	11951	11952	11954	15775	15776	15780	15781
15782	15783	15786	15787	15819	15820	15821	15822
15823	15824	15825	15826	15828	15829	15832	15833
15834	15835	15836	15837	15838	15839	15876	15877
15878	15879	17360	17380	21497	27193	27591	27881
28531	32850	32855	32856	33930	33933	33935	33940
33944	36416	36468	36469	36540	43265	43770	43771
43772	43774	43886	43887	43888	44132	44133	44135
44136	44715	44720	44721	44979	45520	46500	47133
47136	47143	47144	47145	47146	47147	48551	48552
49400	50300	50323	50325	50327	50328	50329	54401
54405	54406	54408	54410	54411	54660	54900	54901
55870	55970	55980	56805	57170	58321	58322	58323
58970	58974	58976	59072	59430	59898	65760	65771
65781	65782	68340	69090	69710	69711	76948	76986
78890	78891	80103	83087	84061	87001	87003	87472
87477	87902	88000	88005	88007	88012	88014	88016
88020	88025	88027	88028	88029	88036	88037	88040
88045	88099	88188	88189	89250	89251	89253	89254
89255	89257	89258	89259	89260	89261	89264	89268
89272	89281	89290	89291	89335	89342	89343	89344
89346	89352	89353	89354	89356	90378	90379	90384
90465	90466	90467	90468	90471	90472	90473	90474
90476	90477	90586	90680	90693	90717	90719	90723
90725	90727	90736	90760	90761	90773	90783	90845
90846	90865	90875	90876	90880	90885	90887	90889
90901	90911	90918	90919	90920	90921	91060	92065
92070	92285	92310	92311	92312	92313	92314	92315
92316	92317	92325	92326	92330	92335	92340	92341
92342	92352	92353	92354	92355	92358	92370	92371
92592	92593	92596	92597	92605	92606	92609	93668
93701	93797	93798	94452	94453	94656	94657	94660
94662	94667	94668	94762	95078	95250	95806	96000

Procedure Codes							
96001	96002	96003	96004	96102	96103	96110	96116
96150	96151	96152	96153	96154	96155	97002	97004
97005	97006	97010	97012	97014	97016	97018	97020
97022	97024	97026	97028	97032	97033	97034	97035
97036	97039	97112	97113	97116	97124	97139	97140
97530	97532	97535	97537	97542	97545	97546	97755
97802	97803	97804	97810	97811	97813	97814	99000
99001	99002	99024	99026	99027	99056	99070	99071
99075	99078	99080	99090	99091	99239	99261	99262
99263	99315	99316	99324	99325	99326	99327	99328
99334	99335	99336	99337	99339	99340	99344	99345
99350	99358	99359	99361	99362	99371	99372	99373
99374	99375	99377	99378	99379	99380	99386	99387
99396	99397	99403	99404	99411	99412	99420	99429
99431	99433	99435	99450	99455	99456	99499	99500
99501	99502	99503	99504	99505	99506	99507	99509
99510	99511	99512					

292.410 Abortion Procedure Codes 10-1-06

Abortion procedures performed when the life of the mother would be endangered if the fetus were carried to term require prior authorization from the Arkansas Foundation of Medical Care, Inc. (AFMC).

Abortion for pregnancy resulting from rape or incest must be prior authorized by the Division of Medical Services, Administrator, Utilization Review.

The physician must request prior authorization for the abortion procedures and for anesthesia. Refer to section 260.000 of this manual for prior authorization procedures. The physician is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes.

All claims must be made on paper with attached documentation. A completed Certification Statement for Abortion (form DMS-2698 Rev. 8/04), patient history and physical exam are required for processing of claims. When filing paper claims, type of service code 2 must be used for the abortion procedure, and type of service code **"7"** must be used for anesthesia.

Use the following procedure codes when billing for abortions.

01966*	59840	59841	59850	59851	59852
59855	59856	59857			

***Effective for dates of service on and after March 1, 2006, CPT anesthesia procedure code **01964** is non-payable and has been replaced with procedure code **01966**.

Refer to section 251.220 of this manual for policies and procedures regarding coverage of abortions and section 261.000, 261.100, 261.200, 261.260 for prior authorization instructions.

292.430 Ambulatory Infusion Device 10-1-06

Procedure code **E0779**, modifier **RR**, **Ambulatory Infusion Device**, is payable only when services are provided to patients receiving chemotherapy, pain management or antibiotic treatment in the home. One unit of service equals one day. A reimbursement rate has been established and represents a daily rental amount. For paper claims, use type of service code **"1"** with the modifier **RR**. Refer to section 241.000 of this manual for coverage information and section 261.220 for prior authorization procedures.

292.440 Anesthesia Services 10-1-06

Anesthesia procedure codes (**00100** through **01999**) must be bill in anesthesia time. Anesthesia modifiers **P1** through **P5** listed under Anesthesia Guidelines in the CPT must be used. When appropriate anesthesia procedure codes that have a base of 4 or less, type of service code **"7,"** are eligible to be billed with a second modifier, **"22,"** referencing surgical field avoidance.

Any surgical procedure with local/topical anesthesia is computed to include the administration of the local anesthetic agent, as it is already computed into the reimbursement amount and is billed by the primary surgeon. No modifiers or time may be billed with these procedures.

A. Electronic Claims

PES or electronic claims submission may be used unless paper attachments are required.

B. Paper Claims

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

A type of service code is required along with applicable modifiers when filing paper claims. Providers must use type of service code **"7"** with procedure codes 00100 through 01999.

Any surgical procedure that includes local/topical anesthesia must be billed by the primary surgeon with a type of service code **"2."**

The procedure codes listed under "Qualifying Circumstances" in the Anesthesia Guidelines of CPT require a type of service code (paper only) "1."

C. The following national CPT procedure code for abortion and locally assigned procedure code for anesthesia for abdominal hysterectomy are to be billed with a type of service code "7" to indicate anesthesia, time units and modifiers as appropriate. These codes must be billed on CMS-1500 (formerly HCFA-1500) paper claims only because they require attachments.

National Code	Local Code	Description	Documentation Required
01966*		Anesthesia for induced abortion procedures Use for billing anesthesia service for all elective, induced abortions, including abortions performed for rape or incest	Certification Statement for Abortion (DMS-2698) (See sections 251.220, 261.000, 261.100, 261.200 and 261.260 of this manual.) **View or print form DMS-2698 and instructions for completion.**

National Code	Local Code	Description	Documentation Required
None	Z9940	Anesthesia for Abdominal Hysterectomy	Acknowledgement of Hysterectomy (DHS-2606) **View or print form DMS-2606 and instructions for completion.**

D. The following CPT procedure codes must be billed on CMS-1500 (formerly HCFA-1500) paper claims because they require attachments or documentation:

Procedure Code	Documentation Required
00846	Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00848	Operative Report
01962 01963	Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00922	Operative Report
00944	Acknowledgement of Hysterectomy Information (DMS-2606)) **View or print form DMS-2606 and instructions for completion.**
01999	Procedure Report
00800	On females only, required to name each procedure done by surgeon in "Procedures, Services or Supplies" column. Example - 1. colon resection 2. lysis of adhesions 3. appendectomy
00840	On females only, required to name each procedure done by surgeon in "Procedures, Services or Supplies" column.
00940	Required to name each procedure done by surgeon in "Procedures, Services or Supplies" column.

Anesthesiologist/anesthetists may bill procedure code **00170** with a type of service code (paper only) "**7**" for any inpatient or outpatient dental surgery using place of service code "**B**," "**1**," "**2**" or "**3**," as appropriate. This code does not require prior approval for anesthesia claims.

A maximum of 17 units of anesthesia is allowed for a vaginal delivery or C-Section. Refer to Anesthesia Guidelines of the CPT book for procedure codes related to vaginal or C-section deliveries.

292.443 Medicaid Coverage for Therapeutic Infusions (Excludes Chemotherapy) 10-1-06

Effective for dates of service on and after March 1, 2006, procedure codes **90780** and **90781** are non-payable. These codes have been replaced with procedure codes **99143** through **99150**.

292.480 Cataract Surgery 10-1-06

Post-cataract lens implant must be billed using procedure code **V2630**. This procedure code may be billed electronically or on paper. When filing paper claims, use type of service code **1**.

The lens implant code is billed in conjunction with the cataract surgery and is covered for eligible Medicaid beneficiaries of all ages in the outpatient setting.

292.550 Family Planning Services 10-1-06

292.551 Family Planning Services For Beneficiaries in Full Coverage Aid Categories 10-1-06

Family planning services are covered for beneficiaries in full coverage aid categories. Family planning procedures payable to physicians require a modifier "**FP**". For paper claims, physicians must use type of service code **"A"** with the modifier. All procedure codes in this table require a family planning or sterilization diagnosis code in each claim detail.

A. The following tables include procedure codes that are covered as family planning services for beneficiaries in full coverage aid categories

Procedure Codes							
11975	11976	11977	55250	55450	58300	58301	58340**
58345**	58565	58600	58605	58611	58615	58661*	58670
58671	58700*	72190**	74740**	74742**	99144**	99145**	

*CPT codes **58661** and **58700** represent procedures to treat medical conditions as well as for elective sterilizations. When filing paper claims for either of these services for elective sterilizations, enter type of service code **"A"**. When using either of these codes for treatment of a medical condition, type of service code **"2"** must be entered for the primary surgeon or type of service code **"8"** for an assistant surgeon.

**These procedures require special billing instructions. Refer to part C of this section.

Procedure Code	**Modifier(s)**	**Description**
J1055	FP	Medroxyprogesterone acetate for contraceptive use
J7300	FP	Intrauterine copper contraceptive
J7302	FP	Levonorgestrel-releasing intrauterine contraceptive system
J7303	FP	Contraceptive supply, hormone containing vaginal ring
J7306	FP	Levonorgestrel (contraceptive) implant system, including implants and supplies
36415	FP	Routine venipuncture for blood collection
99401	FP, UA, UB	Periodic family planning visit
99401	FP, UA, U1	Arkansas Division of Health periodic/follow-up visit
99402	FP, UA	Arkansas Division of Health basic visit
99402	FP, UA, UB	Basic family planning visit

When filing family planning claims for physician services in an outpatient clinic, use modifier **U6** for the basic family planning visit and the periodic family planning visit. If filing on paper, use type of service code **"J"** with the modifier.

B. Effective for dates of service on and after June 28, 2006, procedure code **S0612** is not covered as a family planning procedure. It is covered for regular Medicaid beneficiaries for annual gynecological examinations. When filing paper claims for this service, use type of service code **"1"**.

C. Additional procedures have been added as family planning services when related to procedure **58565** – hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (Essure).

1. Effective for dates of service on and after March 1, 2006, conscious sedation procedure codes **99144** and **99145** may be covered as family planning service only when administered in conjunction with the Essure procedure (**58565**).

   To file electronic claims for these professional services, use modifier **FP**. On paper claims use type of service code **"A"** and modifier **FP**. Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis.

   Claims filed for these professional services when provided in an outpatient hospital clinic do not require modifiers if filed electronically. If billing on paper, type of service **"J"** is required. Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis.

2. Effective for dates of service on and after February 1, 2006, procedure codes **58340**, **58345**, **72190**, **74740** and **74742** are only payable as family planning services within the 6 months after the Essure procedure's date of service.

   a. Professional claims for procedure codes **58340** and **58345** must be filed with modifier **FP**. Paper claims require a type of service code **"A"** and modifier **FP**. Whether billing on paper or electronically, the primary detail diagnosis for each procedure must be a family planning diagnosis code.

      Claims for professional services provided in an outpatient clinic associated with a hospital must be filed with a type of service code **"J"**. Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis.

   b. Professional claims for procedure codes **72190**, **74740** and **74742** must be filed with modifier FP. Paper claims require a type of service code **"A"** and modifier **FP**. Whether billing on paper or electronically, the primary detail diagnosis for each procedure must be a family planning diagnosis code.

      When these radiology procedures are performed as family planning services in an outpatient hospital clinic, claims for the professional component of procedures codes **72190**, **74740** and **74742** require type of service **"J"** on paper claims. Whether billing on paper or electronically, a family planning diagnosis code must be listed as primary on each detail.

3. Procedure codes **J1055**, **11976** and **58301** are covered family planning services. Effective for dates of service on and after February 1, 2006, these procedures are also covered up to six months as necessary for follow-up services to the Essure procedure. When provided as post-Essure follow-up care, billing protocol is unchanged for J1055, 11976 and 58301 for all providers.

   All visits related to post-Essure services during the 6 months following the Essure procedure are included in the fee allowed for **58565**.

292.552 Family Planning Services for Beneficiaries in Limited Aid Category 69

Arkansas covers many family planning services for women of child-bearing age who are Medicaid-eligible in aid category 69 and who participate in the Arkansas Women's Health Waiver.

Covered family planning procedures furnished to beneficiaries in aid category 69 are payable to physicians and must be billed with a modifier **"FP"**. For paper claims, physicians must use type of service code **"A"** with the modifier.

A. The following services are covered for this limited service category.

Procedure Codes							
11975	11976	11977	58300	58301	58340*	58345*	58565
58600	58615	58670	58671	72190*	74740*	74742*	99144*
99145*							

*Asterisked codes require special billing procedures. Refer to part C of this section.

Procedure Code	**Modifier(s)**	**Description**
J1055	FP	Medroxyprogesterone acetate for contraceptive use
J7300	FP	Intrauterine copper contraceptive
J7302	FP	Levonorgestrel-releasing intrauterine contraceptive system
J7303	FP	Contraceptive supply, hormone containing vaginal ring
J7306	FP	Levonorgestrel (contraceptive) implant system, including implants and supplies
36415	FP	Routine venipuncture for blood collection
99401	FP, UA, UB	Periodic family planning visit
99401	FP, UA, U1	Arkansas Division of Health periodic/follow-up visit
99402	FP, UA	Arkansas Division of Health basic visit
99402	FP, UA, UB	Basic family planning visit

When filing family planning claims for physician services in an outpatient clinic, use modifier **U6** for the basic family planning visit and the periodic family planning visit. If filing on paper, use type of service code **"J"** with the modifier.

B. Effective for dates of service on and after June 28, 2006, the following procedure codes are not covered for aid category 69 beneficiaries.

58605	58611	58661	58700	S0612

C. Additional procedures have been added as family planning services when related to procedure **58565** – hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (Essure).

1. Effective for dates of service on and after March 1, 2006, conscious sedation procedure codes **99144** and **99145** may be covered as family planning service only when administered in conjunction with the Essure procedure (**58565**).

To file electronic claims for these professional services, use modifier **FP**. On paper claims use type of service code **"A"** and modifier **FP**. Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis.

Claims filed for these professional services when provided in an outpatient hospital clinic do not require modifiers if filed electronically. If billing on paper, type of service **"J"** is required. Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis.

2. Effective for dates of service on and after February 1, 2006, procedure codes **58340**, **58345**, **72190**, **74740** and **74742** are only payable as family planning services within the 6 months after the Essure procedure's date of service.

   a. Professional claims for procedure codes **58340** and **58345** must be filed with modifier **FP**. Paper claims require a type of service code **"A"** and modifier **FP**. Whether billing on paper or electronically, the primary detail diagnosis for each procedure must be a family planning diagnosis code.

   Claims for professional services provided in an outpatient clinic associated with a hospital must be filed with a type of service code **"J"**. Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis.

   b. Professional claims for procedure codes **72190**, **74740** and **74742** must be filed with modifier FP. Paper claims require a type of service code **"A"** and modifier **FP**. Whether billing on paper or electronically, the primary detail diagnosis for each procedure must be a family planning diagnosis code.

   When these radiology procedures are performed as family planning services in an outpatient hospital clinic, claims for the professional component of procedures codes **72190**, **74740** and **74742** require type of service **"J"** on paper claims. Whether billing on paper or electronically, a family planning diagnosis code must be listed as primary on each detail.

3. Procedure codes **J1055**, **11976** and **58301** are covered family planning services. Effective for dates of service on and after February 1, 2006, these procedures are also covered up to six months as necessary for follow-up services to the Essure procedure. When provided as post-Essure follow-up care, billing protocol is unchanged for **J1055**, **11976** and **58301** for all providers.

   All visits related to post-Essure services during the 6 months following the Essure procedure are included in the fee allowed for **58565**.

292.553 Family Planning Laboratory Procedure Codes 10-1-06

This table contains laboratory procedure codes payable as family planning services for regular Medicaid beneficiaries and for beneficiaries in limited aid category 69. They are also payable when used for purposes other than family planning. Electronic claims require modifier **FP** when the service diagnosis indicates family planning. When filing paper claims use type of service code **"A"** along with modifier **FP** when the service diagnosis indicates family planning. Refer to section 292.730 for other applicable type of service codes (paper only) for laboratory procedures.

Independent Lab CPT Codes							
Q0111	81000	81001	81002	81003	81025	83020	83520
83896	84703	85014	85018	85660	86592	86593	86687
86701	87075	87081	87087	87210	87390	87470	87490
87491***	87536	87590	87591***	87621**	88142*	88143*	88150**

Independent Lab CPT Codes							
88152	88153	88154	88155**	88164	88165	88166	88167
88174	88175	89300	89310	89320			

*** Procedure codes 88142 and 88143 are limited to one unit per beneficiary per state fiscal year.**

**** Payable only to pathologists and independent labs with type of service code (paper only) "A."**

***** Procedure codes 87491 and 87591 are payable as family planning services effective for dates of service on and after February 1, 2006.**

Procedure Code	Required Modifiers	Description
88302	FP	Surgical Pathology, Complete Procedure, Elective Sterilization
88302	FP, U2	Surgical Pathology, Professional Component, Elective Sterilization
88302	FP, U3	Surgical Pathology, Technical Component, Elective Sterilization

292.561 Genetic Testing 10-1-06

Medicaid will reimburse physician services for the following genetic testing procedures.

S3840	S3842	S3843	S3844	S3846	S3847	S3848	S3849
S3850	S3851	S3853					

When filing paper claims, type of service codes **"C",** or **"T"** is required as applicable.

292.591 Injections and Oral Immunosuppressive Drugs 10-1-06

A. Administration of chemotherapy agents is payable only if provided in a physician's office, place of service code: Paper **"3"** or electronic **"11."** These procedures are not payable to the physician if performed in the inpatient or outpatient hospital setting. 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 format. 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 CPT code range **96401** through **96549** for chemotherapy administration procedure codes.

B. The following is a list of covered therapeutic agents payable to the physician when furnished in the office. Multiple units may be billed, if appropriate. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs."

For coverage information regarding any drug not listed, please contact the Medicaid Reimbursement Unit. View or print Medicaid Reimbursement Unit contact information.

This list includes drugs covered for beneficiaries of all ages. However, when provided to individuals aged 21 or older, a diagnosis of ICD-9-CM 140.0 – 208.91, or 042 is required.

Procedure Codes							
J0120	J0128	J0190	J0200	J0205	J0207	J0210	J0256
J0278	J0280	J0285	J0287	J0288	J0289	J0290	J0295
J0300	J0330	J0350	J0360	J0380	J0390	J0456	J0460
J0470	J0475	J0476	J0500	J0515	J0520	J0530	J0540
J0550	J0560	J0570	J0580	J0592	J0595	J0600	J0610
J0620	J0630	J0640	J0670	J0690	J0692	J0694	J0696
J0697	J0698	J0702	J0704	J0706	J0710	J0713	J0715
J0720	J0725	J0735	J0740	J0743	J0744	J0745	J0760
J0770	J0780	J0795	J0800	J0835	J0850	J0895	J0900
J0945	J0970	J1000	J1020	J1030	J1040	J1051	J1060
J1070	J1080	J1094	J1100	J1110	J1120	J1160	J1165
J1170	J1180	J1190	J1200	J1205	J1212	J1230	J1240
J1245	J1250	J1260	J1270	J1320	J1325	J1330	J1364
J1380	J1390	J1410	J1435	J1436	J1450	J1452	J1455
J1457	J1470	J1570	J1580	J1590	J1610	J1620	J1626
J1630	J1631	J1642	J1644	J1645	J1650	J1652	J1655
J1670	J1700	J1710	J1720	J1730	J1742	J1800	J1810
J1815	J1825	J1830	J1835	J1840	J1850	J1885	J1890
J1910	J1940	J1950	J1955	J1956	J1960	J1980	J1990
J2000	J2001	J2010	J2020	J2060	J2150	J2175	J2180
J2185	J2210	J2250	J2270	J2271	J2275	J2278	J2280
J2300	J2310	J2320	J2321	J2322	J2355	J2360	J2370
J2400	J2405	J2410	J2425	J2430	J2440	J2460	J2469
J2501	J2510	J2515	J2540	J2543	J2550	J2560	J2590
J2597	J2650	J2670	J2675	J2680	J2690	J2700	J2710
J2720	J2725	J2730	J2760	J2765	J2770	J2780	J2783*
J2800	J2820	J2912	J2920	J2930	J2941	J2950	J2995
J3000	J3010	J3030	J3070	J3105	J3120	J3130	J3140
J3150	J3230	J3240	J3250	J3260	J3265	J3280	J3301
J3302	J3303	J3305	J3310	J3315	J3320	J3350	J3360
J3364	J3365	J3370	J3400	J3410	J3430	J3470	J3475
J3480	J3485	J3490*	J3520	J7190	J7191	J7192	J7194
J7197	J7308	J7310	J7501	J7504	J7505	J7506	J7507*
J7508*	J7509	J7510	J7511	J7513	J7518	J7599*	J8530
J9000	J9001	J9010	J9015	J9017	J9020	J9031	J9040
J9041	J9045	J9050	J9055	J9060	J9062	J9065	J9070

Procedure Codes							
J9080	J9090	J9091	J9092	J9093	J9094	J9095	J9096
J9097	J9098*	J9100	J9110	J9120	J9130	J9140	J9150
J9151	J9165	J9170	J9178*	J9181	J9182	J9185	J9190
J9200	J9201	J9202	J9206	J9208	J9209	J9211	J9212
J9213	J9214	J9215	J9216	J9217	J9218	J9230	J9245
J9260	J9263*	J9264	J9265	J9266	J9268	J9270	J9280
J9290	J9291	J9293	J9300	J9305	J9310	J9320	J9340
J9355	J9357	J9360	J9370	J9375	J9380	J9390	J9600
J9999*	Q0163	Q0164	Q0165	Q0166	Q0167	Q0168	Q0169
Q0170	Q0171	Q0172	Q0173	Q0174	Q0175	Q0176	Q0177
Q0178	Q0179	Q0180	Q2009	Q2017	Q4075	S0017	S0021
S0023	S0028	S0030	S0032	S0034	S0039	S0040	S0073
S0074	S0077	S0080	S0081	S0092	S0093	S0164	S0171
S0187**							

*Procedure code requires paper billing. Include the name of the drug and the dose given to patient..

Effective for dates of service on and after October 1, 2006, procedure code **S0187 is limited to 2 units per day.

292.592 Other Covered Injections and Immunizations with Special Instructions 10-1-06

Physicians may bill for immunization procedures on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 claim form. **View a DMS-694 sample form.** **View a CMS-1500 sample form.** On paper claims use type of service code "**1**."

When a patient is scheduled for immunization only, reimbursement is limited to the immunization. The provider may bill for the immunization only. Unless otherwise noted in this section of the manual, covered vaccines are payable only for beneficiaries under age 21.The following is a list of injections with special instructions for coverage and billing.

Procedure Code	Modifier(s)	Special Instructions
J0150		Procedure is covered for all ages with no diagnosis restriction.
J0152		Payable for all ages. When administered in the office, the provider must have nursing staff available to monitor the patient's vital signs during infusion. The provider must be able to treat cardiac shock and to provide advanced cardiac life support in the treatment area where the drug is infused.
J0170		Payable if the service is performed on an emergency basis and is provided in a physician's office.

Procedure Code	Modifier(s)	Special Instructions
J0180*		This procedure is covered for treatment of Fabry's disease, ICD-9-CM diagnosis code 272.7. Procedure requires prior approval from DMS Medical Director. See section 244.001 for additional coverage information and instructions for requesting prior approval.
J0585		Payable for individuals of all ages when medically necessary. Botox A is reviewed for medical necessity based on diagnosis.
J0636		Payable for individuals of all ages receiving dialysis due to renal failure (diagnosis codes 584-586).
J0637*		Caspofungin acetate injection is covered when administered to patients with refractory aspergillosis who also have a diagnosis of malignant neoplasm or HIV disease. Complete history and physical exam, documentation of failure with other conventional therapy and dosage must be submitted with invoice. After 30 days of use, an updated medical exam and history must be submitted.
J0702		Covered for beneficiaries of all ages. However, when provided to beneficiaries aged 21 and older, there must be a diagnosis of AIDS, cancer or complications during pregnancy (diagnosis code range 640 – 648.93).
J0881 J0885		Payable for dates of service on and after March 1, 2006, for non-ESRD use. Covered by Medicaid only when provided to patients with anemia associated with rheumatoid arthritis, sideroblastic anemia, anemia associated with multiple myeloma, anemia associated with B-cell malignancies, myelodysplastic anemia and chemotherapy induced anemia.
J0882 J0886		Payable for dates of service on and after March 1, 2006. Covered when administered to patients diagnosed with ESRD (diagnosis range 584 – 586).
J1100		Covered for beneficiaries of all ages. However, when provided to beneficiaries aged 21 and older, there must be a diagnosis of HIV/AIDS, cancer or complications during pregnancy (diagnosis code range 640 – 648.93).
J1440 J1441 J1460 J1470 J1480 J1490 J1500 J1510 J1520 J1530 J1540 J1550 J1560		Covered for individuals of all ages with no diagnosis restrictions.
J1566 J1567		Electronic and paper claims are reviewed for medical necessity, based on the diagnosis code.

Procedure Code	Modifier(s)	Special Instructions
J1600		Payable for patients with a detail diagnosis of rheumatoid arthritis (diagnosis code range 714.0 – 714.9).
J1640		Payable when administered to beneficiaries with ICD-9-CM detail diagnosis 277.1).
J1745*		For beneficiaries under age 18 years, an approval letter is required, regardless of the diagnosis. For beneficiaries age 18 years and older, procedure code J1745 is payable when one of the following conditions exist: 1) ICD-9-CM code 555.9 as the primary detail diagnosis **AND** a secondary diagnosis of 565.1 or 569.81 **OR** 2) ICD-9-CM code range 556.0 – 556.9 **OR** 3) ICD-9-CM code 696.0 **OR** 4) ICD-9-CM code 714.0 **NOTE:** ICD-9 diagnosis code 714.0 requires a prior approval letter from the Medical Director. The request for approval must include documentation showing failed trial of Enbrel or Humira. Claims must be submitted to EDS with any applicable attachments. Claims will be manually reviewed by Medicaid medical staff prior to payment. **OR** 5) ICD-9-CM 724.9. **NOTE:** ICD-9 diagnosis code 724.9 requires a prior approval letter from the Medical Director. The request for approval must include documentation showing failed trial of Enbrel or Humira. Claims must be submitted to EDS with any applicable attachments. Claims will be manually reviewed by Medicaid medical staff prior to payment.
J1751 J1752		Effective for dates of service on and after March 1, 2006, procedure codes J1750 became non-payable and was replaced with procedure codes J1751 and J1752. These services are payable for individuals with a diagnosis of ICD-9-CM code 280.9.
J1785*		This procedure is covered for the treatment of Type I Gaucher disease with complications, with a detail diagnosis of ICD-9 code 272.7. Prior approval from the DMS Medical Director is required. See section 244.001 for additional coverage information and instructions for requesting prior approval. A copy of the prior approval letter must be attached to each claim.

Procedure Code	Modifier(s)	Special Instructions
J1931*		This procedure is covered for treatment of mucopolysaccharidosis (MPS I), ICD-9-CM diagnosis code 277.5. Prior approval from DMS Medical Director is required. See section 244.001 for additional coverage information and instructions for requesting prior approval. A copy of the prior approval letter must be attached to each claim.
J2260		Payable for Medicaid beneficiaries of all ages with congestive heart failure (ICD-9 diagnosis codes 428-428.9)
J2353* J2354*		Payable for Medicaid beneficiaries of all ages. For ages 21 and older, J2353 and J2354 are covered for diagnosis of aids and cancer (ICD-9-CM diagnosis codes 140.0 – 208.91, 230.0 – 238.9 or 042). For other diagnoses, a prior approval letter is required and must be attached to each claim. See section 244.100 for information of requesting a prior approval letter. Paper billing is required for all diagnoses for all beneficiaries.
J2503		Payable for beneficiaries diagnosed with macular degeneration (ICD-9-CM diagnosis code 362.50 – 362.52).
J2504		Payable for beneficiaries of all ages with a primary detail diagnosis of 279.2.
J2505*		Covered for beneficiaries of all ages with a detail diagnosis from diagnosis code ranges 162.0 – 165.9, **or** 174.0 – 175.9 **or** 201.00 – 201.98 **or** 202.80 – 202.88.
J2513		Covered when administered to beneficiaries of all ages with no diagnosis restrictions.
J2788		Limited to one injection per pregnancy.
J2790 J2792		Payable with a primary diagnosis of 999.7; reviewed for medical necessity prior to payment.
J2910		Payable for patients with a primary detail diagnosis of rheumatoid arthritis (ICD-9 diagnosis codes 714.0 – 714.9).
J2916		Payable for beneficiaries aged 21 and older when there is a diagnosis of cancer, aids, or acute renal failure with a diagnosis on the claim that also includes 964.0. indicating that the beneficiary is allergic to iron dextran. May be billed electronically or on paper.
J2997		Payable for beneficiaries of all ages with no diagnosis restrictions. Limited to 2 units per day in the office place of service.
J3396		Covered for all ages if one of the following: diagnoses exist: ICD-9 diagnosis code 362.50 or 362.52; **or** ICD-9 diagnosis code 360.21; **or** ICD-9 diagnosis code 115.02 **or** 115.12 or 115.92. Claims may be filed electronically or on paper. See section 244.003 for additional coverage information.
J3420		Payable for patients with a primary detail diagnosis of pernicious anemia, 281.0. Coverage includes the B-12, administration and supplies. It must not be billed in multiple units.

Procedure Code	Modifier(s)	Special Instructions
J3465*		Covered for non-pregnant beneficiaries aged 18 and older with a diagnosis of AIDS or cancer and one of the following diagnoses: 112.2, 112.3, 112.5, 112.84, 112.85, 112.9 or 117.3. Claims must be filed on paper.
J3487		Payable to physicians when provided in the office if one of the following diagnoses exist: AIDS or cancer along with diagnosis code 275.42 **or** diagnosis code 198.5; **or** diagnosis code 203.0. Claim will be manually reviewed prior to payment.
J7198		Payable for all ages with no diagnosis restrictions.
J7199		Must be billed on a paper claim form with the name of the drug, dosage and the route of administration.
J7320		Requires prior authorization. Limited to 3 injections per knee, per beneficiary, per lifetime. (This includes Synvisc.) See section 261.240.
J7330		Requires prior authorization from AFMC for all providers. See sections 260.000, 261.000, 261.100 and 261.110.
J7341		Payable for beneficiaries of all ages with no diagnosis restrictions.
J9025		Coverage of this procedure code requires an ICD-9-CM diagnosis within the code range of 205.00 – 205.91 with applicable 4th and 5th digits per ICD-9-CM, **or** a diagnosis of 238.7.
J9035*		Coverage of this procedure code requires an ICD-9-CM diagnosis within the code range of 140.0 – 208.91, 230.0 – 238.9, 042, 362.50 or 362.52. A prior approval letter is required and must be attached to each claim. See section 244.100 for information on requesting prior approval.
J9219		This procedure code is covered for males of all ages with ICD-9-CM diagnosis code 185, 198.82 or V10.46. Benefit limit is one procedure every 12 months.
J9225		Payable for beneficiaries with a diagnosis of malignant neoplasm of prostate (ICD-9-CM code 185).
J9250		Payable for beneficiaries of all ages without restriction.
J9350		Covered for beneficiaries of all ages with a primary detail diagnosis of 162.9 or 183.0. Billable on electronic and paper claims. Paper claims require type of service “1”.
J9395*		Payable for beneficiaries of all ages, with a diagnosis of 174.0 – 174.9 after treatment failure with antiestrogen drugs. A prior approval letter is required. Requests for prior approval must include the history, physical exam and plan of treatment stating that request for this drug is due to a treatment failure. See section 244.001 for additional coverage information and instructions for requesting prior approval. A copy of the prior approval letter must be attached to each claim.
Q3025 Q3026		These procedure codes are covered for all ages based on medical necessity.

Procedure Code	Modifier(s)	Special Instructions
Q4079*		Procedure requires a prior approval letter. See section 244.100. The history and physical showing a relapse of multiple sclerosis must be submitted with the request for the prior approval letter. This procedure must be billed on a paper claim. The approval letter must be attached to each claim. Requires review before payment.
S0145 S0146		Procedures are payable when there is a primary detail diagnosis ICD-9-CM 070.54
90371		One unit equals 1/2 cc, with a maximum of 10 units payable per day. Payable for Medicaid beneficiaries of all ages in the physician's office.
90375* 90376*		Covered for all ages. Billing requires paper claims with procedure code and dosage entered infield 24.D of claim form CMS-1500 for each date of service. If date spans are used, I units of service must be identical for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.
90385		Limited to one injection per pregnancy.
90581*		Payable for ages 18 years and older. Indicate dose and attach manufacturer's invoice.
90585		Payable for all ages.
90586		Payable for ages 18 years and older.
90632		Payable when administered to beneficiaries ages 19 years and older.
90633 90634	EP, TJ	Payable when administered to beneficiaries ages 12 months – 18 years. See section 292.593.
90636	EP, TJ	Payable when administered to beneficiaries age 18 years and older. Modifiers are required only when administered to beneficiaries aged 18 years. See section 292.593.
90645 90646 90647	EP, TJ	Payable when administered to beneficiaries of all ages. See section 292.593 for billing instructions when administered to beneficiaries aged 18 years and younger.
90648	EP, TJ	Payable when administered to beneficiaries aged 18 years and younger. Refer to section 292.593 for more information.
90655 90657	EP, TJ	Influenza vaccines payable through the VFC program for beneficiaries 6 – 35 months of age. See section 292.593 for billing instructions.
90656 90658	EP, TJ	Influenza vaccines payable for beneficiaries aged 3 years and older. Modifiers required only when administered to children under age 19. Refer to sections 292.593 and 292.594 for influenza vaccine policy.
90660	EP, TJ	Covered for healthy individuals aged 5-49 and not pregnant. Modifiers required only when administered to beneficiaries under age 19. See sections 292.593 and 292.594 of this manual.
90665		Payable when administered to beneficiaries ages 19 years and older.

Procedure Code	Modifier(s)	Special Instructions
90669	EP, TJ	Administration of vaccine is covered for children under age 5 years. See section 292.593 for billing instructions.
90675* 90676*		Covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in field 24.D of claim form CMS-1500 for each date of service. If date spans are used, i units of service must be identical for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.
90680	EP, TJ	VFC vaccine payable when administered to beneficiaries ages 6 weeks – 32 weeks. See section 292.593 for more information.
90690		Payable for beneficiaries ages 6 years and older.
90691		Payable for beneficiaries aged 3 years and older.
90698		Payable for beneficiaries aged 0 – 7 years.
90700	EP, TJ	VFC vaccine payable when administered to beneficiaries under age 7 years. Modifiers are required. See section 292.593 for more information.
90703		Payable for ages 18 years and older.
90704		Payable for beneficiaries aged 1 year and older.
90705		Payable for ages 9 months and older.
90706		Payable for ages 1 year and older.
90707	U1	Payable when provided to women of childbearing age, ages 21 through 44, who may be at risk of exposure to these diseases. Coverage is limited to two (2) injections per lifetime. U1 modifier is required for this age group. Payable when administered to beneficiaries aged 19 and 20 years.
90707	EP, TJ	Payable when administered to beneficiaries under age 19 years. Modifiers are required when administered to beneficiaries under age 19 years. See section 292.593.
90708		Payable for beneficiaries 9 months of age and older.
90710	EP, TJ	Payable for beneficiaries under age 21 years. Modifiers are required only when administered to children under age 19. See section 292.593 for additional information.
90713	EP, TJ	Payable for beneficiaries of all ages. However, modifiers are required only when administered to beneficiaries under age 19 years. See section 292.593.
90714	EP, TJ	Payable for beneficiaries ages 7 years and older. Modifiers are required when administered to beneficiaries under age 19 years. See section 292.593.

Procedure Code	Modifier(s)	Special Instructions
90715	EP, TJ	This vaccine is covered for individuals aged 7 years and older. Modifiers are required only when administered to beneficiaries under age 19 years. See section 292.593.
90716	EP, TJ	This vaccine is covered for beneficiaries under age 21. Modifiers are required only when administered to beneficiaries under age 19. See section 292.593.
90717		Payable for all ages. Submit invoice with claim.
90718	EP, TJ	This vaccine is covered for individuals aged 7 years and older. Modifiers are required only when administered to beneficiaries under age 19.years. See section 292.593.
90719		This vaccine is covered for individuals of all ages.
90721	EP, TJ	Covered for beneficiaries under age 21 years. Modifiers are required only when administered to beneficiaries under age 19 years. See section 292.593.
90723	EP, TJ	Covered for beneficiaries under age 19 years. See section 292.593.
90725*		Payable for all ages; submit manufacturer's invoice.
90727*		{Payable for all ages; submit manufacturer's invoice.
90732		This code is payable for individuals aged 2 years and older. 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.
90733		Covered for beneficiaries of all ages.
90734	EP, TJ	Covered for beneficiaries of all ages. Modifiers are required only when administered to beneficiaries under age 19 years. See section 292.593.
90735		Payable for individuals under age 21 years.
90740		Three dose schedule. Payable for individuals of all ages.
90743	EP, TJ	Two dose schedule. Payable only when administered to children aged 0 – 18 years. See section 292.593.
90744	EP, TJ	Three dose schedule. Payable for ages 0 – 18 years. See section 292.593.
90746		Payable for ages 19 years and older.
90747	EP, TJ	Covered for beneficiaries of all ages. Modifiers are required **only** when administered to beneficiaries under age 19 years. See section 292.593.
90748	EP, TJ	Covered for beneficiaries of all ages. Modifiers are required **only** when administered to beneficiaries under age 19 years. See section 292.593.

***** Procedure code requires paper billing with applicable attachments.

292.593 Vaccines for Children Program 10-1-06

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. To enroll in the VFC Program, contact the Arkansas Division of Health. Providers may also obtain the vaccines to administer from the Arkansas Division of Health. **View or print Arkansas Division 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**. When filing paper claims, type of service code **"6"** and modifiers **EP**, **TJ**, must be entered on the claim form. When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **TJ** must be used for billing electronically or on paper. Paper claims for vaccines for ARKids First-B beneficiaries also require a type of service code **"1"**.

The following is a list of covered vaccines for children under age 19.

90633*	90634*	90636	90645	90646	90647	90648	90655
90656	90657	90658	90660	90669	90680**	90700	90707
90710*	90713	90714	90715*	90716	90718	90721	90723
90734*	90743	90744	90747	90748			

*Effective for dates of service on and after March 1, 2006, these vaccines are available through the VFC program.

**Effective for dates of service on and after July 10, 2006, procedure code 90680 is available through the VFC program.

292.594 Influenza Virus Vaccine 10-1-06

A. Procedure code **90655**, influenza virus vaccine, split virus, preservative free, for children 6 to 35 months, is currently covered through the VFC program. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**. When filing paper claims, use type of service **6** with modifiers **EP** and **TJ**.

   For ARKids First-B beneficiaries, use modifier **TJ**. When filing paper claims, use type of service **1** with modifier **TJ**.

B. Effective for dates of service on and after October 1, 2005, Medicaid will cover procedure code **90656**, influenza virus vaccine, split virus, preservative free, for ages 3 years and older.

   1. For individuals under 19 years of age, claims must be filed using modifiers **EP** and **TJ**. When filing paper claims, use type of service **6** with the modifiers.
   2. For ARKids First-B beneficiaries, use modifier **TJ**. When filing paper claims, use type of service **1** with the modifier.
   3. For individuals ages 19 and older, no modifier is necessary and type of service **1** must be used when filing paper claims.

C. Effective for dates of service on and after October 1, 2005, procedure code **90660**, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals ages 5 through 49 who are not pregnant.

1. When filing claims for children 5 through18 years of age, use modifiers **EP** and **TJ**. When filing paper claims, use type of service **6** with the modifiers.
2. For ARKids First-B beneficiaries, the procedure code must be billed using modifier **TJ**. When filing paper claims, use type of service **1** with the modifier.
3. No modifier is required for filing claims for beneficiaries ages 19 through 49. Paper claims require type of service **1**.

D. Procedure code **90657**, influenza virus vaccine, split virus, for children ages 6 through 35 months, is covered. Modifiers **EP** and **TJ** are required. Paper claims require type of service **6** with the modifiers.

For ARKids First-B beneficiaries, use modifier **TJ**. When paper claims are filed, use type of service **1** with the modifier.

E. Procedure code **90658**, influenza virus vaccine, split virus, for use in individuals ages 3 years and older, will continue to be covered.

1. When filing paper claims for individuals under age 19, use type of service **6** with modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **TJ**. For paper claims, use type of service **1** with the modifier.
3. No modifier is required for filing claims for beneficiaries aged 19 and older. Use type of service **1** when filing paper claims.

292.595 Special Pharmacy, Therapeutics and Radiopharmaceutical Therapy and Treatments 10-1-06

A. Special pharmacy and therapeutic agents are covered with prior approval from the Division of Medical Services Medical Director.

1. Claims must be submitted to EDS on paper.
2. Each claim must reflect, in the description of service field, the number in the treatment series of each administration for which you are billing Medicaid.
3. No prior authorization number is issued; therefore, a copy of the Medical Director's approval letter must be attached to each claim filed.

Refer to section 244.100 for coverage information and instructions for requesting prior approval.

B. Radiopharmaceutical therapy is covered with prior approval from the Medical Director of the Division of Medical Services.

1. Claims must be submitted to EDS on paper.
2. A copy of the Medical Director's approval letter and a copy of the invoice for the monoclonal antibody used must be attached to the claim form.

Refer to section 244.200 for coverage information and instructions for requesting prior approval.

292.600 Laboratory and X-Ray Services 10-1-06

Only laboratory and X-ray services carried out in the physician's office or under his/her direct supervision may be billed by the physician to the Medicaid Program. Laboratory and X-ray

services ordered by the physician but carried out in an outside facility must be billed directly to Medicaid by the outside facility. Physician will be reimbursed for collection fee only.

Medicaid regulations regarding collection, handling and/or conveyance of specimens are:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen); or, (2) collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

P9612	P9615

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

292.602 Special Billing Requirements for Lab and X-Ray Services 10-1-06

A. Prior approval is required before services associated with the use of procedure codes **A9542**, **A9543**, **A9544** and **A9545** may be provided. To obtain a prior approval letter from the DMS Medical Director, the provider must furnish the following documentation. (See sections 244.100 and 292.595.)

1. The FDA approved diagnosis clearly stated
2. Treatment failures that the patient has previously experienced
3. The patient's history and physical report

B. Prior approval is required before services associated with the use of procedure code **A9547** may be provided. To obtain prior approval, the provider must submit the following documentation.

1. The patient's history and physical
2. A report of the ultrasound or computerized axial tomography (CAT) that was not diagnostic

C. Prior approval is required for the service associated with the use of procedure code **A9555**. To obtain prior approval, the provider must submit:

1. A history and physical
2. A report on what other profusion scans have been tried and are non-diagnostic

D. Some HCPCS laboratory and radiology services are payable only with diagnosis restrictions. For payment these diagnoses must be entered on the claim.

1. Procedure code **A9535** is restricted to ICD-9-CM diagnosis code 289.7.
2. Procedure code **A9549** is restricted to ICD-9-CM diagnosis code 154.8.
3. Procedure code **A9557** is restricted to ICD-9-CM diagnosis code range 430 – 434.91.
4. Procedure code **A9559** is restricted to ICD-9-CM diagnosis code 281.0.
5. Procedure code **A9563** is restricted to ICD-9-CM diagnosis code 238.4.

292.620 Office Medical Supplies - Beneficiaries Under Age 21 10-1-06

For beneficiaries under age 21, procedure code **99070** is payable to physicians for supplies and materials (except eyeglasses), provided by the physician over and above those usually included with the office visit or other services rendered. Procedure code **99070** must not be billed for the provision of drug supply samples and may not be billed on the same date of service as a surgery code. When filing paper claims physicians must bill procedure code **99070** with a type of service code **"6"** and a place of service code **"3".** Electronic claims require place of service code **"11"**. Procedure code **99070** is limited to beneficiaries under age 21.

292.671 Method 1 - "Global" or "All-Inclusive" Rate 10-1-06

The global method of billing should be used when one or more physicians in a group see the patient for a prenatal visit and one of the physicians in the group does the delivery. The physician that delivers the baby should be listed as the attending physician on the claim that reflects the global method.

No benefits are counted against the recipient's physician visit benefit limit if the global method is billed.

A. One charge for total obstetrical care is billed. The single charge includes the following:

1. Antepartum care which includes initial and subsequent history, physical examinations, recording of weight, blood pressure and fetal heart tones, routine chemical urinalyses, maternity counseling and other office or clinic visits directly related to the pregnancy.
2. Admissions and subsequent hospital visits for the treatment of false labor, in addition to admission for delivery.
3. Vaginal delivery (with or without episiotomy, with or without pudendal block, with or without forceps or breech delivery), or cesarean section and resuscitation of newborn infant when necessary.
4. Routine postpartum care (sixty days), which includes routine hospital and office visits following vaginal or cesarean section delivery.

B. The global method must be used when the following conditions exist:

1. At least two months of antepartum care were provided culminating in delivery. The global billing beginning date of service is the date of the first visit that a Medicaid beneficiary is seen with a documented possible pregnancy or a confirmed pregnancy diagnosis.
2. The patient was continuously Medicaid eligible for two months or more months before delivery and on the delivery date.

If either of the two conditions is not met, the services will be denied, stating either "monthly billing required" or "recipient ineligible for service dates."

C. The correct codes for billing Medicaid for global obstetric care are as follows.

National Codes			
59400	59510	59610	59618

When billing these procedure codes, both the first date of antepartum care after Medicaid eligibility has been established and the date of delivery must be indicated on the claim in the date of service field. If these two dates are not entered and are not at least two months

apart, payment will be denied. The 12-month filing deadline is calculated based on the date of delivery.

292.672 Method 2 - "Itemized Billing" 10-1-06

Use this method only when either of the following conditions exists:

A. Less than two months of antepartum care was provided or

B. The patient was NOT Medicaid eligible for at least the last two months of the pregnancy.

Bill Medicaid for the antepartum care in accordance with the special billing procedures set forth in section 292.675. The visits for antepartum care will not be counted against the patient's annual physician benefit limit. Keep in mind that date-of-service spans may not include any dates for which the patient was not eligible for Medicaid.

Bill Medicaid for the delivery and postpartum care with the applicable procedure code from the following table:

National Codes			
59410	59515	59525	59622

National Code	Local Code	Local Code Description
Bill on paper	Z1930	Non-Emergency Hysterectomy after C-Section [Requires prior authorization from the Arkansas Foundation for Medical Care (AFMC)]

If Method 2 is used to bill for OB services, care should be taken to ensure that the services are billed within the 12-month filing deadline.

If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure codes **59409** or **59612** should be billed for vaginal delivery and procedure codes **59514** or **59620** should be billed for cesarean section. Procedure codes **59400**, **59410**, **59510** and **59515** may not be billed in addition to procedure codes **59409, 59612, 59514** or **59620.** These procedures will be reviewed on a post-payment basis to ensure that these procedures are not billed in addition to antepartum or postpartum care.

Operative standby for a C-section must be billed using procedure code **99360.**

Laboratory and X-ray services may be billed separately using the appropriate CPT codes, if this is the physician's standard office practice for billing OB patients. If lab tests and/or X-rays are pregnancy related, the referring physician must be sure to code appropriately when these services are sent to the lab or X-ray facility. The diagnostic facilities are completely dependent on the referring physician for diagnosis information necessary for Medicaid reimbursement.

The obstetrical laboratory profile procedure code **80055** consists of four components: Complete blood count, VDRL, Rubella and blood typing and RH. If the ASO titer (procedure code **86060**) is performed, the test should be billed separately using the individual code.

For laboratory procedures, if a blood specimen is sent to an outside laboratory, only a collection fee may be billed. No additional fees are to be billed for other types of specimens that are sent for testing to an outside laboratory. The laboratory could then bill Medicaid for the laboratory procedure. Refer to Section 292.600 of this manual.

NOTE: Payment will not be made for emergency room physician charges on an OB patient admitted directly from the emergency room into the hospital for delivery.

292.673 Fetal Non-Stress Test and Ultrasound 10-1-06

The Arkansas Medicaid Program covers the fetal non-stress test (procedure code **59025**) and the ultrasound (procedure codes **76801 - 76828**) when performed in conjunction with maternity care.

Arkansas Medicaid imposes a benefit limit of two medically necessary fetal non-stress test procedures per pregnancy. Fetal ultrasound is limited to two per pregnancy. If it is necessary to exceed these limits, the physician must request benefit extensions, when applicable, in accordance with benefit extension request instructions in this provider manual.

292.674 External Fetal Monitoring 10-1-06

Procedure code **59050** must be used exclusively for external fetal monitoring when performed in a physician's office or clinic, place of service code **"3"** for paper claims or **"11"** for electronic claims. Physicians may bill for one unit per day of external fetal monitoring. Physicians may bill for external fetal monitoring in addition to a global obstetric fee. When itemizing obstetric visits, physicians may bill for medically necessary fetal monitoring in addition to obstetric office visits.

292.675 Obstetrical Care Without Delivery 10-1-06

A. Obstetrical care without delivery may be billed using procedure code **59425**, modifier **UA**, when 1 – 3 visits are provided and **59425** with no modifiers when 4 – 6 six visits are provided... Procedure code **59426** with no modifiers is payable for 7 or more visits.

B. These procedure codes enable physicians rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for these services. Units of service billed with these procedure codes are not counted against the patient's annual physician visit benefit limit. Reimbursement for each visit includes routine sugar and protein analysis. Other lab tests may be billed separately within 12 months of the date of service.

C. The procedure codes must be billed with a type of service code **"1"** when filing paper claims. Providers must enter the dates of service in the CMS-1500 claim format and the number of units being billed. One visit equals one unit of service. Providers must submit the claim within 12 months of the first date of service.

View a CMS-1500 sample form.

For example: An OB patient is seen by Dr. Smith on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another physician prior to the delivery. Dr. Smith may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. EDS must receive the claim within the 12 months from the first date of service. Dr. Smith must have on file the patient's medical record that reflects each date of service being billed. Dr. Smith must bill the appropriate code: **59425** with modifier **UA** when 1 – 3 visits are provided, **59425** with no modifiers when 4 – 6 visits are provided and procedure code **59426** when 7 or more visits are provided.

292.730 Professional and Technical Components 10-1-06

Covered laboratory and radiology (procedure codes in code range **70010** through **89399** as well as covered services listed in the Medicine section of CPT and HCPCS procedure codes manuals that require the use of a machine may be billed electronically or on paper.

When filing paper claims, a type of service code must be used along with applicable modifiers. The type of service code indicates whether the charge billed is for the technical component, professional component or complete procedure. The type of service codes are:

A. Type of Service Code **C** - Complete Procedure. This charge consists of the combination of both the technical and the professional components. A complete procedure charge would be made if a physician has a private office and does the procedure within his own office. In these circumstances, he is billing for what is normally considered the technical component and the professional component in one single charge. In a private office environment, the radiologist is personally responsible for the personnel expenses, equipment expenses and also for his own professional services.

B. Type of Service Code **P** - Professional Component. This charge consists of the fee for the professional involvement of the physician in the procedure. This consists of interpretation of the report, personal supervision of the procedure, dictation of the report, consultation with referring physicians and injection of contrast media where required.

C. Type of Service Code **T** - Technical Component. This would be the portion of the charge relating exclusively to the execution of the procedure, exclusive of any service rendered by the physician. The technical component consists of such things as technician's time, salary, film costs, equipment costs, maintenance, space rental, utilities and all other charges normally associated with the provision of the radiology service.

Paper claims require the correct type of service code, **C**, **P**, or **T**, to be entered in Field 24C in the CMS-1500 claim form. Applicable modifiers are required in Field 24D with the procedure code. Modifier **TC** must be used for the technical component and modifier **26** must be used for the professional component.

Electronic billing of covered laboratory and radiology services requires appropriate modifiers: **TC** for the technical component and **26** for the professional component.

292.742 Family/Group Psychotherapy 10-1-06

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family/group psychotherapy:

National Codes			
90847	90849	90853	90857

Procedure codes **90847** and **90849** are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure code **90847** is payable only when the patient is present during the treatment. Procedure codes **90849** and **90853** are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

292.760 Rural Health Clinic (RHC) Non-Core Services 10-1-06

Physician groups whose individual practitioners are contracting with a rural health clinic are limited to billing Medicaid for Rural Health Clinic (RHC) non-core services. These providers may bill the following procedure codes:

RHC NON-CORE SERVICES	
Outpatient Hospital Visits	**Inpatient Hospital Visits**
Non-emergency: T1015 modifier U1	99217 through 99223

RHC NON-CORE SERVICES	
Outpatient Hospital Visits	**Inpatient Hospital Visits**
Emergency: 99281 through 99285	99231 through 99238 99251 through 99255 99291, 99295, 99296, 99297
Electrocardiograms and Echocardiography (Type of service code (paper only) T— technical component- only)	**Radiology (Type of service code (paper claims) T— technical component only)**
93005, 93012, 93041, 93225, 93226, 93231, 93232, 93236, 93270, 93271, 93307, 93308, 93312, 93320, 93321, 93325, 93350	70010 through 76946 76950 through 76977 76999 through 78813 78990 through 79999
Surgery, Outpatient and Inpatient	
All payable CPT procedure codes within range 10040 through 69990	

NOTE: Inpatient and outpatient hospital services are RHC non-core services only if the physician's contract with the RHC does not state that the physician will be compensated by the RHC for those services. Interpretation of X-rays and diagnostic machine tests in the inpatient or outpatient hospital is a non-core service when the visit itself is a non-core service. Home visits, nursing facility visits or other off-site visits are RHC encounters if the physician's agreement with the RHC requires that he or she provide the services and seek compensation from the RHC. Any of these off-site services is payable separately (through the Physician Program) from the RHC encounter fee if it is not a part of the physician's contract with the RHC.

See Sections 201.120 and 246.000 of this manual for additional information.

292.801 Cochlear Implant and External Sound Processor 10-1-06

Procedure code **69930** - Cochlear device implantation, with or without mastoidectomy - may be billed only by the physician performing the surgical procedure up to 50 daily units. When the cochlear device is provided by the physician, the physician may bill procedure code **L8614** for the cochlear device using **EP** modifier. Paper claims require a type of service **"6"** with modifier **EP** for the device. Procedure code **69930** and **L8614** require prior authorization. The physician must attach a copy of the invoice to the CMS-1500 claim form. If the cochlear device is provided by the hospital, the physician may not bill for the device. Refer to Section 251.230 of this manual for coverage information.

External sound processors, procedure code **L8619**, are covered for eligible Medicaid recipients under age 21 in the EPSDT Program. Additional procedure codes **L8615**, **L8616**, **L8617**, **L8618**, **L8621** and **L8622** are also payable to the physician. These procedure codes require prior authorization and the physician must attach a copy of the invoice to the CMS-1500 claim form. Refer to Section 251.230 of this manual for coverage information.

Procedures are covered for beneficiaries under age 21 and must be billed with modifier **EP** and type of service **"6"**.

View a CMS-1500 sample form.

292.812 Telemedicine Evaluation and Management Procedure Codes 10-1-06

Arkansas Medicaid reimburses as telemedicine services, the evaluation and management services listed in this section when the services are billed by their correct procedure codes, type

of service codes (paper only) and place of service codes as listed and defined in Sections 292.812 through 292.814.

HCPCS Code	Modifier	Description	TOS Code (paper claims only) Local Site	TOS Code (paper claims only) Remote Site
T1015	U1	Non-emergency Outpatient Hospital Visit	*Z	V

Procedure Code	TOS (paper only) Local Site	TOS (paper only) Remote Site
99201		V
99202		V
99203		V
99204		V
99205		V
99211	*Z	V
99212	*Z	V
99213	*Z	V
99214	*Z	V
99215	*Z	V
99221		V
99222		V
99223		V
99231	*Z	V
99232	*Z	V
99233	*Z	V
99241		V
99242		V
99243		V
99244		V
99245		V
99251		V
99252		V
99253		V
99254		V
99255		V

Procedure Code	TOS (paper only) Local Site	TOS (paper only) Remote Site
99281	*Z	V
99282	*Z	V
99283	*Z	V
99284	*Z	V
99285	*Z	V

***NOTE: Arkansas Medicaid covers telemedicine evaluation and management services of an attending physician at the local site *only* when the physician is physically attending the patient and is presenting the case to a consulting physician at the remote site by means of telemedicine media.**

292.827 Billing for Liver/Bowel Transplants 10-1-06

A. Liver/bowel transplant procedure codes require prior approval.

B. Procedure code **47135** is to be used for the liver.

C. Procedure codes **44135, 44136, 44132** and **44133** are to be used for the intestine, as applicable.

292.870 Bilaminate Graft or Skin Substitute Procedures 10-1-06

Arkansas Medicaid will reimburse physicians who furnish the manufactured viable bilaminate graft or skin substitute with prior authorization. The product is manually priced and requires paper claims using procedure code **J7340**, type of service code **"1"** (paper claims only). The manufacturer's invoice and the operative report must be attached.

Application procedures for bilaminate skin substitute do not require prior authorization. The procedures are payable to the physician and must be listed separately on claims.

Surgical preparation procedures, CPT codes **15000** and **15001**, may be reimbursed when performed at the same surgical setting. These codes are to be listed separately in addition to the primary procedure and do not require PA.

292.900 Tobacco Cessation Counseling Services 10-1-06

The prescribing provider of tobacco cessation products must provide counseling services and request prior authorization before the products are Medicaid covered for reimbursement. Procedure code **99401**, modifier **SE**, must be used for one 15-minute unit of service, and procedure code **99402**, modifier **SE**, must be used for one 30-minute unit of service.

Oral surgeons must use procedure code **D9920** for one 15-minute unit and procedure code **D1320** for one 30-minute unit when filing claims on the American Dental Association (ADA).

See section 257.000 of this manual for coverage and benefit limit information.