



Division of Medical Services
Program Planning & Development

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480



TO: Arkansas Medicaid Health Care Providers – Hospital/Critical Access Hospital (CAH)/End State Renal Disease (ESRD)

DATE: October 1, 2009

SUBJECT: Provider Manual Update Transmittal #161

Table with 4 columns: REMOVE Section, REMOVE Date, INSERT Section, INSERT Date. Rows include section numbers like 217.130, 244.000, 252.119, 272.404, 272.451 and their respective update dates.

Explanation of Updates

Section 217.130 is revised to explain how the information and procedures needed to obtain a prior authorization for Hyperbaric Oxygen Therapy (HBOT).

Section 244.000 adds procedure code 99183 to the section with procedures which require prior authorization.

Section 245.030 is added to explain how prior authorizations are obtained for Hyperbaric Oxygen Therapy (HBOT).

Section 252.119 is revised to explain reimbursement for Hyperbaric Oxygen Therapy (HBOT); as well as to provide reference to HBOT in other sections of the manual.

Section 272.404 is revised to allow for electronic filing of claims. Providers are referred to other sections of the manual that may be accessed for information regarding HBOT.

Section 272.451 is revised to include Baclofen injections in the updated section which is now titled Other Covered Injections and Immunizations with Special Instructions. Procedure codes which are no longer payable were removed from the chart. Minor language changes are included that do not affect policy.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid Health Care Providers – Hospital/Critical Access Hospital (CAH)/End State
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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.

Roy Jeffus, Director

*TOC required***217.130 Hyperbaric Oxygen Therapy (HBOT)**

10-1-09

Hyperbaric Oxygen Therapy (HBOT) 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 itself. 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).

HBOT prior authorizations will be issued by Arkansas Foundation for Medical Care (AFMC) for all requests received on and after October 1, 2009. All hyperbaric oxygen therapy will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which post-authorization will be allowed per protocol. See section 242.000. Prior authorization will be issued for a specific number of treatments. Subsequent treatments will require a telephone review and an additional prior authorization. All prior authorizations for HBOT are completed by telephone review. **In order to request a prior authorization for HBOT, the provider must call the AFMC prior authorization number, (800) 426-2234.** The caller must be able to provide demographic and clinical information to support the medical necessity of treatment. Calls for prior authorization should be placed by a staff member who can answer questions pertaining to the patient's clinical condition. Providers should gather all necessary information prior to placing a call. All information that is submitted to acquire the prior authorization must be documented in the beneficiary's medical record. The following information is required for prior authorization:

- A. Name of caller requesting HBOT
- B. Beneficiary's Medicaid ID number
- C. Beneficiary's full name
- D. Beneficiary's complete mailing address including zip code
- E. Beneficiary's birth date
- F. Treatment start date
- G. Treatment facility's AR Medicaid provider number
- H. Treating physician's AR Medicaid provider number
- I. Treating physician's office phone number
- J. CPT code for treatment
- K. ICD-9 diagnosis code that justifies HBOT
- L. Number of treatments requested (see table below)
- M. Clinical indications for treatment
 1. Narrative diagnosis, history of illness requiring HBOT and prior treatment including information about specific treatments and length of time
 2. If treatment is for a non-healing wound, a clear description of the wound is required

Refer to Section 242.000, 244.000, 252.119 and 272.404 for additional information on prior authorizations, reimbursement, and information on billing.

NOTE: When approved, only one authorization number will be issued. The prior authorization number and the number of approved HBOT treatments must be communicated to the physician provider so that both the facility and physician may claim reimbursement for the number of approved HBOT sessions. Additionally, if more HBOT sessions are required for the same beneficiary, a new prior authorization will be required and the above process followed to acquire any subsequent prior authorizations. A new prior authorization number will be assigned for any additional sessions approved. The prior authorization information between the facility and the physician is to be reciprocal if the physician acquires the prior authorization.

The following table provides the diagnosis requirements, description of the problem, and number of treatments.

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	6
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
72886, 7854	Necrotizing Soft Tissue Infections, immune compromise	30
73000-73020	Refractory osteomyelitis after aggressive surgical debridement	40
52689, 73010-73019, 7854, 9092, 990	Delayed Radiation Injury	60
99660 - 99769, V423	Compromised skin grafts and flaps	20
9400-9495	Thermal burns >20% TSBA +/- involvement of hands, face, feet or perineum that are deep, partial or full	40

Diagnosis	Description	Number of Treatments
	thickness injury	
95890 - 95899	Compartment syndrome, impending stage fasciotomy not required.	1
9251 - 9299	Problem wounds after primary management	14

Refer to section 272.404 of this manual for billing instructions.

244.000 Procedures that Require Prior Authorization

10-1-09

- A. The procedures represented by the CPT and HCPCS codes in the following table require prior authorization (PA). The performing physician or dentist (or the referring physician or dentist, when lab work is ordered or injections are given by non-physician staff) is responsible for obtaining required PA and forwarding the PA control number to appropriate hospital staff for documentation and billing purposes. A claim for any hospital services that involve a PA-required procedure must contain the assigned PA control number or Medicaid will deny it.

J1565	Q0182	11960	11970	11971	15342	15343	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
22520	22521	22522	30220	30400	30410	30420	30430
30435	30450	30460	30462	33140	33282	33284	36470
36471	37785	37788	38242	42820	42821	42825	42826
42842	42844	42845	42860	42870	43842	43846	43847
43848	43850	43855	43860	43865	50320	50340	50360
50365	50370	50380	51925	54360	54400	54415	54416
54417	55400	57335	58150	58152	58180	58260	58262
58263	58267	58270	58275	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	61850	61860	61870
61875	61880	61885	61886	61888	63650	63655	63660
63685	63688	64573	64585	64809	64818	65710	65730
65750	65755	67900	69300	69310	69320	69714	69715
69717	69718	69930	87901	87903	87904	92607	92608
93980	93981	92393	99183				

B. The following revenue codes require prior authorization.

Revenue Code	Description
0361	Outpatient dental surgery, Group I
0360	Outpatient dental surgery, Group II
0369	Outpatient dental surgery, Group III
0509	Outpatient dental surgery, Group IV

245.030 Hyperbaric Oxygen Therapy (HBOT) Prior Authorization

10-1-09

All hyperbaric oxygen therapy will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which post-authorization will be allowed per protocol. See section 242.000. Prior authorization will be for a certain number of treatments. Further treatments will require reapplication for a prior authorization. **In order to request a prior authorization for HBOT, the provider must call the AFMC prior authorization number, (800) 426-2234.**

Refer to sections 217.130, 242.000, 252.119, and 272.404 for additional information on HBOT.

252.119 Reimbursement for Hyperbaric Oxygen Therapy (HBOT)

10-1-09

Arkansas Medicaid reimburses hospitals at the outpatient surgery Group I rate for hyperbaric oxygen therapy. Refer to Sections 217.130, 242.000, 244.000, 245.030 and 272.404 for additional information on HBOT.

272.404 Hyperbaric Oxygen Therapy (HBOT) Procedures

10-1-09

- Facilities may bill for only one unit of service per day.** The facility's charge for each service date must include all its hyperbaric oxygen therapy charges, regardless of how many treatment sessions per day are administered.
- Facilities may bill for laboratory, X-ray, machine tests and outpatient surgery in addition to procedure code **99183**.
- Hospitals and ambulatory surgical centers **may bill electronically or file paper claims for procedure code 99183 with the prior authorization number placed on the**

claim in the proper field. If multiple prior authorizations are required, enter the prior authorization number that corresponds to the date of service billed.

Procedure Code	Description
99183	Hyperbaric oxygen pressurization, facility charge, one per day, outpatient

Refer to Sections 217.130, 242.000, 244.000, 245.030, and 252.119 for additional information on HBOT.

272.451

Other Covered Injections and Immunizations with Special Instructions

10-1-09

National Code	Special Instructions
90703	Covered for beneficiaries under 21 y
90732	Covered for beneficiaries age 2 y who are considered high risk. All beneficiaries over the age of 65 are considered high risk.
J0170	Covered for beneficiaries of all ages without diagnosis restriction.
J0475	Payable for both sexes, all ages, and without any diagnosis restriction.
J0476	Payable for both sexes, all ages, and without any diagnosis restriction.
J0636	Payable for beneficiaries of all ages receiving dialysis due to renal failure (diagnosis codes 584-586)
J1600	Payable only for beneficiaries with a diagnosis of rheumatoid arthritis.
J2790	Payable for beneficiaries of all ages with no diagnosis restrictions.
J2910	Payable for all beneficiaries with a primary detail diagnosis of rheumatoid arthritis (ICD-9 diagnosis codes 714.0 – 714.9).
J3180	Covered for ages 21 y and above (In conjunction with trauma or injury)
J3420	Payable for beneficiaries with a diagnosis of pernicious anemia, 281.0. This code may not be billed in multiple units.

National Code	Special Instructions
J9031	Payable for all ages, when provided to beneficiaries with a diagnosis of carcinoma in situ of bladder (diagnosis code
90371	One unit equals 1/2 cc with a maximum of 10 units billable per day. Payable for Medicaid beneficiaries of all ages.



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

DATE: October 1, 2009

SUBJECT: Provider Manual Update Transmittal #174

REMOVE

Table with 2 columns: Section, Date. Rows include 258.000 (10-1-06), 262.000 (11-1-08), 292.591 (11-1-08), 292.592 (11-1-08), 292.860 (7-1-07)

INSERT

Table with 2 columns: Section, Date. Rows include 258.000 (10-1-09), 262.000 (10-1-09), 292.591 (10-1-09), 292.592 (10-1-09), 292.860 (10-1-09)

Explanation of Updates

Effective for claims received on or after October 1, 2009, the following provider manual revisions are implemented.

Section 258.000 has been updated to revise the information required for prior authorization of hyperbaric oxygen therapy (HBOT).

Section 262.000 has been updated to add CPT code 99183 to the list of procedure codes that require prior authorization.

Section 292.591 has been updated to delete HCPCS codes J0475 and J0476 from the section and move them to section 292.592. In addition, the CPT code ranges for therapeutic and chemotherapy administration has been changed from 90765 through 90799 to 96365 through 96379.

Section 292.592 has been updated to add HCPCS codes J0475 and J0476 as codes that are payable for beneficiaries of all ages with no diagnosis restrictions.

Section 292.860 has been updated to revise the requirements for hyperbaric oxygen therapy (HBOT) procedures.

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) 682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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Arkansas Medicaid Health Care Providers-Physician/CRNA/Independent Lab/Radiation Therapy
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www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

TOC required**258.000 Hyperbaric Oxygen Therapy (HBOT)**

10-1-09

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

Hyperbaric oxygen therapy (HBOT) 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, hyperbaric oxygen therapy (HBOT) 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).

Hyperbaric oxygen therapy (HBOT) prior authorizations will be issued by the Arkansas Foundation for Medical Care (AFMC) for all requests received on and after October 1, 2009. All hyperbaric oxygen therapy (HBOT) will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which case, post authorization will be allowed per protocol (See section 261.100). Prior authorization will be for a specific number of treatments. Further treatments will require reapplication for a prior authorization. In order to request a prior authorization, the provider must call AFMC at 1-800-426-2234. The provider must be able to provide demographic clinical information to support the medical necessity of the treatment. Calls for prior authorization should be placed by a staff member who can answer questions pertaining to the patient's clinical condition. Providers should gather all necessary information prior to placing a call.

The following information is required for prior authorization:

- A. Name of caller requesting HBOT
- B. Beneficiary's Medicaid ID number
- C. Beneficiary's full name
- D. Beneficiary's complete mailing address including zip code
- E. Beneficiary's birth date
- F. Treatment start date
- G. Treatment facility's AR Medicaid provider number
- H. Treating physician's AR Medicaid provider number
- I. Treating physician's office phone number
- J. CPT code for treatment
- K. ICD-9 diagnosis code justifies HBOT
- L. Number of treatments requested (see table below)
- M. Clinical indications for treatment
 1. Narrative diagnosis, history of illness requiring HBOT and prior treatment including information about specific treatments and length of time
 2. If treatment is for a non-healing wound, a clear description of the wound is required

Refer to section 262.000 and section 292.860 for information on prior authorizations, reimbursement, and information on billing.

NOTE: When approved, only one authorization number will be issued. The prior authorization number and the number of approved HBOT treatments must be shared with the facility provider so that both the physician and the facility may be reimbursed for the number of approved HBOT sessions. Additionally, if more HBOT sessions are required, a new prior authorization will need to be requested and the above process followed to acquire any subsequent prior authorizations. A new prior authorization number will be assigned for any additional sessions approved. The prior authorization information between the physician and the facility is to be reciprocal if the facility acquires the prior authorization.

The following table provides the diagnosis requirements, description of the problem, and number of treatments.

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	6
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
72886, 7854	Necrotizing Soft Tissue Infections, immune compromise	30
73000-73020	Refractory osteomyelitis after aggressive surgical debridement	40
52689, 73010-73019, 7854, 9092, 990	Delayed Radiation Injury	60
9960-99679, V423	Compromised skin grafts and flaps	20

Diagnosis	Description	Number of Treatments
9400-9495	Thermal burns > 20% TSBA +/- involvement of hands, face, feet or perineum that are deep, partial or full thickness injury	40
95890-95899	Compartment syndrome, impending stage fasciotomy not required	1
9251-9299	Problem wounds after primary management	14

Refer to section 292.860 of this manual for billing instructions.

262.000 Procedures That Require Prior Authorization

10-1-09

The following procedure codes require prior authorization:

Procedure Codes							
D9220**	J7319	J7320	J7330	S0500	S2112	V2623	V2625
01966	11960	11970	11971	15400	15830	15847	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	27416	28446	29866	29867	29868	30220	30400
30410	30420	30430	30435	30450	30460	30462	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	58275	58280

Procedure Codes							
58290	58291	58292	58293	58294	58345	58541*	58542*
58543*	58544*	58550	58552	58553	58554	58570***	58571***
58572***	58573***	58672	58673	58750	58752	59135	59840
59841	59850	59851	59852	59855	59856	59857	59866
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	92326	93980	93981	99183	

* These procedure codes will be manually reviewed prior to payment and require prior authorization from AFMC and a paper claim with form DMS-2606 attached.

** Manually Priced

*** These procedure codes require a paper claim with form DMS-2606 attached.

Procedure Code	Modifier	Description
E0779	RR	Ambulatory infusion device
D0140	EP	EPSDT interperiodic dental screen
J7330		Autologous cultured chondrocytes, implant
L8614	EP	Cochlear device includes all internal and external components.
L8615	EP	Headset/headpiece for use with cochlear implant device, replacement.
L8616	EP	Microphone for use with cochlear implant device, replacement.
L8617	EP	Transmitter coil for use with cochlear implant device, replacement.
L8618	EP	Transmitter cable for use with cochlear implant device, replacement.
L8619	EP	External sound processor
L8621	EP	Zinc air battery for use with cochlear implant device, replacement, each.
L8622	EP	Alkaline battery for use with cochlear implant device, any size, replacement, each.
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
V5014**		Repair/modification of a hearing aid

Procedure Code	Modifier	Description
Z1930		Non-emergency hysterectomy following c-section
92002*		Low vision services – evaluation

*Procedures payable to physicians under the Visual Services program. See the Visual Services Provider manual or contact DMS, Medical Assistance for information on prior authorization protocol for these codes. [View or print contact information for Arkansas Division of Medical Services, Visual Care Coordinator.](#)

**Procedures payable to physicians under the Hearing Services program. See the Hearing Services provider manual or contact DMS, Utilization Review for information on prior authorization protocol for these codes. [View or print contact information for Arkansas Division of Medical Services, Utilization Review Section.](#)

292.591 Injections and Therapeutic Agents

10-1-09

- A. Administration of therapeutic agents is payable only if provided in a physician's office, place of service code "11." These procedures are not payable to the physician if performed in any other setting. Therapeutic injections should only be provided by physicians experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim 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 ranges **96365** through **96379** and **96401** through **96549** for therapeutic and 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, 230.0-238.9, or 042 is required.

Procedure Codes							
J0120	J0128	J0190	J0205	J0207	J0210	J0256	J0278
J0280	J0285	J0287	J0288	J0289	J0290	J0295	J0300
J0330	J0350	J0360	J0380	J0390	J0456	J0460	J0470

Procedure Codes							
J0500	J0515	J0520	J0530	J0540	J0550	J0560	J0580
J0592	J0595	J0600	J0610	J0620	J0630	J0640	J0670
J0690	J0692	J0694	J0696	J0697	J0698	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	J1320	J1325
J1330	J1364	J1380	J1390	J1410	J1435	J1436	J1450
J1452	J1455	J1457	J1570	J1580	J1590	J1610	J1620
J1626	J1630	J1631	J1642	J1644	J1645	J1655	J1670
J1700	J1710	J1720	J1730	J1742	J1800	J1810	J1815
J1825	J1830	J1835	J1840	J1850	J1885	J1890	J1940
J1950	J1955	J1956	J1960	J1980	J1990	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	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
J7197	J7308	J7310	J7501	J7504	J7505	J7506	J7507
J7509	J7510	J7511	J7513	J7518	J7599*	J8530	J9000
J9001	J9010	J9015	J9017	J9020	J9031	J9040	J9045
J9050	J9060	J9062	J9065	J9070	J9080	J9090	J9091
J9092	J9093	J9094	J9095	J9096	J9097	J9098*	J9100
J9110	J9120	J9130	J9140	J9150	J9151	J9165	J9170

Procedure Codes							
J9181	J9182	J9185	J9190	J9200	J9201	J9202	J9206
J9208	J9209	J9211	J9212	J9213	J9214	J9215	J9216
J9217	J9218	J9230	J9245	J9260	J9265	J9266	J9268
J9270	J9280	J9290	J9291	J9300	J9310	J9320	J9340
J9355	J9357	J9360	J9370	J9375	J9380	J9390	J9600
J9999*	Q2009	Q2017	S0017	S0021	S0023	S0028	S0030
S0032	S0034	S0039	S0040	S0073	S0074	S0077	S0080
S0081	S0092	S0093	S0108	S0164	S0177	S0179	S0187

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

292.592 Other Covered Injections and Immunizations with Special Instructions

10-1-09

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.](#)

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
J0129*		Requires ICD-9-CM diagnosis code of 714.0-714.2 as primary diagnosis. Patient must have had inadequate response to one or more disease-modifying anti-rheumatic drugs such as Methotrexate or Tumor Necrosis Factor antagonists (Humira, Remicade, etc.). Records submitted with claim must include history and physical exam showing severity of rheumatoid arthritis, treatment with disease-modifying anti-rheumatic drugs, and treatment failure resulting in progression of joint destruction, swelling, tendonitis, etc. Prior approval letter from DMS Medical Director required to be attached to each claim. See 244.100 for information regarding requests for prior approval letters.
J0133		Payable for beneficiaries of all ages with diagnosis codes 053.0 – 054.9.
J0150		Procedure is covered for all ages with no diagnosis restriction. Maximum units 4 per day.
J0152*		Payable for all ages. When administered in the office, the provider must have nursing staff available to monitor the patient's vital signs

Procedure Code	Modifier(s)	Special Instructions
		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. Requires paper claim with copy of report of diagnostic procedure. Maximum units 1 per day.
J0170		Payable if the service is performed on an emergency basis and is provided in a physician's office.
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 244.100 for additional coverage information and instructions for requesting prior approval.
J0220*		Requires an ICD-9-CM diagnosis code of 271.0. Evaluation by a physician with a specialty in clinical genetics documenting progress required annually. A prior approval letter from DMS Medical Director required and must be attached to each claim. See 244.100 for information regarding acquiring the prior approval letter.
J0348		Valid for any condition below, along with ICD-9-CM diagnosis code of 112.5 or 112.8 (and any valid 5 th digits), or 112.9. (1) End-stage Renal Disease (ICD-9-CM codes 584 – 586) or (2) AIDS or cancer (ICD-9-CM diagnosis codes 042, 140.0-208.9, 230.0-238.9) or (3) Post transplant status (i.e., ICD-9-CM diagnosis code 986.80-996.89) or specify transplanted organ and transplant date
J0475		Payable for beneficiaries of all ages with no diagnosis restrictions.
J0476		Payable for beneficiaries of all ages with no diagnosis restrictions.
J0570		Payable for beneficiaries of all ages with no diagnosis restrictions.
J0585		Payable for beneficiaries of all ages when medically necessary. Botox A is reviewed for medical necessity based on diagnosis.
J0636		Payable for beneficiaries of all ages receiving dialysis due to renal failure (diagnosis codes 584-586).
J0637*		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. After 30 days of use, an updated medical exam and history must be submitted.
J0702		Payable 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		Use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for red blood cell transfusion. In addition to the primary diagnosis, an ICD-9-CM diagnosis code

Procedure Code	Modifier(s)	Special Instructions																												
		from each column below must be billed on the claim.																												
		<table border="1"> <thead> <tr> <th>Column 1</th> <th colspan="2">Column II</th> </tr> <tr> <td></td> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td rowspan="3">285.9 Secondary Anemia</td> <td>V58.11</td> <td>Encounter for antineoplastic chemotherapy</td> </tr> <tr> <td>V67.2</td> <td>Following chemotherapy</td> </tr> <tr> <td>E933.1</td> <td>Antineoplastic and immunosuppressive drugs</td> </tr> </tbody> </table> <p>Use ICD-9-CM code 285.29 (primary) with 070.54, 238.72-238.75, or 714.0-714.4 (secondary) to represent patients with anemia due to either hepatitis C (patients being treated with ribavirin and interferon alfa or ribavirin and peginterferon alfa), myelodysplastic syndrome, or rheumatoid arthritis.</p> <p>Use the lowest dose that will gradually increase the HGB concentration to the lowest level sufficient to avoid the need for red blood cell transfusion.</p> <p>In addition to the primary diagnosis, an ICD-9-CM diagnosis code from each column below must be billed on the claim.</p> <table border="1"> <thead> <tr> <th>Column I</th> <th colspan="2">Column II</th> </tr> <tr> <td></td> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td rowspan="4">285.29 Anemia of other chronic disease</td> <td>070.54</td> <td>Chronic Hepatitis C without mention of coma</td> </tr> <tr> <td>238.72-238.75</td> <td>Myelodysplastic</td> </tr> <tr> <td>714.0-714.4</td> <td>Rheumatoid Arthritis</td> </tr> <tr> <td></td> <td></td> </tr> </tbody> </table>	Column 1	Column II			Code	Description	285.9 Secondary Anemia	V58.11	Encounter for antineoplastic chemotherapy	V67.2	Following chemotherapy	E933.1	Antineoplastic and immunosuppressive drugs	Column I	Column II			Code	Description	285.29 Anemia of other chronic disease	070.54	Chronic Hepatitis C without mention of coma	238.72-238.75	Myelodysplastic	714.0-714.4	Rheumatoid Arthritis		
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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).																												
J0894*		Requires ICD-9-CM diagnosis codes of 205.00-205.91, 238.71-238.76, or 238.79. Prior approval letter from DMS Medical Director required to be attached to each claim. Refer to 244.100 for information regarding requesting prior approval.																												
J1100		Payable 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).																												
J1270		Payable for beneficiaries with diagnosis codes 042,140.0 -208.91 + 230.0-238-9 + 787.2 + 588.81; Or ESRD 584 – 586 +787.2+ 588.81.																												

Procedure Code	Modifier(s)	Special Instructions
		Claims will be manually reviewed prior to reimbursement.
J1440 J1441		Payable for beneficiaries of all ages with no diagnosis restrictions.
J1458*		Payable for treatment of mucopolysaccharidosis (MPS VI), diagnosis code 277.5. Prior approval letter from DMS Medical Director required. Copy of prior approval letter must be attached to each claim. See section 244.100 for additional coverage information and instructions for requesting prior approval.
J1460 J1470 J1480 J1490 J1500 J1510 J1520 J1530 J1540 J1550 J1560		Covered for individuals of all ages with no diagnosis restrictions.
J1561		Claims are reviewed for medical necessity based on the diagnosis code.
J1562		Payable for all ages without diagnosis restriction.
J1566 J1568 J1569		Claims are reviewed for medical necessity, based on the diagnosis code.
J1600		Payable for patients with a detail diagnosis of rheumatoid arthritis (diagnosis code range 714.0 – 714.9).
J1640		Payable when administered to all beneficiaries with ICD-9-CM detail diagnosis 277.1).
J1650		Payable for all ages with no diagnosis restriction.
J1652		Payable for beneficiaries of all ages with no diagnosis restrictions.
J1740		Payable for beneficiaries of all ages with no diagnosis restrictions.
J1743*		Requires ICD-9-CM diagnosis code of 277.5 (MPS II). An evaluation by a physician with a specialty in clinical genetics, documenting progress and response to the medication is required annually. Requires prior approval letter from DMS Medical Director and a copy must be attached to each paper claim. Refer to section 244.100 for information on how to acquire a prior approval letter.
J1745*		For beneficiaries under 18 years of age: Effective for dates of service on and after 05/20/06, J1745 is payable without an approval letter for beneficiaries under age 18

Procedure Code	Modifier(s)	Special Instructions
		<p>years when the diagnosis is 555.0, 555.1 or 555.9. No other diagnosis is required. All other diagnoses for beneficiaries under age 18 years will continue to require a prior approval letter.</p> <p>For beneficiaries aged 18 years and above: Procedure code J1745 is payable when one of the following conditions exist:</p> <p>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.</p>
J1751 J1752		Payable for all ages with no diagnosis restriction.
J1785*		<p>This procedure is covered for the treatment of Type I Gaucher disease with complications, with a detail diagnosis of ICD-9 code 272.7. A prior approval letter from the DMS Medical Director is required. See section 244.001 and 244.100 for additional coverage information and instructions for requesting prior approval. A copy of the prior approval letter must be attached to each claim.</p>
J1931*		<p>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 and 244.100 for additional coverage information and instructions for requesting prior approval. A copy of the prior approval letter must be attached to each claim.</p>

Procedure Code	Modifier(s)	Special Instructions
J2260		Payable for Medicaid beneficiaries of all ages with congestive heart failure (ICD-9 diagnosis codes 428.0-428.9).
J2323*		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.
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.
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		Payable 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. Diagnosis codes 288.00-288.04, 288.09 or 288.4 or 288.50-288.51 or 288.59, 289.53, V58.69, V67.51 and E933.1 are covered along with a diagnosis of AIDS or cancer. Diagnosis codes must be shown on the claim form.
J2513		Payable for beneficiaries of all ages with no diagnosis restrictions.
J2778*		Requires ICD-9-CM diagnosis code of 362.50 or 362.52 as primary diagnosis. Requires prior approval letter from DMS Medical Director attached to each claim. Refer to section 244.100 for information on how to acquire a prior approval letter.
J2788		Payable for beneficiaries of all ages with no diagnosis restrictions.
J2790 J2791		Payable for beneficiaries of all ages with no diagnosis restrictions.
J2792		Payable without restriction.
J2910		Payable for all beneficiaries with a primary detail diagnosis of rheumatoid arthritis (ICD-9 diagnosis codes 714.0 – 714.9).
J2916		Payable for beneficiaries of all ages with no restrictions.
J2993		Payable for beneficiaries of all ages with no diagnosis restrictions. Limited to 4 units per day in the office place of service. For the purpose of declotting catheters. Bill diagnosis 996.74 on the claim.

Procedure Code	Modifier(s)	Special Instructions
J2997		Payable for beneficiaries of all ages with no diagnosis restrictions. Limited to 4 units per day in the office place of service. For the purpose of declotting catheters. Bill diagnosis 996.74 on the claim.
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 244.002 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.
J3465*		Covered for non-pregnant beneficiaries of all ages with no restrictions.
J3487		Payable to physicians when provided in the office if one of the following diagnoses exist: A primary diagnosis of AIDS or cancer, or diagnosis code 275.42, 198.5, 203.0, or 733.90. Claims will be manually reviewed prior to payment.
J3488		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7187 J7190 J7191 J7192 J7193 J7194 J7195 J7197		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7198		Payable for all ages with no diagnosis restrictions.
J7199		For consideration, this code must be billed on a paper claim form with the name of the drug, dosage and the route of administration.
J7321 J7322 J7323 J7324		Requires prior authorization through Utilization Review Section of DMS. Providers must specify brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization. Written request must be submitted to DMS Utilization Review. Refer to 261.240 for PA information.
J7330		Requires prior authorization from AFMC for all providers. See sections 260.000, 261.000, 261.100 and 261.110.
J7340		Payable for beneficiaries of all ages with no diagnosis restrictions
J7341		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7346		Requires submission of operative report with each claim.
J7502		Payable for beneficiaries of all ages with no diagnosis restrictions.

Procedure Code	Modifier(s)	Special Instructions
J7515		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7516		Payable for beneficiaries of all ages with no diagnosis restrictions
J7517		Payable for beneficiaries of all ages with no diagnosis restrictions
J7520 J7525 J7599*		For consideration, this code must be billed on a paper claim form with the name of the drug, dosage and the route of administration.
J9025		Coverage of this procedure code requires an ICD-9-CM diagnosis within the code range of 205.00 – 205.91, 238.71 - 238.76 or 238.79. A prior approval letter from the DMS Medical Director is required to be attached to each claim. Refer to 244.100 for information regarding requesting prior approval.
J9035*		Coverage of this procedure code requires an ICD-9-CM diagnosis within the code range of 153.0 – 154.8, 162.0 – 162.9, 174.0-175.9, or 189.0 – 189.9. A prior approval letter is required and must be attached to each claim. See section 244.100 for information on requesting prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9041		Coverage of this procedure code requires an ICD-9-CM diagnosis code of 203.0 – 203.8, and 200.40-200.48. A prior approval letter is required and must be attached to each claim. See section 244.100 for information on requesting prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9055		This procedure code requires an ICD-9-CM diagnosis code of 140.0 – 140.9, 153.0 – 154, 160.0 – 161.9, 171.0, 172.0 – 172.4, 173.0 – 173.4, or 195.0. A prior approval letter is required and must be attached to each claim. See section 244.100 for information on requesting prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9160		This procedure code is covered for all ages with ICD-9-CM diagnosis within the diagnosis range 202.10 - 202.18, 202.20 - 202.28, or 202.80 - 202.88. A prior approval letter is required and must be attached to each claim. See section 244.100 for information on requesting prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9178		This procedure code requires an ICD-9-CM diagnosis code of 150.0-150.8, 151.0-151.9, 162.0-162.9, 171.0-171.9, 174.0 – 175.9, 183.0, 200.0-200.8 or 202.0 - 202.90. A prior approval letter from the DMS Medical Director is required and must be attached to each claim. See section 244.100 for additional coverage information and instructions for requesting prior approval.
J9219		Payable for male beneficiaries of all ages with ICD-9-CM diagnosis code 185, 198.82 or V10.46. Benefit limit is one procedure every 12 months.

Procedure Code	Modifier(s)	Special Instructions
J9225		Payable for male beneficiaries with a diagnosis of malignant neoplasm of prostate (ICD-9-CM code 185).
J9226		Supprelin LA: Coverage of this procedure code requires an ICD-9-CM diagnosis code 259.1. Approved only for children 12 years of age and under. A prior approval letter from the DMS Medical Director is required to be attached to each claim. Prior to initiation of treatment a clinical diagnosis of CPP, 259.1, should be confirmed by measurement of blood concentrations of total sex steroids, luteinizing hormone (LH) and follicle stimulating hormone (FSH) following stimulation with a GnRH analog, and assessment of bone age versus chronological age. Baseline evaluations should include height and weight measurements, diagnostic imaging of the brain (to rule out intracranial tumor), pelvic/testicular/adrenal ultrasound (to rule out steroid secreting tumors), human chorionic gonadotropin levels (to rule out a chorionic gonadotropin secreting tumor, and adrenal steroids to exclude congenital adrenal hyperplasia. All tests and screenings must be documented by medical records and submitted with History and Physical examination when requesting prior approval. Refer to 244.100 for information regarding requesting prior approval.
J9250		Payable for beneficiaries of all ages without restriction.
J9261		Requires ICD-9-CM diagnosis codes of 202.80 – 202.89 or 204.0 - 208.90. The disease must have not responded to, or either has relapsed, following treatment with at least 2 chemotherapy regimens. Prior approval letter from DMS Medical Director required. See section 244.100 for information on requesting prior approval.
J9263		Payable for beneficiaries of all ages with diagnosis of 151.0-151.9, 153.0 – 154.8, 183.0 – 183.9 and 202.00 – 202.99. Prior approval letter from DMS Medical Director required with letter attached to claim. See section 244.100 for additional coverage information and instructions for prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9264		Coverage of this procedure code requires an ICD-9-CM diagnosis code of 141.0 – 151.9, 158.8, 158.9, 160.9, 161.9, 162.0 – 162.9, 174.0 – 176.9, 180.9, 182.0, 183.0 – 183.9, 185.0, 186.0 – 186.9, 188.0 – 188.9, 195.9, 199.0 and 199.1. A prior approval letter from the DMS Medical Director is required and must be attached to each claim. See section 244.100 for additional coverage information and instructions for requesting prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9293		Payable for all ages. Will be manually reviewed for medical necessity based on diagnosis code for cancer or AIDS or diagnosis code 340.

Procedure Code	Modifier(s)	Special Instructions
J9303*		Requires ICD-9-CM diagnosis code of 153.0 – 154.8. Prior approval letter from DMS Medical Director required with copy attached to each claim. Refer to section 244.100 for information on how to acquire a prior approval letter.
J9305		Coverage of this procedure code requires an ICD-9-CM diagnosis code of 162.0 – 163.9. A prior approval letter from the DMS Medical Director is required and must be attached to each claim. See section 244.100 for additional coverage information and instructions for requesting prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9350		Payable for beneficiaries of all ages with a primary detail diagnosis of 162.0-162.9 or 180.0–180.9 or 183.0 or 205.10–205.11 or 230.9-238.9.
J9395*		Payable for beneficiaries of all ages, with a diagnosis of 174.0 – 175.9. A prior approval letter from the DMS Medical Director is required and must be attached to each claim. See section 244.100 for additional coverage information and instructions for requesting prior approval. Any one of the diagnosis codes from the above listed range is acceptable.
P9041		Payable to beneficiaries of all ages with no restrictions.
P9045		Payable to beneficiaries of all ages with no restrictions.
P9046		Payable to beneficiaries of all ages with no restrictions.
P9047		Payable to beneficiaries of all ages with no restrictions.
Q3025 Q3026		These procedure codes are covered for all ages based on medical necessity.
S0145 S0146		Procedures are payable when there is a primary detail diagnosis ICD-9-CM 070.54
Z1847		Torecan oral tablets. Limit of (4) 10mg tabs per day.
90371		One unit equals $\frac{1}{2}$ 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 in field 24.D of claim form CMS-1500 for each date of service. If date spans are used, units of service must be identified 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.

Procedure Code	Modifier(s)	Special Instructions
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. Modifiers are required only when administered to beneficiaries aged 18 years and younger. 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 2-49 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.
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, appropriate units of service must be indicated and must be identified 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.

Procedure Code	Modifier(s)	Special Instructions
90700	EP, TJ	VFC vaccine payable when administered to beneficiaries under age 7 years. Modifiers are required. See section 292.593 for more information.
90702	EP, TJ	Payable for beneficiaries ages 0-6 years of age.
90703		Payable for all ages without restrictions and without modifiers.
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 without modifiers.
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.
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.

Procedure Code	Modifier(s)	Special Instructions
90720	EP, TJ	This vaccine is covered under the VFC program for ages 0-18 years of age. Modifiers are required.
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.

292.860 Hyperbaric Oxygen Therapy (HBOT) Procedures

10-1-09

Physicians may be reimbursed for attendance and supervision of hyperbaric oxygen therapy (HBOT). Physicians billing for the physician component of "Physician attendance and supervision of hyperbaric oxygen therapy" **may bill for only one unit of service per day.** The physician's charge for each service date must include all his or

her hyperbaric oxygen therapy charges, regardless of how many treatment sessions per day are administered.

- A. Physicians may bill for surgery and professional components of anatomical lab procedures, X-rays and machine tests in addition to **99183**.
- B. Physicians may file paper or electronic claims for **99183** with the prior authorization number placed on the claim in the proper field. If multiple prior authorizations are required, enter the prior authorization number that corresponds to the date of service billed.

NOTE: Refer to section 258.000 of this manual for coverage policy, diagnosis requirements and treatment schedules.