



Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-682-2480
TDD/TTY: 501-682-6789



Emergency Rule

TO: Health Care Providers – Ambulatory Surgical Center, Area Health Education Centers (AHECs), ARKids First-B, Critical Access Hospital, Dental, Home Health, End-Stage Renal Disease, Hospital, Independent Radiology, Nurse Practitioner, Physician, Podiatrist, Prosthetics, Rehabilitative Hospital and Transportation

DATE: June 15, 2014

SUBJECT: 2014 Healthcare Common Procedural Coding System Level II (HCPCS) Code Conversion

I. General Information

A review of the 2014 HCPCS procedure codes has been completed and the Arkansas Medicaid Program will begin accepting updated Healthcare Common Procedural Coding System Level II (HCPCS) procedure codes on claims with dates of service on and after June 15, 2014. Drug procedure codes require National Drug Code (NDC) billing protocol. Drug procedure codes that represent radiopharmaceuticals, vaccines and allergen immunotherapy are exempt from the NDC billing protocol.

Procedure codes that are identified as deletions in 2014 HCPCS Level II will become non-payable for dates of service on and after June 15, 2014.

Please NOTE: The Arkansas Medicaid website fee schedules will be updated soon after the implementation of the 2014 CPT and HCPCS conversions.

II. 2014 HCPCS Payable Procedure Codes Tables Information

Procedure codes are in separate tables. Tables are created for each affected provider type (i.e., prosthetics, home health, etc.).

The tables of payable procedure codes for all affected programs are designed with eight columns of information. All columns may not be applicable for each covered program, but are devised for ease of reference.

Please NOTE: An asterisk indicates that the procedure code requires a paper claim.

1. The first column of the list contains the HCPCS procedure codes. The procedure code may be on multiple lines on the table, depending on the applicable modifier(s) based on the service performed.
2. The second column indicates any modifiers that must be used in conjunction with the procedure code, when billed, either electronically or on paper.
3. The third column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years.
4. Certain procedure codes are covered only when the primary diagnosis is covered within a specific ICD-9-CM diagnosis range. This information is used, for example, by physicians and hospitals. The fourth column, for all affected programs, indicates the beginning and ending range of ICD-9-CM diagnoses for which a procedure code may be used, (i.e., 053.0 through 054.9).
5. The fifth column contains information about the diagnosis list for which a procedure code may be used. (See Section V of this notice for more information about diagnosis range and lists.)
6. The sixth column indicates whether a procedure is subject to medical review before payment. The column is titled "Review." The word "Yes" or "No" in the column indicates whether a review is necessary or not. Providers should consult their program manual to obtain the information that is needed for a review.
7. The seventh column shows procedure codes that require prior authorization (PA) before the service may be provided. The column is titled "PA". The word "Yes" or "No" in the column indicates if a procedure code requires prior authorization. Providers should consult their program manual to ascertain what information should be provided for the prior authorization process.
8. The eighth column indicates a procedure code requires a prior approval letter from the Arkansas Medicaid Medical Director for Clinical Affairs for the Division of Medical Services. The word "Yes" or "No" in the column indicates if a procedure code requires a prior approval letter.

III. Acquisition of Prior Approval Letter

A prior approval letter, when required, must be attached to a paper claim when it is filed. Providers must obtain prior approval in accordance with the following procedures for special pharmacy, therapeutic agents and treatments:

- A. Process for Acquisition: Before treatment begins, the Medical Director for Clinical Affairs in the Division of Medical Services (DMS) must approve any drug, therapeutic agent or treatment not listed as covered in a provider manual or in official DMS correspondence. This requirement also applies to any drug, therapeutic agent or treatment with a prior approval letter indicated for coverage in a provider manual or official DMS correspondence.
- B. The Medical Director for Clinical Affairs' review is necessary to ensure approval for medical necessity. Additionally, all other requirements must be met for reimbursement.
 - 1. The provider must submit a history and physical examination with the treatment plan before beginning any treatment.
 - 2. The provider will be notified by mail of the DMS Medical Director for Clinical Affairs' 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 paper claim submission.

Any change in approved treatment requires resubmission and a new prior approval letter.

- 3. Requests for a prior approval letter must be addressed to the attention of the Medical Director for Clinical Affairs. Contact the Medical Director for Clinical Affairs' office for any additional coverage information and instructions.

Mailing address: Attention: Medical Director for Clinical Affairs Division of Medical Services AR Department of Human Services P.O. Box 1437, Slot S412 Little Rock, AR 72203-1437	Fax: 501-682-8013 Phone: 501-682-9868
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IV. Process for Obtaining Prior Authorization

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

In-state and out-of-state toll free for inpatient reviews, prior authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax	(479) 649-0799
Web portal	http://review.afmc.org/MedicaidReview/iEXCHANGE%c2%ae.aspx
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	1000 Fianna Way Fort Smith, AR 72919-9008
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

V. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Diagnosis Range and Diagnosis Lists

Diagnosis is documented using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Certain procedure codes are covered only for a specific primary diagnosis or a particular diagnosis range. Diagnosis list 003 is specified below. For any other diagnosis restrictions, reference the table for each individual program.

Diagnosis List 003

- 042
- 140.0-209.36
- 209.70 through 209.75
- 209.79
- 230.0 through 238.9
- 511.81
- V58.11 through V58.12

VI. Dental

The following ADA Dental procedure codes **are not covered** by Arkansas Medicaid.

D0393	D0394	D0395	D0601	D0602	D0603	D1999	D2921
D2941	D2949	D3355	D3356	D3357	D3427	D3428	D3429
D3431	D3432	D4921	D5863	D5864	D5865	D5866	D5994
D6011	D6013	D6052	D8694	D9985			

VII. HCPCS Procedure Codes Payable to End-Stage Renal Disease Providers

The following information is related to procedure codes payable to End-Stage Renal Disease providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9441	No	18y & up	280.0-280.9 and 285.1 or 585.1-585.9	No	No	No	No

NOTE: **Injectafer** is an iron replacement product indicated for the treatment of iron deficiency anemia, in adult patients who have intolerance to oral iron, have had an unsatisfactory response to oral iron or who have non-dialysis dependent chronic kidney disease. Patients must have a history and physical exam documenting kidney disease or iron deficiency anemia with intolerance to oral iron. Patients must have lab values showing no increase in iron studies or hemoglobin after administration of oral iron.

VIII. HCPCS Procedure Codes Payable to Home Health Providers

The following information is related to procedure codes payable to Home Health providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
T4544	No	3y & up	No	No	No	No	No

IX. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes payable to Hospital providers:
 An asterisk (*) after the procedure code denotes the requirement of a paper claim.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9520	No	18y & up	172.0-175.9	No	No	No	No
A9575	No	2y & up	No	No	No	No	No
C1841*	No	No	362.74	No	No	No	No

NOTE: Requires manufacturer's invoice with paper claim.

C9132	No	18y & up	286.7	No	Yes	No	No
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NOTE: **Kcentra** is indicated for the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKZ, e.g. warfarin) therapy in adult patients with major bleeding. **Kcentra** is not indicated for urgent reversal of VKA anticoagulation in patients without acute major bleeding. Documentation of the major bleed should be included in a complete history and physical exam. All treatments needed for the major bleed prior to **Kcentra** should be documented. A hemoglobin and hematocrit should be documented in the record as well as the dose of warfarin.

C9133	No	18y & up	No	No	No	No	No
C9441	No	No	280.0-280.9 and 285.1 or 585.1-585.9	No	No	No	No

NOTE: **Injectafer** is an iron replacement product indicated for the treatment of iron deficiency anemia, in adult patients who have intolerance to oral iron, have had an unsatisfactory response to oral iron or who have non-dialysis dependent chronic kidney disease. Patients must have a history and physical exam documenting kidney disease or iron deficiency anemia with intolerance to oral iron. Patients must have lab values showing no increase in iron studies or hemoglobin after administration of oral iron.

C9734	No						
J0151	No						
J0221							

NOTE: See Section XVII of this notice for coverage information.

J0401	No	13y & up	295.00-295.95	No	No	No	No
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Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0717*	No	18y & up	555.0-555.9 or 714.0	No	Yes	No	Yes

NOTE: Prior approval letter requests with clinical documentation are considered for certolizumab pegol (**Cimzia**) for adult beneficiaries 18 years of age and above with:

- 1) Moderately-to-severely active Crohn's disease as manifested by any of the following signs/symptoms:
 - Diarrhea
 - Internal fistulae
 - Abdominal pain
 - Intestinal obstruction
 - Bleeding
 - Extra-intestinal manifestations
 - Weight loss
 - Arthritis
 - Perianal disease
 - Spondylitis

and

Crohn's disease has remained active despite treatment with corticosteroids or 6-mercaptopurine/azathioprine.

or

- 2) For the treatment of moderately-to-severely active rheumatoid arthritis (RA). Patient must have failed **Enbrel** and **Humira**.

J1442	No	No	No	No	No	No	No
J1556*	No	6y & up	279.06	No	Yes	No	Yes

NOTE: **Bivigam** is an immune globulin Intravenous solution indicated for the treatment of primary humoral immunodeficiency. For patients at risk for renal dysfunction or thrombotic events, administer at the minimum infusion rate practical. Previous treatments with other agents should be documented. A complete history and physical exam documenting the severity of the illness and prior treatments should be submitted for approval.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1602*	No	18y & up	556.0- 556.9 696.0, 714.0- 714.9 721.9	No	Yes	No	Yes

NOTE: **Simponi** is a tumor necrosis factor (TNF) blocker indicated in the treatment of adults with:

- 1) Moderately to severely active rheumatoid arthritis in combination with methotrexate that has failed **Humira** and **Enbrel**.
- 2) Active psoriatic arthritis alone or in combination with methotrexate that has failed **Humira** and **Enbrel**.
- 3) Active ankylosing spondylitis that has failed **Humira** and **Enbrel**.
- 4) Moderate to severe ulcerative colitis that has failed **Humira**.

Medical documentation of physician history and physical exam with records showing failed trial of **Humira** and **Enbrel** as indicated should also be submitted.

J3060*	No	18y & up	272.7	No	Yes	No	Yes
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NOTE: This procedure code is indicated for a diagnosis of Type 1 Gaucher Disease. A history and physical exam with a complete evaluation by a geneticist is required each year. This exam must include the prognosis and all abnormalities associated with Gaucher Disease.

J3489	No	No	174.0- 174.9 198.5 203.00- 203.02 203.10- 203.12 203.80- 203.82 275.42 731.0 733.00- 733.09 or 733.90	No	No	No	No
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J7302

NOTE: See Section XVII of this notice for coverage information.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7316*	No	18y & up	379.27	No	Yes	No	Yes
NOTE: Jetrea is a proteolytic enzyme indicated for the treatment of symptomatic vitreomacular adhesion. Immediately following the injection the patient must be monitored for elevation in intraocular pressure. The dose, lot number and manufacturer must be documented. A complete history and physical with visual exam including visual acuity must be submitted with the request for a prior approval letter.							
J7508	No	No	V42.0- V42.89	No	No	No	No
J9047*	No	18y & up	203.00- 203.02	No	Yes	No	Yes
NOTE: Kyprolis is indicated for the treatment of adult patients with multiple myeloma, who have received at least two prior therapies including Velcade and an immunomodulatory agent and have demonstrated disease progression on or within 60 days of completion of the last therapy. Approval is based upon response rate. A physical exam and history documenting the above requirements must be included. All monitoring and warnings and precautions from the Federal Drug Administration must be complied with for this drug to be approved. Females should avoid becoming pregnant. Consideration will be on a case-by-case basis.							
J9262*	No	18y & up	205.10- 205.12	No	Yes	No	Yes
NOTE: Synribo is indicated for treatment of adult patients with chronic or accelerated chronic myeloid leukemia with resistance and/or tolerance to two or more tyrosine inhibitors. A history and physical exam documenting previous treatment should be submitted with the request for a prior approval letter.							
J9306*	No	18y & up	174.0- 175.9	No	Yes	No	Yes
NOTE: Perjeta is an agent for the treatment of adults, age 18-99 years old, that is a Her2/neu receptor antagonist indicated in combination with tratuzumab and docetaxol for the treatment of patients with Her2-positive metastatic breast cancer who have not received prior anti-Her2 therapy or chemotherapy for metastatic disease. A physician history and physical exam documenting all previous treatment should be included. All Federal Drug Administration warnings and precautions should be followed.							

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9354*	No	18y & up	174.0-175.9	No	Yes	No	Yes
<p>NOTE: Kadcyla is a Her2-targeted antibody and microtubule inhibitor conjugate indicated, as a single agent, for the treatment of adults with Her2-positive, metastatic breast cancer, who previously received trastuzumab and a taxane, separately or in combination. Patients should have either:</p> <ol style="list-style-type: none"> 1) received prior therapy for metastatic disease, <li style="text-align: center;">or 2) developed disease recurrence during or within six months of completing adjuvant therapy. <p>All of the above requirements should be documented in a history and physical exam included in the request. All prior treatments should be listed. Approval will be on a case-by-case basis.</p>							
J9371*	No	18y & up	204.00-204.02	No	Yes	No	Yes
<p>NOTE: Marqibo is a vinca alkaloid indicated for the treatment of adult patients with Philadelphia chromosome negative (Ph-) acute lymphoblastic leukemia in second or greater relapse or whose disease has progressed following two or more anti-leukemic therapies. A complete history and physical exam documenting all previous therapies should be submitted. Approval will be on a case-by-case basis.</p>							
J9400*	No	18y & up	153.0-154.8	No	Yes	No	Yes
<p>NOTE: This procedure code is indicated in adults with a diagnosis of metastatic colorectal cancer (mCRC), that is resistant to or has progressed following an oxaliplatin-containing regimen. A complete history and physical exam documenting stage of cancer and all regimens that the patient has been on should be sent.</p>							
Q2050	No	No	No	003	No	No	No
Q3027	No	18y & up	340	No	No	No	No
Q4121							
NOTE: See Section XVII of this notice for coverage information.							
Q4141*	No	No	No	No	No	No	No
NOTE: Must be billed with manufacturer's invoice attached.							
Q4145*	No	No	No	No	No	No	No
NOTE: Must be billed with manufacturer's invoice attached.							

X. HCPCS Procedure Codes Payable to Independent Radiology

The following information is related to procedure codes payable to Independent Radiology providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9520	No	18y & up	172.0-175.9	No	No	No	No
A9575	No	2y & up	No	No	No	No	No
C9734	No	No	No	No	No	No	No

XI. HCPCS Procedure Codes Payable to Nurse Practitioners

The following information is related to procedure codes payable to Nurse Practitioner providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0151	No	No	No	No	No	No	No
J1442	No	No	No	No	No	No	No

XII. HCPCS Procedure Codes Payable to Physicians and Area Health Care Education Centers (AHECs)

The following information is related to procedure codes payable to Physician and AHEC providers:

An asterisk (*) after the procedure code denotes the requirement of a paper claim.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9520	No	18y & up	172.0-175.9	No	No	No	No
A9575	No	2y & up	No	No	No	No	No

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9132	No	18y & up	286.7	No	Yes	No	No
NOTE: Kcentra is indicated for the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKZ, e.g. warfarin) therapy in adult patients with major bleeding. Kcentra is not indicated for urgent reversal of VKA anticoagulation in patients without acute major bleeding. Documentation of the major bleed should be included in a complete history and physical exam. All treatments needed for the major bleed prior to Kcentra should be documented. A hemoglobin and hematocrit should be documented in the record as well as the dose of warfarin.							
C9133	No	18y & up	No	No	No	No	No
C9441	No	18y & up	280.0-280.9 and 285.1 or 585.1-585.9	No	No	No	No
NOTE: Injectafer is an iron replacement product indicated for the treatment of iron deficiency anemia, in adult patients who have intolerance to oral iron, have had an unsatisfactory response to oral iron or who have non-dialysis dependent chronic kidney disease. Patients must have a history and physical exam documenting kidney disease or iron deficiency anemia with intolerance to oral iron. Patients must have lab values showing no increase in iron studies or hemoglobin after administration of oral iron.							
C9734	No	No	No	No	No	No	No
J0151	No	No	No	No	No	No	No
J0221							
NOTE: See Section XVII of this notice for coverage information.							
J0401	No	13y & up	295.00-295.95	No	No	No	No

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0717*	No	18y & up	555.0-555.9 or 714.0	No	Yes	No	Yes

NOTE: Prior approval letter requests with clinical documentation are considered for certolizumab pegol (**Cimzia**) for adult beneficiaries 18 years of age and above with:

1) Moderately-to-severely active Crohn's disease as manifested by any of the following signs/symptoms:

- Diarrhea
- Internal fistulae
- Abdominal pain
- Intestinal obstruction
- Bleeding
- Extra-intestinal manifestations
- Weight loss
- Arthritis
- Perianal disease
- Spondylitis

and

Crohn's disease has remained active despite treatment with corticosteroids or 6-mercaptopurine/azathioprine.

or

2) For the treatment of moderately-to-severely active rheumatoid arthritis (RA). Patient must have failed **Enbrel** and **Humira**.

J1442	No	No	No	No	No	No	No
J1556*	No	6y & up	279.06	No	Yes	No	Yes

NOTE: **Bivigam** is an immune globulin intravenous solution indicated for the treatment of primary humoral immunodeficiency. For patients at risk for renal dysfunction or thrombotic events, administer at the minimum infusion rate practical. Previous treatments with other agents should be documented. A complete history and physical exam documenting the severity of the illness and prior treatments should be submitted for approval.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1602*	No	18y & up	556.0- 556.9 696.0, 714.0- 714.9 721.9	No	Yes	No	Yes

NOTE: **Simponi** is a tumor necrosis factor (TNF) blocker indicated in the treatment of adults with:

- 1) Moderately to severely active rheumatoid arthritis in combination with methotrexate that has failed **Humira** and **Enbrel**.
- 2) Active psoriatic arthritis alone or in combination with methotrexate that has failed **Humira** and **Enbrel**.
- 3) Active ankylosing spondylitis that has failed **Humira** and **Enbrel**.
- 4) Moderate to severe ulcerative colitis that has failed **Humira**.

Medical documentation of physician history and physical exam with records showing failed trial of **Humira** and **Enbrel** as indicated should also be submitted.

J3060*	No	18y & up	272.7	No	Yes	No	Yes
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NOTE: This procedure code is indicated for a diagnosis of Type 1 Gaucher Disease. A complete history and physical exam with a complete evaluation by a geneticist is required each year. This exam must include the prognosis and all abnormalities associated with Gaucher Disease.

J3489	No	No	174.0- 174.9 198.5 203.00- 203.02 203.10- 203.12 203.80- 203.82 275.42 731.0 733.00- 733.09 or 733.90	No	No	No	No
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J7302

NOTE: See Section XVII of this notice for coverage information.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7316*	No	18y & up	379.27	No	Yes	No	Yes
<p>NOTE: Jetrea is a proteolytic enzyme indicated for the treatment of symptomatic vitreomacular adhesion. Immediately following the injection the patient must be monitored for elevation in intraocular pressure. The dose, lot number and manufacturer must be documented. A complete history and physical with visual exam including visual acuity must be submitted with the request for the prior approval letter.</p>							
J7508	No	No	V42.0- V42.89	No	No	No	No
J9047*	No	18y & up	203.00- 203.02	No	Yes	No	Yes
<p>NOTE: Kyprolis is indicated for the treatment of adult patients with multiple myeloma, who have received at least two prior therapies including Velcade and an immunomodulatory agent and have demonstrated disease progression on or within 60 days of completion of the last therapy. Approval is based upon response rate. A physical exam and history documenting the above requirements must be included. All monitoring and warnings and precautions from the Federal Drug Administration must be complied with for this drug to be approved. Females should avoid becoming pregnant. Consideration will be on a case-by-case basis.</p>							
J9262*	No	18y & up	205.10- 205.12	No	Yes	No	Yes
<p>NOTE: Synribo is indicated for treatment of adult patients with chronic or accelerated chronic myeloid leukemia with resistance and/or tolerance to two or more tyrosine inhibitors. A history and physical exam documenting previous treatment should be submitted with the request for a prior approval letter.</p>							
J9306*	No	18y & up	174.0- 175.9	No	Yes	No	Yes
<p>NOTE: Perjeta is an agent for the treatment of adults, age 18-99 years old, that is a Her2/neu receptor antagonist indicated in combination with tratuzumab and docetaxol for the treatment of patients with Her2-positive metastatic breast cancer who have not received prior anti-Her2 therapy or chemotherapy for metastatic disease. A physician history and physical exam documenting all previous treatment should be included. All Federal Drug Administration warnings and precautions should be followed.</p>							

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9354*	No	18y & up	174.0-175.9	No	Yes	No	Yes
<p>NOTE: Kadcyla is a Her2-targeted antibody and microtubule inhibitor conjugate indicated, as a single agent, for the treatment of adults with Her2-positive, metastatic breast cancer, who previously received trastuzumab and a taxane, separately or in combination. Patients should have either:</p> <ol style="list-style-type: none"> 1) received prior therapy for metastatic disease, <li style="text-align: center;">or 2) developed disease recurrence during or within six months of completing adjuvant therapy. <p>All of the above requirements should be documented in a history and physical exam included in the request. All prior treatments should be listed. Approval will be on a case-by-case basis.</p>							
J9371*	No	18y & up	204.00-204.02	No	Yes	No	Yes
<p>NOTE: Marqibo is a vinca alkaloid indicated for the treatment of adult patients with Philadelphia chromosome negative (Ph-) acute lymphoblastic leukemia in second or greater relapse or whose disease has progressed following two or more anti-leukemic therapies. A complete history and physical exam documenting all previous therapies should be submitted. Approval will be on a case-by-case basis.</p>							
J9400*	No	18y & up	153.0-154.8	No	Yes	No	Yes
<p>NOTE: This procedure code is indicated in adults with a diagnosis of metastatic colorectal cancer (mCRC), that is resistant to or has progressed following an oxaliplatin-containing regimen. A complete history and physical exam documenting stage of cancer and all regimens that the patient has been on should be sent.</p>							
Q2050	No	No	No	003	No	No	No
Q3027	No	18y & up	340	No	No	No	No
Q4121							
NOTE: See Section XVII of this notice for coverage information.							
Q4141*	No	No	No	No	No	No	No
NOTE: Must be billed with manufacturer's invoice attached.							
Q4145*	No	No	No	No	No	No	No
NOTE: Must be billed with manufacturer's invoice attached.							

XIII. HCPCS Procedure Codes Payable to Podiatrists

The following information is related to procedure codes payable to Podiatrist providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
Q4121							
NOTE: See Section XVII of this notice for coverage information.							
Q4141*	No	No	No	No	No	No	No
NOTE: Must be billed with manufacturer's invoice attached.							
Q4145*	No	No	No	No	No	No	No
NOTE: Must be billed with manufacturer's invoice attached.							

XIV. HCPCS Procedure Codes Payable to Prosthetics Providers

The following information is related to procedure codes payable to Prosthetics providers:

Procedure codes in the table must be billed with appropriate modifiers. For procedure codes that require a prior authorization, the written PA request must be submitted to the Utilization Review Section of the Division of Medical Services (DMS) for wheelchairs and wheelchair related equipment and services.

For other durable medical equipment (DME), a written request must be submitted to the Arkansas Foundation for Medical Care. Please refer to your Arkansas Medicaid Prosthetics Provider Manual for details on requesting a DME prior authorization.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
L0455	NU	21y & up	No	No	No	No	No
L0455	EP	0y-20y	No	No	No	No	No
L0457	NU	21y & up	No	No	No	No	No
L0457	EP	0y-20y	No	No	No	No	No
L0467	NU	21y & up	No	No	No	No	No
L0467	EP	0y-20y	No	No	No	No	No
L0469	NU	21y & up	No	No	No	No	No
L0469	EP	0y-20y	No	No	No	No	No
L0641	NU	21y & up	No	No	No	No	No
L0641	EP	0y-20y	No	No	No	No	No
L0642	NU	21y & up	No	No	No	No	No
L0642	EP	0y-20y	No	No	No	No	No

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
L0643	NU	21y & up	No	No	No	No	No
L0643	EP	0y-20y	No	No	No	No	No
L0648	NU	21y & up	No	No	No	No	No
L0648	EP	0y-20y	No	No	No	No	No
L0649	NU	21y & up	No	No	No	No	No
L0649	EP	0y-20y	No	No	No	No	No
L0650	NU	21y & up	No	No	No	No	No
L0650	EP	0y-20y	No	No	No	No	No
L0651	NU	21y & up	No	No	No	No	No
L0651	EP	0y-20y	No	No	No	No	No
L1812	NU	21y & up	No	No	No	No	No
L1812	EP	0y-20y	No	No	No	No	No
L1833	NU	21y & up	No	No	No	No	No
L1833	EP	0y-20y	No	No	No	No	No
L1848	NU	21y & up	No	No	No	No	No
L1848	EP	0y-20y	No	No	No	No	No
L3678	NU	21y & up	No	No	No	No	No
L3678	EP	0y-20y	No	No	No	No	No
L3809	NU	21y & up	No	No	No	No	No
L3809	EP	0y-20y	No	No	No	No	No
L3916	NU	21y & up	No	No	No	No	No
L3916	EP	0y-20y	No	No	No	No	No
L3918	NU	21y & up	No	No	No	No	No
L3918	EP	0y-20y	No	No	No	No	No
L3924	NU	21y & up	No	No	No	No	No
L3924	EP	0y-20y	No	No	No	No	No
L3930	NU	21y & up	No	No	No	No	No
L3930	EP	0y-20y	No	No	No	No	No
L4361	NU	21y & up	No	No	No	No	No
L4361	EP	0y-20y	No	No	No	No	No
L4387	NU	21y & up	No	No	No	No	No
L4387	EP	0y-20y	No	No	No	No	No
L4397	NU	21y & up	No	No	No	No	No

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
L4397	EP	0y-20y	No	No	No	No	No
L5969	NU	21y & up	No	No	No	Yes	No
L5969	EP	0y-20y	No	No	No	Yes	No
T4544	No	3y & up	No	No	No	No	No

XV. HCPCS Procedure Codes Payable to Rehabilitative Hospitals

The following procedure code is payable to Rehabilitative Hospital providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
Q4141*	No	No	No	No	No	No	No

NOTE: Must be billed with manufacturer's invoice attached.

XVI. HCPCS Procedure Codes Payable to Transportation Providers

The following information is related to procedure codes payable to Transportation providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0151	No	No	No	No	No	No	No

XVII. Miscellaneous Information

A. Existing HCPCS procedure code **J0221** is payable to AHEC, Hospital and Physician providers:

See the coverage criteria listed below:

An asterisk (*) after the procedure code denotes the requirement of a paper claim.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0221*	No	8y & up	271.0	No	Yes	No	Yes

NOTE: Payable for beneficiaries who have the primary detail diagnosis of late onset, not infantile Pompe disease. The history and physical by a geneticist showing a diagnosis of late onset, not infantile, Pompe disease must be submitted with the request for the prior approval letter. The beneficiary, physician and infusion center should be enrolled in the Lumizyme ACE Program. The history and physical should document compliance with this program including discussion of the risks of anaphylaxis, severe allergic reactions and immune-mediated reactions according to the Black Box Warning from the FDA. This drug should only be administered in a facility equipped to deal with anaphylaxis, including Advanced Life Support capability.

- B. Existing HCPCS procedure code **Q4121** is payable to AHEC, Hospital, Physician and Podiatrist providers:

See the coverage criteria listed below.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
Q4121	No	No	No	No	No	No	No

- C. Existing HCPCS procedure code **J7302** is currently covered as a Family Planning service. **J7302** will become payable for therapeutic use to AHEC, Hospital, Nurse Practitioner and Physician providers:

See the coverage criteria listed below.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7302	No	No	617.0- 617.9 627.2 627.8 or 627.9	No	No	No	No

NOTE: Covered for therapeutic use and treatment of heavy menstrual bleeding in women who have had a child or who have been pregnant.

- D. The following existing procedure codes are payable to Prosthetic providers and now require Prior Authorization.

A6021	A6022	A6023	A6024
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- E. Existing HCPCS procedure codes **J0881** and **J0885** are currently payable to AHEC, End-Stage Renal Disease, Home Health, Hospital, Nurse Practitioner and Physician providers:

These codes may also be billed with ICD-9-CM diagnosis code 285.21 when the beneficiary is not on dialysis.

XVIII. Non-Covered 2014 HCPCS with Elements of CPT or Other Procedure Codes

The following new 2014 HCPCS procedure codes are not payable because these services are covered by a CPT code, another HCPCS code or a revenue code.

C5271	C5272	C5273	C5274
C5275	C5276	C5277	C5278

XIX. Non-Covered 2014 HCPCS Procedure Codes

The following procedure codes are not covered by Arkansas Medicaid.

A4555	A7047	A9599	C9497	C9735	C9737	E0766	E1352
G0460	G0461	G0462	G0463	G9187	G9188	G9189	G9190
G9191	G9192	G9193	G9194	G9195	G9196	G9197	G9198
G9199	G9200	G9201	G9202	G9203	G9204	G9205	G9206
G9207	G9208	G9209	G9210	G9211	G9212	G9213	G9214
G9215	G9216	G9217	G9218	G9219	G9220	G9221	G9222
G9223	G9224	G9225	G9226	G9227	G9228	G9229	G9230
G9231	G9232	G9233	G9234	G9235	G9236	G9237	G9238
G9239	G9240	G9241	G9242	G9243	G9244	G9245	G9246
G9247	G9248	G9249	G9250	G9251	G9252	G9253	G9254
G9255	G9256	G9257	G9258	G9259	G9260	G9261	G9262
G9263	G9264	G9265	G9266	G9267	G9268	G9269	G9270
G9271	G9272	G9273	G9274	G9275	G9276	G9277	G9278
G9279	G9280	G9281	G9282	G9283	G9284	G9285	G9286
G9287	G9288	G9289	G9290	G9291	G9292	G9293	G9294

G9295	G9296	G9297	G9298	G9299	G9300	G9301	G9302
G9303	G9304	G9305	G9306	G9307	G9308	G9309	G9310
G9311	G9312	G9313	G9314	G9315	G9316	G9317	G9318
G9319	G9320	G9321	G9322	G9323	G9324	G9325	G9326
G9327	G9328	G9329	G9340	G9341	G9342	G9343	G9344
G9345	G9346	G9347	G9348	G9349	G9350	G9351	G9352
G9353	G9354	G9355	G9356	G9357	G9358	G9359	G9360
J1446	J7301	K0008	K0013	K0900	L8679	Q0161	Q0507
Q0508	Q0509	Q2028	Q2052	Q3028	Q4137	Q4138	Q4139
Q4140	Q4142	Q4143	Q4146	Q4147	Q4148	Q4149	S9960
S9961							

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Zekis
Interim Director