Arkansas Department of Health and Human Services

Division of Medical Services

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

DATE: **August 1, 2007**

SUBJECT: **Provider Manual Update Transmittal #127**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
203.120	5-1-06	203.120	8-1-07
220.000	10-13-03	220.000	8-1-07
243.500	10-1-06	243.500	8-1-07
—	—	244.003	8-1-07
244.100	10-1-06	244.100	8-1-07
251.280	10-13-03	251.280	8-1-07
253.000	10-1-06	253.000	8-1-07
261.000	10-1-06	261.000	8-1-07
261.130	10-1-06	261.120	8-1-07
261.240	4-1-07	261.240	8-1-07
262.000	10-1-06	262.000	8-1-07
292.110	10-1-06	292.110	8-1-07
292.200	4-3-06	292.200	8-1-07
292.440	10-1-06	292.440	8-1-07
—	—	292.511	8-1-07
292.552	omitted	292.552	8-1-07
292.561	10-1-06	292.561	8-1-07
292.575	7-1-05	292.570	8-1-07
292.580	10-13-03	292.580	8-1-07
292.590	7-1-05	292.590	8-1-07
292.591	10-1-06	292.591	8-1-07
292.592	10-1-06	292.592	8-1-07
292.672	10-1-06	292.672	8-1-07
292.801	10-1-06	292.801	8-1-07
292.813	10-13-03	292.813	8-1-07

Explanation of Updates

Updated information has been added to the manual and references to type of service and type of service codes have been removed throughout the policy.

Section 203.120 has been revised at A. 1. to add information that billing may be done on paper or electronically for screening performed on the same date as an office visit. Information has also been added in this section stating that CPT evaluation and management codes should be used when an office visit for treatment of an acute or chronic condition is billed as a separate visit for the same date of service and that no modifiers are to be used.

Section 220.000 is included to provide additional information regarding benefit limits and to correct the policy numbers referenced for benefit extension request procedures. The correct policy reference is Section 229.000 through Section 229.120.

Section 243.500 has been revised and renumbered to include the Implanon implantable contraceptive device as a covered Medicaid service. This device is not covered in the Family Planning Medicaid category. Sterilization has also been included as a contraceptive procedure.

Section 244.003 has been added to provide information regarding the Retisert, Fluocinolone Acetonide Intravitreal Implant.

Section 244.100 has been added to provide information regarding special pharmacy, therapeutic agents and treatments.

Section 251.280.D is included to add new information regarding laparoscopic supracervical hysterectomies.

Section 253.000 is included to delete the last sentence in the first paragraph.

Section 261.000 is included to change the policy reference for instructions on requesting PA.

Section 261.130, Prior Authorization of Cochlear Implant and External Sound Processor has been renumbered to 261.120.

Section 261.240 has been added to provide instructions for prior authorization of Hyaluronon (sodium hyaluronate) injections.

Section 262.000 is included as procedure codes **J7319 and J7330** have been added as procedure codes that require prior authorization. Procedure code **SO512*** has been added as payable to physicians under the Visual Services program and **V5014**** has been added as payable under the Hearing Services program.

Section 292.110 is included to correct a procedure code number that was transposed. **09169** has been changed to **01969**.

Section 292.200 has been revised to add the statement that Arkansas Medicaid recognizes valid national CPT/HCPCS modifiers on claims submitted for processing and to remove “Type of Service” from the heading.

Section 292.440 has been revised to add outline letter “E” and “F” and to add a new paragraph at the end of “F”.

Section 292.511 has been added to provide information regarding physician’s professional services for home peritoneal dialysis training.

Section 292.552 has been revised to remove references to type of service and paper claim information. Special billing instructions for certain codes have been added.

Section 292.561 has been revised to include new codes for genetic testing procedures.

Section 292.575 has been added to provide information about billing EPSDT screenings and sick visits on the same day.

Section 292.580 has been revised to include information regarding billing of hysterectomies.

Section 292.590 has been added to provide information regarding billing for covered injections.

Section 292.591 is included to change the word "chemotherapy" to "therapeutic". New information has been added at A. regarding therapeutic injections and treatment of infusion reactions. The list at B. has been revised to remove codes that are no longer covered for beneficiaries of all ages or individuals aged 21 or older with diagnosis codes **140.0 – 208.91** or **042**. Procedure codes **J0570**, **J1270, J1470, J1910, J2000, J7190, J7191, J7192, J7194, J7508, J9293, Q0163 – Q180** and **Q4075** have been removed.

Section 292.592 has been revised to include the following information:

- **C9232** requires ICD-9-CM diagnosis code of 277.5 and evaluation by genetics specialist with prior approval letter from DMS Medical Director.
- **C9233** requires ICD-9-CM primary diagnosis code of 362.50 or 362.52, and prior approval letter.
- **C9235** requires ICD-9-CM primary diagnosis code of 153.0 -154.8 and prior approval letter.
- **C9350** requires attachment of manufacturer's invoice and procedure report.
- **J0129** requires ICD-9-CM diagnosis code of 714.0-714.2 as primary diagnosis and other special instructions.
- **J0133** has been added with instructions that it is payable for beneficiaries of all ages with diagnosis codes 053.0-054.9.
- **J0150** has a maximum of 4 units per day.
- Information has been added to **J0152** to advise that a paper claim with copy of the report of diagnostic procedure is required and that there is a maximum of 1 unit per day.
- **J0348** has been added as valid for any of the listed conditions with special instructions.
- **J0570** has been added and is payable for beneficiaries of all ages with no diagnosis restrictions.
- **J0881** and **J0885** have been added with special instructions.
- **J0894** has been added with special instructions.
- **J1270** has been added and is payable for beneficiaries with diagnosis codes 042, 140.0-208.91 + 787.2 + 588.81; or ESRD 584-586 + 787.2 + 588.81. TOS 1. Claims will be manually reviewed prior to reimbursement. **J1270** is payable only to physicians in their offices.
- **J1458** has been added as payable for mucopolysaccharidosis with special instructions.
- **J1562** has been added as payable for all ages without diagnosis restriction.

- Information has been added to **J1745** stating that on and after 5/20/06, **J1745** is payable without an approval letter for beneficiaries under age 18. **J1745** is payable without an approval letter when the diagnosis is 550.0, 555.1 or 555.9. No other diagnosis is required. All other diagnoses for beneficiaries under age 18 will continue to require a prior approval letter.
- Information has been added to **J2505** stating diagnosis codes **288.03, V58.69, v67.51** and **E933.1** are covered with diagnosis of AIDS or cancer, and that diagnosis must be shown on the claim form.
- Wording at **J2916** has been changed to state it is payable with a primary diagnosis of **964.0**.
- The section reference at **J3396** has been changed from 244.003 to 244.002.
- Wording at **J3487** has been changed to "primary diagnosis" rather than diagnosis.
- Procedure Code **J3590** has been removed.
- **J7319** has been added with prior authorization and other special instructions.
- **J7346** has been added requiring submission of operative report with claims.
- Additional diagnosis codes have been added to **J9055** and **J9178.**
- **J9261** has been added with special instructions.
- **J9293** has been added and is payable for all ages. It will be manually reviewed for medical necessity based on diagnosis code for cancer or AIDS or diagnosis code 340.
- At **J9395** section 244.001 has been changed to 244.100 and additional diagnosis codes have been added.
- **SO147** has been added with special instructions.
- **SO180** has been added with special instructions.
- **Z1847** has been added for Torecan oral tablets, limit of 4 10mg tabs per day.
- At 90675 and 90676 the words "Indicate appropriate" have been added as they were previously omitted.

Section 292.672 is included as the table has been removed for **Z1930** and information shown in paragraph form with reference to section 292.580 for billing instructions for hysterectomy after C-section.

Section 292.801 is included to remove the limit of up to 50 daily units.

Section 292.813 is included to add new procedure codes **76801**, **76802**, **76811, 76812** and **76817**.

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

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

TOC required

203.120 Physician's Role in the Child Health Services (EPSDT) Program 8-1-07

The Child Health Services (EPSDT) program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth up to their 21st birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with screening, diagnostic and treatment services delivered on a periodic basis.

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a preventive health care program designed for: (1) newborn health evaluations as soon after birth as possible; (2) routine, timely childhood immunizations; (3) regular screenings to detect physical or developmental health problems and (4)treatment and other measures to correct or improve any defects and chronic conditions discovered.

1. Screening

   The Arkansas Medicaid Program requires that ***all*** eligible EPSDT participants under age 21 receive regularly scheduled examinations and evaluations of their general physical and mental health, growth, development and nutritional status.

   Screenings must include, but are not limited to:

   a. Comprehensive health and developmental history.
   b. Comprehensive unclothed physical examination.
   c. Appropriate vision testing.
   d. Appropriate hearing testing.
   e. Appropriate laboratory tests.
   f. Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.

   Screening services must be provided in accordance with reasonable standards of medical and dental practice, as soon as possible in a child's life and at intervals established by the American Academy of Pediatrics.

   An age appropriate screening may be performed when a child is being evaluated or treated for an acute or chronic condition.

   The primary care physician may provide the screening or refer the child to a qualified Medicaid provider for screening. Primary care physician referral for ESPDT screening is mandatory in the 75 counties in Arkansas. See Section I of this manual.

2. Diagnosis

   Diagnosis is the determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history, physical, developmental and psychological examination, laboratory tests and X-rays.

3. Treatment

   Treatment means physician, hearing, visual services, or dental services and any other type of medical care and services recognized under State law to prevent or correct disease or abnormalities detected by screening or by diagnostic procedures.

   Physicians and other health professionals who provide Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment. If immunization is recommended at the time of screening, immunization(s) should be provided at that time .

When a condition is diagnosed through a Child Health Services (EPSDT) screen and requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services will be considered for reimbursement if the service is medically necessary and permitted under federal Medicaid regulations. The PCP must request consideration for reimbursement using the EPSDT Prescription/Referral for Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan Form DMS-693. **View or print form DMS-693.**

Refer to Section I of this manual (Services Available through the Child Health Services (EPSDT) Program) for additional information.

B. Physicians who are Child Health Services (EPSDT) providers are encouraged to refer to the Child Health Services (EPSDT) provider manual for additional information.

Physicians interested in becoming a Child Health Services (EPSDT) provider should contact the central Child Health Services Office. **View or print Child Health Services Office contact information.**

220.000 Benefit Limits 8-1-07

Benefit limits are the limits on the *quantity* of covered services Medicaid-eligible beneficiaries may receive. Medicaid-eligible beneficiaries are responsible for payment for services beyond the established benefit limits, unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit

If a service is denied for exceeding the benefit limit, and the Medicaid beneficiary had elected to receive the service by written informed consent prior to the delivery of the service, the Medicaid beneficiary is responsible for the payment, unless that service has been deemed not medically necessary.

Benefit extensions are considered after the service has been rendered and the provider has received a denial for "benefits exhausted." DMS considers requests for benefit extensions based on the medical necessity of the service. If a Medicaid provider chooses to file for an extension of benefits and is denied due to the service not being medically necessary, the beneficiary is not responsible for the payment. Once the extension of benefits request has been initiated on a particular service, the provider cannot abort the process before a final decision is rendered.

Please see Section 229.000 through Section 229.120 and Section 131.000 points A and C for benefit extension request procedures. DMS reviews extension of benefits requests for Home Health, personal care, diapers and medical supplies. AFMC reviews extension of benefits requests for physician, lab, radiology and machine tests, using AFMC form 103.

243.500 Contraception 8-1-07

A. Prescription and Non-Prescription Contraceptives

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

B. Levonorgestrel Implant System

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

C. Etonogestrel (contraceptive) Implant System

1. Medicaid covers the etonogestrel contraceptive implant system, including implants and supplies in full-service Medicaid categories only.
2. Medicaid covers insertion, removal and removal with reinsertion.
3. The Family Planning category of Medicaid does not cover the etonogestrel contraceptive device. The PES eligibility transaction response identifies this Aid Category as Aid Category 69 (FP-W).

D. Intrauterine Device (IUD)

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

E. Medroxyprogesterone Acetate

Medicaid covers medroxyprogesterone acetate injections for birth control.

F. Sterilization

1. All adult (21 or older) female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures and medically necessary follow-ups as long as they remain Medicaid-eligible.
2. All adult (21 or older) male Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures and medically necessary follow-ups as long as they remain Medicaid-eligible.
3. Adult (21 or older) women in the Women's Health Waiver category, Aid Category 69, who are mentally competent, are eligible for sterilization procedures.
4. Medicaid covers Occlusion by Placement of Permanent Implants, (Essure implant system) a type of sterilization procedure. Coverage includes the physician's services, implant and the supplies and follow-up procedures.
5. Refer to Section 251.290 of this manual for Medicaid policy regarding sterilization.

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

244.003 Fluocinolone Acetonide Intravitreal Implant (Retisert) 8-1-07

Medicaid covers Retisert implantation for ages and indications approved by the FDA under the following conditions:

NOTE: Supply of the Fluocinolone Acetonide Intravitreal Implant (Retisert) is only payable to the hospital provider.

A. There must be documentation by eye exam of an ICD-9-CM diagnosis of 363.20, chronic non-infectious uveitis of the posterior segment of the eye.

B. An evaluation by an ophthalmologist documenting failure of all other treatments and complications that will lead to blindness must be clearly stated.

C. Which eye will be treated with that administration should be clearly documented along with current visual acuity.

D. All requests will be reviewed on a case-by-case basis.

E. The physician must obtain a Prior Approval letter from the DMS Medical Director. The Prior Approval letter must be provided to the hospital provider for billing for the provision of the implant. See Section 244.100 for instruction on obtaining Prior Approval letters.

NOTE: The procedure code for the implant is NOT payable to the physician. The physician may bill for the procedure to do the implantation.

F. Physician is to provide the hospital with a copy of the prior approval letter at the time of the implantation procedure.

244.100 Special Pharmacy, Therapeutic Agents and Treatments 8-1-07

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

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

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

B. The Medical Director's prior approval is necessary to ensure approval for medical necessity. Additionally, all other requirements must be met for reimbursement.

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

Send requests for a prior approval letter for pharmacy and therapeutic agents to the attention of the **Medical Director of the Division of Medical Services**.

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

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

251.280 Hysterectomies 8-1-07

Hysterectomies, except those performed for malignant neoplasm, carcinoma in-situ and severe dysplasia will require prior authorization regardless of the age of the beneficiary. (See Section 261.100 of this manual for instructions for obtaining prior authorization.) Those hysterectomies performed for carcinoma in-situ or severe dysplasia must be confirmed by a tissue report. The tissue report must be obtained prior to surgery. Cytology reports alone will not confirm the above two diagnoses, nor will cytology reports be considered sufficient documentation for performing a hysterectomy. Mild or moderate dysplasia is not included in the above and any hysterectomy performed for mild or moderate dysplasia will require prior authorization.

A. Any Medicaid beneficiary who is to receive a hysterectomy, regardless of her age, must be informed both orally and in writing that the hysterectomy will render her permanently incapable of reproduction. The patient or her representative may receive this information from the individual who secures the usual authorization for the hysterectomy procedure.

The patient or her representative, if any, must sign and date the Acknowledgement of Hysterectomy Information (Form DMS-2606) not more than 180 days prior to the hysterectomy procedure being performed. **View or print form DMS-2606 and**

instructions for completion. Copies of this form can be ordered from EDS according to the procedures in Section III.

Please note that the acknowledgement statement must be submitted with the claim for payment.

The patient or her representative must sign the acknowledgement statement. The Medicaid agency will not approve any hysterectomy for payment until the acknowledgement statement has been received.

If the patient needs the Acknowledgement of Hysterectomy Information Form (DMS-2606) in an alternative format, such as large print, contact our Americans with Disabilities Coordinator. **View or print the Americans with Disabilities Coordinator contact information.**

B. Random Audits of Hysterectomies

All hysterectomies paid by Federal and State funds will be subject to random selection for post-payment review. At the time of such review, the medical records must document the medical necessity of hysterectomies performed for carcinoma in-situ and severe dysplasia and must contain tissue reports confirming the diagnosis. The tissue must have been obtained prior to surgery.

The medical record of those hysterectomies performed for malignant neoplasms must contain a tissue report confirming such a diagnosis. However, the tissue may be obtained during surgery, e.g., frozen sections. Any medical record found on post-payment review which does not contain a tissue report confirming the diagnosis or any medical record found which does not document the medical necessity of performing such surgery will result in recovery of payments made for that surgery.

C. Hysterectomies Performed for Sterilization

Medicaid **does not cover** any hysterectomy performed for the sole purpose of sterilization.

D. Medicaid does not cover laparoscopic supracervical hysterectomy (Subtotal hysterectomy) with or without removal of tube(s), with or without removal of ovary(s).

253.000 Bilaminate Graft or Skin Substitute 8-1-07

Arkansas Medicaid covers bilaminate graft or skin substitute, known as dermal and epidermal tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements. Some of these products require prior authorization. Check the procedure code for the product to be used to determine if prior authorization is required. The application procedure codes do not require prior authorization.

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

A. Indications and Documentation:

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

1. Partial or full-thickness skin ulcers due to venous insufficiency or full-thickness neuropathic diabetic foot ulcers
2. Ulcers of greater than three (3) months duration

3. Ulcers that have failed to respond to documented conservative measures of greater than two (2) months duration.

4. There must be measurements of the initial ulcer size, the size of the ulcer following cessation of conservative management and the size at the beginning of skin substitute treatment.

5. For neuropathic diabetic foot ulcers, appropriate steps must be taken to off-load pressure during treatment and documented in the patient's medical record.

6. The ulcer must be free of infection and underlying osteomyelitis and treatment of the underlying disease (e.g., peripheral vascular disease) must be provided and documented in conjunction with skin substitute treatment.

B. Diagnosis Restrictions:

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

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

261.000 Obtaining Prior Authorization of Restricted Medical and Surgical Procedures 8-1-07

A. Certain medical and surgical procedures are covered only with prior authorization (PA). Most restricted procedures are prior authorized by the Arkansas Foundation for Medical Care, Inc. (AFMC). Refer to sections 261.100 through 261.130 for instructions on requesting PA from AFMC.

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

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

261.120 Prior Authorization of Cochlear Implant and External Sound Processor 8-1-07

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

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

261.240 Prior Authorization of Hyaluronon (sodium hyaluronate) Injection 8-1-07

A. Prior authorization is required for coverage of the Hyaluronon (sodium hyaluronate) injection in the physician's office. Providers must specify the brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code (J7319).

B. A written request must be submitted to Division of Medical Services Utilization Review Section. **View or print the Division of Medical Services Utilization Review Section address.**

C. The request must include the patient's name, Medicaid ID number, physician's name, physician's provider identification number, patient's age, and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one series of injections per knee, per beneficiary, per lifetime.

262.000 Procedures That Require Prior Authorization 8-1-07

The following procedure codes require prior authorization:

Procedure Codes							
00170	01966	11960	11970	11971	15400	19318	19324
19325	19328	19330	19340	19342	19350	19355	19357
19361	19364	19366	19367	19368	19369	19370	19371
19380	20974	20975	21076	21077	21079	21080	21081
21082	21083	21084	21085	21086	21087	21088	21089
21120	21121	21122	21123	21125	21127	21137	21138
21139	21141	21142	21143	21145	21146	21147	21150
21151	21154	21155	21159	21160	21172	21175	21179
21180	21181	21182	21183	21184	21188	21193	21194
21195	21196	21198	21199	21208	21209	21244	21245
21246	21247	21248	21249	21255	21256	27412	27415
29866	29867	29868	30220	30400	30410	30420	30430
30435	30450	30460	30462	32851	32852	32853	32854
33140	33282	33284	33945	36470	36471	37785	37788
38240	38241	38242	42820	42821	42825	42826	42842
42844	42845	42860	42870	43257	43644	43645	43842
43845	43846	43847	43848	43850	43855	43860	43865
47135	48155	48160	48554	48556	50320	50340	50360
50365	50370	50380	51925	54360	54400	54415	54416
54417	55400	57335	58150	58152	58180	58260	58262
58263	58267	58270	58280	58290	58291	58292	58293
58294	58345	58550	58552	58553	58554	58672	58673
58750	58752	59135	59840	59841	59850	59851	59852
59855	59856	59857	59866	60512	61850	61860	61862
61870	61875	61880	61885	61886	61888	63650	63655
63660	63685	63688	64555	64573	64585	64809	64818
65710	65730	65750	65755	67900	69300	69310	69320
69714	69715	69717	69718	69930	87901	87903	87904

Procedure Codes							
92081	92100	92326	92393	93980	93981	J7319	J7320
J7330	J7340	L8614	L8615	L8616	L8617	L8618	L8619
S2213							

Procedure Code	Modifier	Description
E0779	RR	Ambulatory infusion device
D0140	EP	EPSDT interperiodic dental screen
J7330		Autologous cultured chondrocytes, implant
L8619	EP	External sound processor
SO512*		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
Z1930		Non-emergency hysterectomy following c-section
92002*	UB	Low vision services – evaluation

*Procedures payable to physicians under 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 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.

292.110 Non-covered CPT Procedure Codes 8-1-07

The following is a list of CPT procedure codes that are non-covered by the Arkansas Medicaid Program to providers of Physician/Independent Lab/CRNA/Radiation Therapy Center services. Some procedure codes are non-payable, but the service is payable under another procedure code. Refer to Special Billing Procedures, sections 292.000 through 292.860.

Procedure Codes							
01953	01968	01969	11900	11901	11920	11921	11922
11950	11951	11952	11954	15775	15776	15780	15781
15782	15783	15786	15787	15819	15820	15821	15822
15823	15824	15825	15826	15828	15829	15832	15833
15834	15835	15836	15837	15838	15839	15876	15877
15878	15879	17360	17380	21497	27193	27591	27881
28531	32850	32855	32856	33930	33933	33935	33940

Procedure Codes							
33944	36416	36468	36469	36540	43265	43770	43771
43772	43774	43886	43887	43888	44132	44133	44135
44136	44715	44720	44721	44979	45520	46500	47133
47136	47143	47144	47145	47146	47147	48551	48552
49400	50300	50323	50325	50327	50328	50329	54401
54405	54406	54408	54410	54411	54660	54900	54901
55870	55970	55980	56805	57170	58321	58322	58323
58970	58974	58976	59072	59430	59898	65760	65771
65781	65782	68340	69090	69710	69711	76948	78890
78891	80103	83087	84061	87001	87003	87472	87477
87902	88000	88005	88007	88012	88014	88016	88020
88025	88027	88028	88029	88036	88037	88040	88045
88099	88188	88189	89250	89251	89253	89254	89255
89257	89258	89259	89260	89261	89264	89268	89272
89281	89290	89291	89335	89342	89343	89344	89346
89352	89353	89354	89356	90378	90379	90384	90465
90466	90467	90468	90471	90472	90473	90474	90476
90477	90586	90680	90693	90717	90719	90723	90725
90727	90736	90760	90761	90773	90783	90845	90846
90865	90875	90876	90880	90885	90887	90889	90901
90911	90918	90919	90920	90921	91060	92065	92070
92285	92310	92311	92312	92313	92314	92315	92316
92317	92325	92326	92330	92335	92340	92341	92342
92352	92353	92354	92355	92358	92370	92371	92592
92593	92596	92597	92605	92606	92609	93668	93701
93797	93798	94452	94453	94660	94662	94667	94668
94762	95078	95250	95806	96000	96001	96002	96003
96004	96102	96103	96110	96116	96150	96151	96152
96153	96154	96155	97002	97004	97005	97006	97010
97012	97014	97016	97018	97020	97022	97024	97026
97028	97032	97033	97034	97035	97036	97039	97112
97113	97116	97124	97139	97140	97530	97532	97535
97537	97542	97545	97546	97755	97802	97803	97804
97810	97811	97813	97814	99000	99001	99002	99024
99026	99027	99056	99070	99071	99075	99078	99080
99090	99091	99239	99261	99262	99263	99315	99316

Procedure Codes							
99324	99325	99326	99327	99328	99334	99335	99336
99337	99339	99340	99344	99345	99350	99358	99359
99361	99362	99371	99372	99373	99374	99375	99377
99378	99379	99380	99386	99387	99396	99397	99403
99404	99411	99412	99420	99429	99431	99433	99435
99450	99455	99456	99499	99500	99501	99502	99503
99504	99505	99506	99507	99509	99510	99511	99512

292.200 Physician Place of Service Codes and Modifiers 8-1-07

Arkansas Medicaid's claims processing system recognizes valid national CPT/HCPCS modifiers.

292.440 Anesthesia Services 8-1-07

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

Reimbursement for use and administration of local or topical anesthesia is included in the primary surgeon's reimbursement for the surgery that requires such anesthesia. No modifiers or time may be billed with these procedures.

A. Electronic Claims

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

B. Paper Claims

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

C. The following national CPT procedure code for abortion and locally assigned procedure code for anesthesia for abdominal hysterectomy are to be billed on CMS-1500 paper claims only because they require attachments.

National Code	Local Code	Description	Documentation Required
01966*		Anesthesia for induced abortion procedures Use for billing anesthesia service for all elective, induced abortions, including abortions performed for rape or incest	Certification Statement for Abortion (DMS-2698) (See sections 251.220, 261.000, 261.100, 261.200 and 261.260 of this manual.) **View or print form DMS-2698 and instructions for completion.**
None	Z9940	Anesthesia for Abdominal Hysterectomy	Acknowledgement of Hysterectomy (DHS-2606) **View or print form DMS-2606 and instructions for completion.**

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

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

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

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

Only one anesthesia service is billable for Arkansas Medicaid as the anesthesia for a delivery. The anesthesia service ultimately provided should contain all charges for the anesthesia. No add-on codes are payable.

292.511 Home Peritoneal Dialysis – Physician's Professional Services 8-1-07

Arkansas Medicaid covers peritoneal dialysis performed by an appropriately trained patient and/or caregiver in the home setting. Additionally, Medicaid will cover up to 15 training sessions for home dialysis candidates provided by the ESRD facility or outpatient hospital clinic certified by Medicare to provide home peritoneal dialysis and training.

Physician services for home peritoneal dialysis and training include selection of patients to receive home dialysis training and oversight of the training provided by the clinic. Medicaid may cover additional training when medically necessary and requested in writing by the patient's attending physician.

Home Dialysis – Physicians Professional Services must be billed using procedure code **90989** for individuals completing the course and **90993** when the course is not completed.

292.552 Family Planning Services for Beneficiaries in Limited Aid Category 69 8-1-07

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

Covered family planning procedures furnished to beneficiaries in aid category 69 are payable to physicians and must be billed with a modifier **"FP**

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

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

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

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

When filing family planning claims for physician services in an outpatient clinic, use modifier **U6** for the basic family planning visit and the periodic family planning visit

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

58605	58611	58661	58700	S0612

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

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

   Sterilization procedure code **58565** requires billing on a paper claim with modifier **FP.**

   To file electronic claims for professional services codes **99144** and **99145**, use modifier **FP**. On paper claims use modifier **FP**. Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis.

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

   NOTE: For payment to be allowed for 99144 and 99145 for family planning, beneficiary claim history must show a paid or pending claim for 58565

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

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

      Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis.

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

      Whether billing on paper or electronically, a family planning diagnosis code must be listed as primary on each detail.

      NOTE: For payment to be allowed for 58340, 58345, 72190, 74740, 0r 74742, beneficiary claim history must show a paid or pending claim for 58565. The date of service for the post Essure procedure codes listed in the previous statement must be within 6 months after the date of service of 58565.

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

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

292.561 Genetic Testing 8-1-07

Medicaid reimburses physicians for the following genetic testing procedures.

S3840	S3842	S3843	S3844	S3846	S3847	S3848	S3849
S3850	S3851	S3853	83898	83904	83894		

292.575 EPSDT Screenings and Sick Visits 8-1-07

Screenings performed on the same date of service as an office visit for treatment of an acute or chronic condition may be billed as a periodic EPSDT screening, electronically or on paper using the Form DMS-694. **View a DMS-694 sample form.**

Effective for dates of service on and after May 1, 2006, a Child Health Services screening performed during an office visit for treatment of an acute or chronic condition may be billed as a separate visit for the same date of service using a CPT evaluation and management procedure code. Do not use modifiers on the sick visit procedure code. The visit must be billed electronically, or on paper using form CMS-1500**.** **View a form CMS-1500 sample form.**

292.580 Hysterectomies 8-1-07

Physicians may use procedure code **Z0663** when billing for a total hysterectomy procedure when the diagnosis is malignant neoplasm or severe dysplasia. Procedure code **Z0663** does not require prior authorization. All hysterectomies require paper billing using claim form CMS-1500. Form DMS-2606 must be properly signed and attached to the claim form.

Procedure code **59525** is covered for emergency hysterectomy **immediately** following C-section. It requires no PA but does require form DMS-2606 and an operative report/discharge summary to confirm the emergency status.

Procedure code Z1930 for non-emergency hysterectomy after C-section requires a PA. The claim must be filed on paper with required attachments. **See sections 261.000-261.100.**

292.590 Injections 8-1-07

Providers billing the Arkansas Medicaid Program for covered injections should bill the appropriate CPT or HCPCS procedure code for the specific injection administered. The procedure codes and their descriptions may be found in the CPT coding book, in the HCPCS coding book and in this section of this manual.

Most of the covered drugs can be billed electronically. **However, any drug marked with an asterisk (*) must be billed on paper with the name of the drug and dosage listed in the "Procedures, Services, or Supplies" column, Field 24D, of the CMS-1500 claim form.** **View a CMS-1500 sample form.** If requested, additional documentation may be required to justify medical necessity. Reimbursement is based on the "Red Book" drug price. If preferred, a copy of the invoice verifying the provider's cost of the drug may be attached to the Medicaid claim form.

292.591 Injections and Therapeutic Agents 8-1-07

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

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

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

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

Procedure Codes							
J0120	J0128	J0190	J0200	J0205	J0207	J0210	J0256
J0278	J0280	J0285	J0287	J0288	J0289	J0290	J0295
J0300	J0330	J0350	J0360	J0380	J0390	J0456	J0460
J0470	J0475	J0476	J0500	J0515	J0520	J0530	J0540
J0550	J0560	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	J1652	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

Procedure Codes							
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	J9041	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	J9181	J9182	J9185
J9190	J9200	J9201	J9202	J9206	J9208	J9209	J9211
J9212	J9213	J9214	J9215	J9216	J9217	J9218	J9230
J9245	J9260	J9263*	J9264	J9265	J9266	J9268	J9270
J9280	J9290	J9291	J9300	J9305	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.

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

292.592 Other Covered Injections and Immunizations with Special Instructions 8-1-07

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
C9232*		Requires ICD-9-CM diagnosis code of 277.5. Evaluation by physician with specialty in clinical genetics, documenting progress required annually. Requires prior approval letter from DMS Medical Director attached to each claim.
C9233*		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.
C9235*		Requires ICD-9-CM diagnosis code of 153.0 – 154.8. Prior approval letter from DMS Medical Director required with copy

Procedure Code	Modifier(s)	Special Instructions
		attached to each claim.
C9350*		Requires attachment of manufacturer's invoice and procedure report to each claim.
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, Rimicade, 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 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 244.001 for additional coverage information and instructions for requesting prior approval.
J0348		Valid for any condition below, along with ICD-9-CM diagnosis code of 112.5 or 112.8 (and any valid 5th 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) or (3) Post transplant status (i.e., ICD-9CM diagnosis code 986.80-996.89) or specify transplanted organ and transplant date
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*		Caspofungin acetate injection is covered when administered to patients with refractory aspergillosis who also have a diagnosis of malignant neoplasm or HIV disease. Complete history and physical exam, documentation of failure with other conventional therapy and dosage must be submitted with invoice. After 30 days

<table>
<tr><th>Procedure Code</th><th>Modifier(s)</th><th>Special Instructions</th></tr>
<tr><td></td><td></td><td>of use, an updated medical exam and history must be submitted.</td></tr>
<tr><td>J0702</td><td></td><td>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)</td></tr>
<tr><td>J0881
J0885</td><td></td><td>Payable on electronic and paper claims. Effective for dates of service on and after August 1, 2007, for non-ESRD use.

Covered by Medicaid only with primary ICD-9-CM diagnosis code of 285.9, used to indicate symptomatic anemia. Secondary ICD-9-CM diagnosis codes are V58.11, encounter for antineoplastic chemotherapy, V67.2, following chemotherapy, or E933.1, antineoplastic and immunosuppressive drugs.

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.

<table>
<tr><th>Primary Diagnosis</th><th colspan="2">Secondary Diagnosis</th></tr>
<tr><th></th><th>Code</th><th>Description</th></tr>
<tr><td>285.9 Secondary Anemia</td><td>V58.11</td><td>Encounter for antineoplastic chemotherapy</td></tr>
<tr><td></td><td>V67.2</td><td>Following chemotherapy</td></tr>
<tr><td></td><td>E933.1</td><td>Antineoplastic and immunosuppressive drugs</td></tr>
</table>

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.

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.

<table>
<tr><th>Primary Diagnosis</th><th colspan="2">Secondary Diagnosis</th></tr>
<tr><th></th><th>Code</th><th>Description</th></tr>
<tr><td>285.29 Anemia of other chronic disease</td><td>070.54</td><td>Chronic Hepatitis C without mention of coma</td></tr>
<tr><td></td><td>238.72-238.75</td><td>Myelodysplastic</td></tr>
<tr><td></td><td>714.0-714.4</td><td>Rheumatoid Arthritis</td></tr>
</table>
</td></tr>
<tr><td>J0882
J0886</td><td></td><td>Payable for dates of service on and after March 1, 2006. Covered when administered to patients diagnosed with ESRD (diagnosis range 584 – 586).</td></tr>
<tr><td>J0894*</td><td></td><td>Requires ICD-9-CM diagnosis codes of 205.00-205.91, 238.71-238.76, or 238.79 or 281.3. Prior approval letter from DMS Medical Director required to be attached to each claim. Refer to 244.100 for information regarding requesting prior approval.</td></tr>
</table>

Procedure Code	Modifier(s)	Special Instructions
J1270		Payable for beneficiaries with diagnosis codes 042,140.0 -208.91 + 787.2 + 588.81; or ESRD 584 – 586 +787.2+ 588.81. TOS 1. Claims will be manually reviewed prior to reimbursement. Payable only to physicians in their offices.
J1440 J1441		Payable for beneficiaries of all ages with no diagnosis restrictions.
J1458*		Payable for treatment of mucopolysaccharidosis (MPS IV), diagnosis code 277.5. Prior approval 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.
J1562		Payable for all ages without diagnosis restriction.
J1566 J1567		Electronic and paper 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 beneficiaries with ICD-9-CM detail diagnosis 277.1).
J1650		Payable for all ages with no diagnosis restriction.
J1745*		Effective for dates of service on and after 05/20/06, **J1745** is payable without an approval letter for beneficiaries under age 18 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. For beneficiaries age 18 years and older, procedure code **J1745** is payable when one of the following conditions exist: 1) ICD-9-CM code 555.9 as the primary detail diagnosis **AND** a secondary diagnosis of 565.1 or 569.81 **OR** 2) ICD-9-CM code range 556.0 – 556.9 **OR** 3) ICD-9-CM code 696.0 **OR**

Procedure Code	Modifier(s)	Special Instructions
		4) ICD-9-CM code 714.0 **NOTE:** ICD-9 diagnosis code 714.0 requires a prior approval letter from the Medical Director. The request for approval must include documentation showing failed trial of Enbrel or Humira. Claims must be submitted to EDS with any applicable attachments. Claims will be manually reviewed by Medicaid medical staff prior to payment. **OR** 5) ICD-9-CM 724.9. **NOTE:** ICD-9 diagnosis code 724.9 requires a prior approval letter from the Medical Director. The request for approval must include documentation showing failed trial of Enbrel or Humira. Claims must be submitted to EDS with any applicable attachments. Claims will be manually reviewed by Medicaid medical staff prior to payment.
J1751 J1752		Effective for dates of service on and after March 1, 2006, procedure codes J1750 became non-payable and was replaced with procedure codes J1751 and J1752. These services are payable for beneficiaries with a diagnosis of ICD-9-CM code 280.9.
J1785*		This procedure is covered for the treatment of Type I Gaucher disease with complications, with a detail diagnosis of ICD-9 code 272.7. A prior approval letter from the DMS Medical Director is required. See section 244.001 for additional coverage information and instructions for requesting prior approval. A copy of the prior approval letter must be attached to each claim.
J1931*		This procedure is covered for treatment of mucopolysaccharidosis (MPS I), ICD-9-CM diagnosis code 277.5. Prior approval from DMS Medical Director is required. See section 244.001 for additional coverage information and instructions for requesting prior approval. A copy of the prior approval letter must be attached to each claim.
J2260		Payable for Medicaid beneficiaries of all ages with congestive heart failure (ICD-9 diagnosis codes 428-428.9)
J2353* J2354*		Payable for Medicaid beneficiaries of all ages. For ages 21 and older, J2353 and J2354 are covered for diagnosis of aids and cancer (ICD-9-CM diagnosis codes 140.0 – 208.91, 230.0 – 238.9 or 042). For other diagnoses, a prior approval letter is required and must be attached to each claim. See section 244.100 for information of requesting a prior approval letter. Paper billing is required for all diagnoses for all beneficiaries.
J2503		Payable for beneficiaries diagnosed with macular degeneration (ICD-9-CM diagnosis code 362.50 – 362.52).
J2504		Payable for beneficiaries of all ages with a primary detail diagnosis of 279.2.
J2505*		Payable for beneficiaries of all ages with a detail diagnosis from

Procedure Code	Modifier(s)	Special Instructions
		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.
J2788		Payable for beneficiaries of all ages with no diagnosis restrictions. Billable electronically or on paper.
J2790		Payable for beneficiaries of all ages with no diagnosis restrictions. Billable electronically or on paper.
J2792		Payable without restriction. Billable electronically or on paper.
J2910		Payable for patients with a primary detail diagnosis of rheumatoid arthritis (ICD-9 diagnosis codes 714.0 – 714.9).
J2916		Payable for beneficiaries aged 21 and older when there is a diagnosis of cancer, AIDS, or acute renal failure with a primary diagnosis on the claim that is 964.0 indicating that the beneficiary is allergic to iron dextran. May be billed electronically or on paper.
J2997		Payable for beneficiaries of all ages with no diagnosis restrictions. Limited to 2 units per day in the office place of service.
J3396		Covered for all ages if one of the following diagnoses exist: ICD-9 diagnosis code 362.50 or 362.52; **or** ICD-9 diagnosis code 360.21; **or** ICD-9 diagnosis code 115.02 **or** 115.12 or 115.92. Claims may be filed electronically or on paper. See section 244.002 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 aged 18 and older with a diagnosis of AIDS or cancer and one of the following diagnoses: 112.2, 112.3, 112.5, 112.84, 112.85, 112.9 or 117.3. Claims must be filed on paper.
J3487		Payable to physicians when provided in the office if one of the following diagnoses exist: 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.
J7198		Payable for all ages with no diagnosis restrictions.
J7199		Must be billed on a paper claim form with the name of the drug, dosage and the route of administration.
J7319		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

Procedure Code	Modifier(s)	Special Instructions
		sections 260.000, 261.000, 261.100 and 261.110.
J7346		Requires submission of operative report with each claim.
J7341		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7515		Payable for beneficiaries of all ages with no diagnosis restrictions.
J9025		Coverage of this procedure code requires an ICD-9-CM diagnosis within the code range of 205.00 – 205.91 with applicable 4th and 5th digits per ICD-9-CM, **or** a diagnosis of 238.7.
J9035*		Coverage of this procedure code requires an ICD-9-CM diagnosis within the code range of 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, 202.8, and 202.3. 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 153.0 – 154.8 or 140.0 – 140.9, 160.0 – 161.9, 171.0, 172.0 – 172.4 or 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.
J9225		Payable for beneficiaries with a diagnosis of malignant neoplasm of prostate (ICD-9-CM code 185).
J9250		Payable for beneficiaries of all ages without restriction.
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

Procedure Code	Modifier(s)	Special Instructions
		regimens. Prior approval letter from DMS Medical Director required.
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.
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 162.9 or 183.0. Billable on electronic and paper claims.
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.
Q3025 Q3026		These procedure codes are covered for all ages based on medical necessity.
Q4079*		Procedure requires a prior approval letter. See section 244.100. The history and physical showing a relapse of multiple sclerosis must be submitted with the request for the prior approval letter. This procedure must be billed on a paper claim. The approval letter must be attached to each claim. Requires review before payment.
S0145 S0146		Procedures are payable when there is a primary detail diagnosis ICD-9-CM 070.54
S0147		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

Procedure Code	Modifier(s)	Special Instructions
		Director required and must be attached to each claim. See 244.100 for information regarding acquiring the prior approval letter.
S0180	FP	Covered as a family planning benefit for regular full-coverage Medicaid beneficiaries. Not covered in family planning aide category 69. Benefit limited to two per seven years per beneficiary. A primary family planning diagnosis is required.
Z1847		Torecan oral tablets. Limit of 4 10mg tabs per day.
90371		One unit equals 1/2 cc, with a maximum of 10 units payable per day. Payable for Medicaid beneficiaries of all ages in the physician's office.
90375* 90376*		Covered for all ages. Billing requires paper claims with procedure code and dosage entered infield 24.D of claim form CMS-1500 for each date of service. If date spans are used, units of service must be identical for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.
90385		Limited to one injection per pregnancy.
90581*		Payable for ages 18 years and older. Indicate dose and attach manufacturer's invoice.
90585		Payable for all ages.
90586		Payable for ages 18 years and older.
90632		Payable when administered to beneficiaries ages 19 years and older.
90633 90634	EP, TJ	Payable when administered to beneficiaries ages 12 months – 18 years. See section 292.593.
90636	EP, TJ	Payable when administered to beneficiaries age 18 years and older. Modifiers are required only when administered to beneficiaries aged 18 years. See section 292.593.
90645 90646 90647	EP, TJ	Payable when administered to beneficiaries of all ages. See section 292.593 for billing instructions when administered to beneficiaries aged 18 years and younger.
90648	EP, TJ	Payable when administered to beneficiaries aged 18 years and younger. Refer to section 292.593 for more information.
90655 90657	EP, TJ	Influenza vaccines payable through the VFC program for beneficiaries 6 – 35 months of age. See section 292.593 for billing instructions.
90656 90658	EP, TJ	Influenza vaccines payable for beneficiaries aged 3 years and older. Modifiers required only when administered to children under age 19. Refer to sections 292.593 and 292.594 for influenza vaccine policy.
90660	EP, TJ	Covered for healthy individuals aged 5-49 and not pregnant. Modifiers required only when administered to beneficiaries under age 19. See sections 292.593 and 292.594 of this manual.
90665		Payable when administered to beneficiaries ages 19 years and older.

Procedure Code	Modifier(s)	Special Instructions
90669	EP, TJ	Administration of vaccine is covered for children under age 5 years. See section 292.593 for billing instructions.
90675* 90676*		Covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in field 24.D of claim form CMS-1500 for each date of service. If date spans are used, appropriate units of service must be indicated and must be identical for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.
90680	EP, TJ	VFC vaccine payable when administered to beneficiaries ages 6 weeks – 32 weeks. See section 292.593 for more information.
90690		Payable for beneficiaries ages 6 years and older.
90691		Payable for beneficiaries aged 3 years and older.
90698		Payable for beneficiaries aged 0 – 7 years.
90700	EP, TJ	VFC vaccine payable when administered to beneficiaries under age 7 years. Modifiers are required. See section 292.593 for more information.
90703		Payable for 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.
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

Procedure Code	Modifier(s)	Special Instructions
		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 19years. See section 292.593.
90719		This vaccine is covered for individuals of all ages.
90721	EP, TJ	Covered for beneficiaries under age 21 years. Modifiers are required only when administered to beneficiaries under age 19 years. See section 292.593.
90723	EP, TJ	Covered for beneficiaries under age 19 years. See section 292.593.
90725*		Payable for all ages; submit manufacturer's invoice.
90727*		Payable for all ages; submit manufacturer's invoice.
90732		This code is payable for individuals aged 2 years and older. Patients age 21 years and older who receive the injection must be considered by the provider as high risk. All beneficiaries over age 65 may be considered high risk.
90733		Covered for beneficiaries of all ages.
90734	EP, TJ	Covered for beneficiaries of all ages. Modifiers are required only when administered to beneficiaries under age 19 years. See section 292.593.
90735		Payable for individuals under age 21 years.
90740		Three dose schedule. Payable for individuals of all ages.
90743	EP, TJ	Two dose schedule. Payable only when administered to children aged 0 – 18 years. See section 292.593.
90744	EP, TJ	Three dose schedule. Payable for ages 0 – 18 years. See section 292.593.
90746		Payable for ages 19 years and older.
90747	EP, TJ	Covered for beneficiaries of all ages. Modifiers are required **only** when administered to beneficiaries under age 19 years. See section 292.593.
90748	EP, TJ	Covered for beneficiaries of all ages. Modifiers are required **only** when administered to beneficiaries under age 19 years. See section 292.593.

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

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

A. Less than two months of antepartum care was provided

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

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

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

National Codes			
59410	59515	59614	59622

Procedure code **Z1930**, non-emergency hysterectomy after C-section, requires prior authorization from the Arkansas Foundation for Medical Care (AFMC). Refer to section 292.580 for billing instructions for emergency and non-emergency hysterectomy after C-section.

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

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

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

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

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

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

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

292.801 Cochlear Implant and External Sound Processor 8-1-07

Procedure code **69930** - Cochlear device implantation, with or without mastoidectomy - may be billed only by the physician performing the surgical procedure. When the cochlear device is provided by the physician, the physician may bill procedure code **L8614** for the cochlear device using **EP** modifier. Paper claims require a modifier **EP** for the device. Procedure code **69930** and **L8614** require prior authorization. The physician must attach a copy of the invoice to the

CMS-1500 claim form. If the cochlear device is provided by the hospital, the physician may not bill for the device. Refer to Section 251.230 of this manual for coverage information.

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

Procedures are covered for beneficiaries under age 21 and must be billed with modifier **EP.**

View a CMS-1500 sample form.

292.813 Telemedicine Echography and Echocardiography Procedure Codes 8-1-07

Arkansas Medicaid reimburses as telemedicine services, the radiology procedures listed in this subsection when the services are billed by their correct procedure codes and place of service codes as listed and defined in Sections 292.812 through 292.814.

A. The local site may bill only the technical component of the ultrasound procedures listed below. The TOS (paper only) for a telemedicine technical component is Y.

B. If the professional component of the service is performed at the remote site in real time, the TOS (paper only) for that service is W.

C. Please note that, when billing for remote site services, the place of service code is determined by the patient's location or by the patient's inpatient status, as explained at Section 292.812, subpart E.

Procedure Code	TOS (paper only) Local Site	TOS (paper only) Remote Site
76801	Y	W
76802	Y	W
76805	Y	W
76810	Y	W
76811	Y	W
76812	Y	W
76815	Y	W
76816	Y	W
76817	Y	W
76818	Y	W
76825	Y	W
76826	Y	W
76827	Y	W
76828	Y	W
76830	Y	W
76856	Y	W
76857	Y	W