Arkansas Department
Of Health and Human Services
Division of Medical Services

P.O. Box 1437, Slot S295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

OFFICIAL NOTICE

DMS-2007-A-2	**DMS-2007-G-1**	**DMS-2007-SS-1**	**DMS-2007-QQ-2**
DMS-2007-AR-2	**DMS-2007-CA-1**	**DMS-2007-DD-1**	**DMS-2007-YY-1**
DMS-2007-0-2	**DMS-2007-Z-1**	**DMS-2007-KK-2**	**DMS-2007-YC-1**
DMS-2007-HH-1	**DMS-2007-II-3**	**DMS-2007-R-3**	**DMS-2007-OO-2**
DMS-2007-C-1	**DMS-2007-L-3**	**DMS-2007-EE-1**	**DMS-2007-SB-1**
			DMS-2007-U-1

TO: **Health Care Provider –Ambulatory Surgical Center; ARKids First-B; Certified Nurse-Midwife; Certified Registered Nurse Anesthetists (CRNA); Child Health Management Services (CHMS); Child Health Services (EPSDT); Critical Access Hospital; End Stage Renal Disease; Federally Qualified Health Center (FQHC); Hospital; Independent Labs; Licensed Mental Health Practitioner (LMHP); Nurse Practitioner; Physician; Podiatrist; Radiation Therapy Center; Rehabilitative Services for Persons with Mental Illness (RSPMI); Rehabilitative Services for Youth and Children (RSYC); Rural Health Clinic (RHC); School-Based Mental Health Services; Visual Care and Arkansas Division of Health.**

DATE: **March 1, 2007**

SUBJECT: **2007 Current Procedural Terminology (CPT) Procedure Code Conversion**

I. General Information

A review of the 2007 CPT procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting *CPT 2007* procedure codes for dates of service on and after March 1, 2007. Please add this information to your Medicaid provider manual until revised manual sections have been included in future updates.

Procedure codes that are identified as deletions in the *CPT 2007* (Appendix B) are **non-payable** for dates of service on and after March 1, 2007.

II. Non-Covered *CPT 2007* Procedure Codes

A. The following CPT procedure codes are **non-covered for all providers.**

22526	**22527**	**43647**	**43648**	**43881**	**43882**	**58541**
58542	**58543**	**58544**	**70554**	**70555**	**94002**	**94003**
94004	**94005**	**94774**	**94775**	**94776**	**94777**	**96020**
96040	**99363**	**99364**				

B. All *CPT 2007* procedure codes listed in **Category II** and **Category III** are **non-covered.**

C. Effective for dates of service on and after March 1, 2007, the following new 2007 CPT procedure codes are not payable to outpatient hospital and ambulatory surgical centers because these services are covered by another CPT procedure code, another HCPCS code or a revenue code.

15003	**15005**	**15847**	**17312**	**17314**
17315	**35306**	**49326**	**49435**	**94645**

III. Prior Authorization

The following 2007 CPT procedure codes require prior authorization (PA).

15830	**15847**	**76813**	**76814**

IV. *CPT 2007* Procedure Codes Manually Reviewed

Effective for dates of service on and after March 1, 2007, the CPT procedure codes listed below are manually reviewed before payment. Providers must submit paper claims with supporting documentation.

37210	**58548**	**91111**

V. Podiatry Program

The following *CPT 2007* procedure codes are payable to podiatry providers.

15002	**15003**	**15004**	**15005**
17311	**17312**	**17315**	

VI. Oral Surgery Program

The following *CPT 2007* procedure codes are payable to oral surgeons.

15004	**15005**	**17311**	**17312**	**17315**

Thank you for your participation in the Arkansas Medicaid Program.

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 (TDD only)

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

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

Roy Jeffus, Director

Arkansas Department of Health and Human Services

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DMS-2007-AR-1	**DMS-2007-A-1**	**DMS-2007-ZZ-1**	**DMS-2007-X-1**
DMS-2007-II-1	**DMS-2007-I-1**	**DMS-2007-L-1**	**DMS-2007-QQ-1**
DMS-2007-R-1	**DMS-2007-J-1**	**DMS-2007-E-1**	

TO: **Health Care Providers – AHECS, ARKids-1-B, Ambulatory Surgical Center, Dental, Hemodialysis, Family Planning, Federally Qualified Health Center (FQHC), Home Health, Hospital, Independent Radiology, Oral Surgeon, Physician, Prosthetics**

DATE: **March 1, 2007**

SUBJECT: **2007 HCPCS Procedure Code Conversion**

I. **General Information**

A review of the 2007 HCPCS procedure codes has been completed and the Arkansas Medicaid Program will begin accepting updated HCPCS procedure codes on claims with dates of service on and after March 1, 2007.

II. **2007 HCPCS Payable Procedure Code Tables Information**

Procedure codes have been broken into separate tables. Tables have been created for each affected provider type (e.g.: physician, hospital etc.).

The tables of payable procedure codes are designed with nine columns of information. All columns may not be applicable for each covered program, but have been devised for ease of reference.

The first column contains the HCPCS procedure code. The procedure code may be shown on multiple lines of the table, depending on the number of types of service (TOS) for which it can be used by a provider.

The second column contains the type of service (TOS) code that may be used in conjunction with the procedure code. TOS codes are used with procedure codes billed on paper by some provider types. **This information is provided when pertinent to billing protocol.**

II. **2007 HCPCS Payable Procedure Code Tables Information (continued)**

The third column shows procedure codes that require manual pricing and is titled Manually Priced Y/N. A letter "Y" in the column indicates that an item is manually priced and an "N" shows that an item is not manually priced. **This information is provided when pertinent to billing protocol.** Providers should consult their program manual to review the process involved in manual pricing.

Certain procedure codes are covered only when the primary diagnosis is covered within a specific diagnosis range. This information is used, for example, by physicians, hospitals and others. The fourth and fifth columns indicate the beginning and ending range of diagnoses for which a procedure code may be used. (e.g.: 0530 through 0549).

The sixth column indicates whether a procedure is subject to medical review before payment. The column is titled "Review Y/N". The letter "Y" in the column indicates that a review is necessary; and an "N" indicates that a review is not necessary. Providers should consult their program manual to obtain the information that is needed for a review.

The seventh column shows procedure codes that require prior authorization (PA) before the service may be provided. The column is titled "PA Y/N". The letter "Y" in the column indicates that a procedure code requires prior authorization and an "N" indicates that the code does not require prior authorization. Providers should consult their program manual to ascertain what information should be provided for the prior authorization process.

The eighth column indicates any modifiers that must be used in conjunction with the procedure code, when billed, either electronically or on paper.

The ninth column indicates which procedure code requires a "prior approval letter" from the Arkansas Medicaid Medical Director. The letter "Y" in the column indicates that a procedure code requires a prior approval letter and an "N" indicates that a prior approval letter is not required. A prior approval letter, when required, must be attached to the paper claim when it is filed.

III. HCPCS Procedure Codes Payable to ARKids

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
E0936	H	Y			N			N

IV. HCPCS Procedure Codes Payable to Ambulatory Surgical Centers (ASC)

The following information is related to procedure codes found in the ASC table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol applies to that procedure code in the grid.

[J] J7319 Prior authorization must be obtained through the Utilization Review Section of the Division of Medical Services (DMS). Providers must specify the brand name of Hyaluronon or derivative when requesting prior authorization for this procedure code. A written request must be submitted to the Division of Medical Services Utilization Review Section.

The request must include the patient's name, Medicaid ID number, physician's name, Physician's Medicaid provider number 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.

The contact information for Utilization Review is:

In-State WATS:
Direct: (501) 682-8340
Voice Mail: 1-800-482-1141
FAX: (501) 682-8013
Mailing Address: Arkansas Division of Medical Services Utilization Review Section
P. O. Box 1437, Slot S413
Little Rock, AR 72203-1437

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
J7319[J]		Y			N	Y		Y
S2344		Y			N	N		N

V. HCPCS Procedure Codes Payable to Family Planning Clinic

Family planning services require a family planning detail diagnosis code.

The following information is related to procedure codes found in the family planning clinic table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol applies to that procedure code in the grid. A family planning diagnosis code is required.

[N] S0180 This procedure code is covered as a family planning benefit for "regular Medicaid" beneficiaries. It is not covered for aid category 69 beneficiaries. It is benefit limited to two per seven years per beneficiary.

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
S0180[N]	A	Y			N	N	FP	N

VI. HCPCS Procedure Codes Payable to Federally Qualified Health Centers (FQHC)

Family planning services require a family planning detail diagnosis code.

The following information is related to procedure codes found in the FQHC table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol applies to that procedure code in the grid. A primary family planning diagnosis code is required.

[N] S0180 This procedure code is covered as a family planning benefit for "regular Medicaid" beneficiaries. It is not covered for aid category 69 beneficiaries. It is benefit limited to two per seven years per beneficiary.

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
S0180[N]	A	Y			N	N	FP	N

VII. HCPCS Procedure Codes Payable to Hemodialysis Providers

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
Q4081		N	584	586	N	N		N

VIII. HCPCS Procedure Codes Payable to Home Health

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
T4543	H	N			N	N		N

IX. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes found in the hospital table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol applies to that procedure code in the grid.

[A] C9232 This procedure code requires an ICD-9-CM diagnosis code of 277.5 (MPSII). An evaluation by a physician with a specialty in clinical genetics, documenting progress is required annually. A prior approval letter from the DMS Medical Director is required for billing, and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions or contact the DMS Medical Director at (501)-682-9868.

[B] C9233 This procedure code requires an ICD-9-CM diagnosis code of 362.50 or 362.52 as the principle diagnosis. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[C] C9235 This procedure code requires an ICD-9-CM diagnosis code of 153.0-154.8. A prior approval letter from the DMS Medical Director is required for billing and must be attached to each claim. A copy of the prior approval letter must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[D] C9350 This procedure code requires attachment of manufacturer's invoice and procedure report to the claim.

IX. **HCPCS Procedure Codes Payable to Hospitals (continued)**

[E] J0129 This procedure code requires an ICD-9-CM diagnosis code of 714.0-714.2 as a primary diagnosis. The patient must have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs, such as methotrexate or Tumor Necrosis Factor antagonists (Humira, Remicade, etc.). The records submitted must include a history and physical exam showing (1) the severity of the rheumatoid arthritis (2) Treatment with one of the above listed drugs (3) treatment failure resulting in progression of joint destruction, swelling, or tendonitis, etc. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[F] J0348 This procedure code is covered for any of the conditions below, along with an ICD-9-CM diagnosis code of 112.5 or 112.8 (and any valid 5th digits), or 112.9.

(1) Endstage Renal Disease (ICD-9-CM diagnosis codes, 584 through 586).

OR

(2) AIDS or cancer (ICD-9-CM diagnosis codes 042, 140.0-208.9)
OR

(3) Post transplant status (i.e., ICD-9 CM diagnosis code 986.80-996.89) or specify transplanted organ and transplant date.

[G] J0894 This procedure code requires ICD-9-CM diagnosis codes of 205.00-205.91, 238.72, 238.74, 238.75, or 281.3. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[H] J1458 This procedure code requires an ICD-9-CM diagnosis code of 277.5 (MPSVI). An evaluation by a physician with a specialty in clinical genetics documenting progress is required annually. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

IX. **HCPCS Procedure Codes Payable to Hospitals (continued)**

[I] J7311 This procedure code requires an ICD-9-CM diagnosis code of 363.20. Only indications and age ranges approved by the FDA will be considered. Each request will be reviewed on a case by case basis. An evaluation by an ophthalmologist documenting failure of all other treatments and the complication of all current treatments must be clearly documented. Complications that will lead to blindness must be clearly stated. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[J] J7319 Prior authorization must be obtained through the Utilization Review Section of the Division of Medical Services (DMS). Providers must specify the brand name of Hyaluronon or derivative when requesting prior authorization for this procedure code. A written request must be submitted to the Division of Medical Services Utilization Review Section.

The request must include the patient's name, Medicaid ID number, physician's name, Physician's Medicaid provider number 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.

The contact information for Utilization Review is:

In-State WATS:
Direct: (501) 682-8340
Voice Mail: 1-800-482-1141
FAX: (501) 682-8013
Mailing Address: Arkansas Division of Medical Services Utilization Review Section
P. O. Box 1437, Slot S413
Little Rock, AR 72203-1437

[K] J7346 This procedure code requires submission of operative report with claim.

IX. **HCPCS Procedure Codes Payable to Hospitals (continued)**

[L] **J9261** This procedure code 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 two chemotherapy regimens. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[M] **S0147** This procedure code requires an ICD-9-CM diagnosis code of 271.0. An evaluation by a physician with a specialty in clinical genetics documenting progress is required annually. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[N] **S0180** This procedure code is covered as a family planning benefit for "regular Medicaid" beneficiaries. It is not covered for aid category 69 beneficiaries. It is benefit limited to two per seven years per beneficiary. A primary family planning diagnosis is required.

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
A9527		Y			N	N		N
A9568		Y			N	N		N
C9232[A]		N	2775	2775	Y	N		Y
C9233[B]		N			Y	N		Y
C9235[C]		N			Y	N		Y
C9350[D]		Y			N	N		N
J0129[E]		N			Y	N		Y
J0348[F]		N			Y	N		N
J0364		N			N	N		N
J0594		N			N	N		N
J0894[G]		N			Y	N		Y
J1324		Y			N	N		N
J1458[H]		N			Y	N		Y
J1562		Y			N	N		N
J1740		N			N	N		N
J2248		N			N	N		N
J3243		N			N	N		N

IX. HCPCS Procedure Codes Payable to Hospitals (continued)

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
J3473		N			N	N		N
J7187		N			N	N		N
J7311[I]		N			Y	N		Y
J7319[J]		Y			M	Y		N
J7345		N			N	N		N
J7346[K]		N			Y	N		N
J8650		Y			N	N		N
J9261[L]		N			Y	N		Y
Q4081		N	584	586	N	N		N
S0147[M]		Y			Y	N`		Y
S0180[N]		Y			N	N		N
S2344		Y			N	N		N

X. HCPCS Procedures Codes Payable to Independent Radiology

The following information is related to certain codes found within the independent radiology section below.

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
A9527	1	Y			N	N		N
A9568	1	Y			N	N		N

XI. HCPCS Procedure Codes Payable to Oral Surgeons

The following information is related to procedure codes found in the oral surgeon section table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol applies to that procedure code in the grid.

[D] C9350 This procedure code requires attachment of manufacturer's invoice and procedure report to the claim.

[K] J7346 This procedure code requires submission of operative report with claim.

XI. HCPCS Procedure Codes Payable to Oral Surgeons (continued)

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
C9350[D]	1	Y			N	N		N
J7345	1	N			N	N		N
J7346[K]	1	N			Y	N		N

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

The following information is related to procedure codes found in the physicians and AHECs section table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol applies to that procedure code in the grid.

[A] C9232 This procedure code requires an ICD-9-CM diagnosis code of 277.5 (MPSII). An evaluation by a physician with a specialty in clinical genetics, documenting progress is required annually. A prior approval letter from the DMS Medical Director is required for billing, and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions or contact the DMS Medical Director at (501)-682-9868.

[B] C9233 This procedure code requires an ICD-9-CM diagnosis code of 362.50 or 362.52 as the principle diagnosis. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[C] C9235 This procedure code requires an ICD-9-CM diagnosis code of 153.0-154.8. A prior approval letter from the DMS Medical Director is required for billing and must be attached to each claim. A copy of the prior approval letter must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[D] C9350 This procedure code requires attachment of manufacturer's invoice and procedure report to the claim.

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

[E] J0129 This procedure code requires an ICD-9-CM diagnosis code of 714.0-714.2 as a primary diagnosis. The patient must have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs, such as methotrexate or Tumor Necrosis Factor antagonists (Humira, Remicade, etc.). The records submitted must include a history and physical exam showing (1) the severity of the rheumatoid arthritis (2) Treatment with one of the above listed drugs (3) treatment failure resulting in progression of joint destruction, swelling, or tendonitis, etc. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[F] J0348 This procedure code is covered for any of the conditions below, along with an ICD-9-CM diagnosis code of 112.5 or 112.8 (and any valid 5th digits), or 112.9.

(1) Endstage Renal Disease (ICD-9-CM diagnosis codes, 584 through 586)

OR

(2) AIDS or cancer (ICD-9-CM diagnosis codes 042, 140.0-208.9)

OR

(3) Post transplant status (i.e., ICD-9 CM diagnosis code 986.80-996.89) or specify transplanted organ and transplant date.

[G] J0894 This procedure code requires ICD-9-CM diagnosis codes of 205.00-205.91, 238.72, 238.74, 238.75, or 281.3. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[H] J1458 This procedure code requires an ICD-9-CM diagnosis code of 277.5 (MPSVI). An evaluation by a physician with a specialty in clinical genetics documenting progress is required annually. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

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

[J] **J7319** Prior authorization must be obtained through the Utilization Review Section of the Division of Medical Services (DMS). Providers must specify the brand name of Hyaluronon or derivative when requesting prior authorization for this procedure code. A written request must be submitted to the Division of Medical Services Utilization Review Section.

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

The contact information for Utilization Review is:

In-State WATS:
Direct: (501) 682-8340
Voice Mail: 1-800-482-1141
FAX: (501) 682-8013
Mailing Address: Arkansas Division of Medical Services Utilization Review Section
P. O. Box 1437, Slot S413
Little Rock, AR 72203-1437

[K] **J7346** This procedure code requires submission of operative report with claim.

[L] **J9261** This procedure code 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 two chemotherapy regimens. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

[M] **S0147** This procedure code requires an ICD-9-CM diagnosis code of 271.0. An evaluation by a physician with a specialty in clinical genetics documenting progress is required annually. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

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

[N] S0180 This procedure code is covered as a family planning benefit for "regular Medicaid" beneficiaries. It is not covered for aid category 69 beneficiaries. It is benefit limited to two per seven years per beneficiary. A primary family planning diagnosis is required.

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
A9527	1	Y			N	N		N
A9568	1	Y			N	N		N
C9232[A]	1	N	2775	2775	Y	N		Y
C9233[B]	1	N			Y	N		Y
C9235[C]	1	N			Y	N		Y
C9350[D]	1	Y			N	N		N
JO129[E]	1	N			Y	N		Y
J0348[F]	1	N			Y	N		N
JO364	1	N			N	N		N
J0594	1	N			N	N		N
J0894[G]	1	N			Y	N		Y
J1324	1	Y			N	N		N
J1458[H]	1	N			Y	N		Y
J1562	1	Y			N	N		N
J1740	1	N			N	N		N
J2248	1	N			N	N		N
J3243	1	N			N	N		N
J3473	1	N			N	N		N
J7187	1	N			N	N		N
J7319[J]	1	Y			N	Y		N
J7345	1	N			N	N		N
J7346[K]	1	N			Y	N		N
J8650	1	Y			N	N		N
J9261[L]	1	N			Y	N		Y
Q4081	1	N	584	586	N	N		N
S0147[M]	1	Y			Y	N		Y
S0180[N]	A	Y			N	N	FP	N

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

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
S2344	2	Y			N	N		N
S2344	8	Y			N	Y		N

XIII. HCPCS Procedure Codes Payable to Prosthetics

** Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.

The purchase of this wheelchair component is limited to one per five-year period for individuals age 21 and older.

+ Limited to one per 12 months.

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
A8000	H	N			N	N		N
A8000	6	N			N	N	EP	N
A8001	H	N			N	N		N
A8001	6	N			N	N	EP	N
E0936	H	Y			N	Y**		N
E0936	6	Y			N	Y**	EP	N
E2373	H	N			N	Y		N
E2373	6	N			N	Y	EP	N
E2375	H	N			N	Y		N
E2375	6	N			N	Y	EP	N
E2376	H	N			N	Y		N
E2376	6	N			N	Y	EP	N
E2377	H	N			N	Y		N
E2377	6	N			N	Y	EP	N
E2381	H	N			N	Y		N
E2381	6	N			N	Y	EP	N
E2382	H	N			N	Y		N
E2382	6	N			N	Y	EP	N
E2383	H				N	Y		N
E2383	6	N			N	Y	EP	N
E2384	H	N			N	Y		N

XIII. **HCPCS Procedure Codes Payable to Prosthetics (continued)**

2007 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Review Y/N	PA Y/N	Modifier	Prior Approval Letter Y/N
E2384	6	N			N	Y	EP	N
E2385	H	N			N	Y		N
E2385	6	N			N	Y	EP	N
E2386	H	N			N	Y		N
E2386	6	N			N	Y	EP	N
E2387	H	N			N	Y		N
E2387	6	N			N	Y	EP	N
L3915+	H	Y			N	N		N
L3915	6	Y			N	N	EP	N
L6624	H	Y			N	Y		N
L6624	6	Y			N	N	EP	N
L6703#	H	N			N	N		N
L6703	6	N			N	N	EP	N
L6704#	H	N			N	N		N
L6704	6	N			N	N	EP	N
L6706#	H	N			N	N		N
L6706	6	N			N	N	EP	N
L6707#	H	N			N	N		N
L6707	6	N			N	N	EP	N
L6708#	H	N			N	N		N
L6708	6	N			N	N	EP	N
L6709#	H	N			N	N		N
L6709	6	N			N	N	EP	N
L7007#	H	N			N	Y		N
L7007	6	N			N	N	EP	N
L7008	H	N			N	Y		N
L7008#	6	N			N	N	EP	N
L7009	H	N			N	Y		N
L7009	6	N			N	N	EP	N
T4543	H	N			N	N		N

NOTE: Procedure codes L7007 and L7008 are for replacement only.

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

The following 2007 HCPCS procedure codes are not payable because these services are covered by another CPT procedure code, another HCPCS procedure code or by a revenue code.

C1820	G0389	K0807	K0820	K0826	K0835	K0841	K0851	K0857	K0863	K0877	K0886	Q5004
C1821	G0390	K0808	K0821	K0827	K0836	K0842	K0852	K0858	K0864	K0878	K0890	Q5005
C9234	G0392	K0813	K0822	K0828	K0837	K0843	K0853	K0859	K0868	K0879	K0891	Q5006
C9351	G0393	K0814	K0823	K0829	K0838	K0848	K0854	K0860	K0869	K0880	Q5001	Q5007
C9726	G0394	K0815	K0824	K0830	K0839	K0849	K0855	K0861	K0870	K0884	Q5002	S2325
D1555	K0806	K0816	K0825	K0831	K0840	K0850	K0856	K0862	K0871	K0885	Q5003	S3855

XV. Non-Payable HCPCS Procedure Codes for the ARKids First-B Program

A8000	E2383	E2392	K0737	K0813	K0825	K0837	K0850	K0859	K0871	K0891	L6708
A8001	E2384	E2393	K0738	K0814	K0826	K0838	K0851	K0860	K0877	K0898	L6709
E2373	E2385	E2394	K0800	K0815	K0827	K0839	K0852	K0861	K0878	K0899	L7007
E2374	E2386	E2395	K0801	K0816	K0828	K0840	K0853	K0862	K0879	L3915	L7008
E2375	E2387	E2396	K0802	K0820	K0829	K0841	K0854	K0863	K0880	L6624	L7009
E2376	E2388	K0733	K0806	K0821	K0830	K0842	K0855	K0864	K0884	L6703	T4543
E2377	E2389	K0734	K0807	K0822	K0831	K0843	K0856	K0868	K0885	L6704	
E2381	E2390	K0735	K0808	K0823	K0835	K0848	K0857	K0869	K0886	L6706	
E2382	E2391	K0736	K0812	K0824	K0836	K0849	K0858	K0870	K0890	L6707	

XVI. Non-Covered HCPCS Procedure Codes

The following procedure codes are not covered by Arkansas Medicaid.

A4461	D1206	E2393	G8202	G8223	G8246	G8267	G8288	G8309	G8330	G9134	J7670	L8690
A4463	D4230	E2394	G8203	G8224	G8247	G8268	G8289	G8310	G8331	G9135	J7685	L8691
A4559	D4231	E2395	G8204	G8225	G8248	G8269	G8290	G8311	G8332	G9136	K0733	L8695
A4600	D6012	E2396	G8205	G8226	G8249	G8270	G8291	G8312	G8333	G9137	K0734	Q4082
A4601	D6091	G0380	G8206	G8227	G8250	G8271	G8292	G8313	G8334	G9138	K0735	Q5008
A8002	D6092	G0381	G8207	G8228	G8251	G8272	G8293	G8314	G8335	G9139	K0736	Q5009
A8003	D6093	G0382	G8208	G8229	G8252	G8273	88294	G8315	G8336	H0049	K0737	S0345
A8004	D7292	G0383	G8209	G8230	G8253	G8274	G8295	G8316	G8337	H0050	K0738	S0346
A9279	D7293	G0384	G8210	G8231	G8254	G8275	G8296	G8317	G8338	J2170	K0800	S0347
C9227	D7294	G8085	G8211	G8232	G8255	G8276	G8297	G8318	G8339	J2315	K0801	
C9228	D7951	G8191	G8212	G8234	G8256	G8277	G8298	G8319	G8340	J7607	K0802	
C9229	D7998	G8192	G8213	G8235	G8257	G8278	G8299	G8320	G8341	J7609	K0812	
C9230	D8693	G8193	G8214	G8236	G8258	G8279	G8300	G8321	G8342	J7610	K0898	
C9231	D9612	G8194	G8215	G8237	G8259	G8280	G8301	G8322	G8343	J7615	K0899	
C9727	E0676	G8195	G8216	G8238	G8260	G8281	G8302	G8323	G8344	J7634	L1001	
D0145	E2374	G8196	G8217	G8239	G8261	G8282	G8303	G8324	G8345	J7645	L3806	
D0273	E2388	G8197	G8218	G8240	G8262	G8283	G8304	G8325	G8346	J7647	L3808	

XVI. **Non-Covered HCPCS Procedure Codes (continued)**

D0360	E2389	G8198	G8219	G8241	G8263	G8284	G8305	G8326	G8347	J7650	L5993	
D0362	E2390	G8199	G8220	G8242	G8264	G8285	G8306	G8327	G9131	J7657	L5994	
D0363	E2391	G8200	G8221	G8243	G8265	G8286	G8307	G8328	G9132	J7660	L6611	
D0486	E2392	G8201	G8222	G8245	G8266	G8287	G8308	G8329	G9133	J7667	L6639	

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 (TDD only).

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