Division of Medical Services
Program Planning & Development

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

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

DATE: **November 1, 2008**

SUBJECT: **Provider Manual Update Transmittal #154**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
203.170	10-1-06	203.170	11-1-08
220.000	8-1-07	220.000	11-1-08
225.100	10-1-06	225.100	11-1-08
226.000	10-1-06	226.000	11-1-08
227.100	11-1-05	227.100	11-1-08
227.200	12-1-07	227.200	11-1-08
227.400	11-1-05	227.400	11-1-08
251.000	3-15-05	251.000	11-1-08
251.280	8-1-07	251.280	11-1-08
251.290	10-13-03	251.290	11-1-08
256.000	2-1-06	256.000	11-1-08
261.130	10-1-06	—	—
262.000	8-1-07	262.000	11-1-08
292.110	8-1-07	292.110	11-1-08
292.410	7-1-07	292.410	11-1-08
292.440	8-1-07	292.440	11-1-08
292.447	7-1-07	292.447	11-1-08
292.551	7-1-07	292.551	11-1-08
292.552	8-1-07	292.552	11-1-08
292.553	7-1-07	292.553	11-1-08
292.560	7-1-07	292.560	11-1-08
292.580	8-1-07	292.580	11-1-08
292.590	8-1-07	292.590	11-1-08

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
292.591	8-1-07	292.591	11-1-08
292.592	8-1-07	292.592	11-1-08
292.593	7-1-07	292.593	11-1-08
292.594	7-1-07	292.594	11-1-08
292.596	7-1-07	—	—
292.597	7-1-07	—	—
292.598	7-1-07	—	—
292.790	7-1-07	292.790	11-1-08
292.870	7-1-07	292.870	11-1-08
292.890	7-1-07	292.890	11-1-08
—	—	292.910	11-1-08

Explanation of Updates

Effective for claims received on or after November 1, 2008, the following provider manual revisions are implemented.

Section 264.000 (contents) has been updated to replace the term “Recipients” with the term “Beneficiaries.”

Section 203.170 has been updated to add the wording “for physician’s and hospital services.”

Section 220.000 has been updated to advise providers that form DMS-671 will now be used instead of AFMC form 103.

Section 225.100 has been updated to expand ICD-9-CM cancer diagnosis codes to include ranges from 230.0-238.9.

Section 226.000 has been updated to expand ICD-9-CM cancer diagnosis codes to include ranges from 230.0-238.9.

Section 227.100 has been updated to delete “Arkansas Foundation for Medical Care, Inc. (AFMC)” and to add “Q Source of Arkansas” in its place.

Section 227.200 has been updated to delete “Arkansas Foundation for Medical Care, Inc. (AFMC)” and to add “Quality Improvement Organization (QIO)” in its place.

Section 227.400 has been updated to add clarifying wording and to delete “Arkansas Foundation for Medical Care, Inc (AFMC).”

Section 251.000 has been updated to delete the reference to “(See section 251.250)” since that section is not in the manual.

Section 251.280 has been updated to add information about consent forms and to delete obsolete information.

Section 251.290 has been updated to delete the direction that “Some sterilization procedures require prior authorization if done inpatient (e.g., laparoscopic sterilization).”

Section 256.000 has been updated to delete obsolete information about coverage for this procedure.

Section 261.130 has been deleted.

Section 262.000 has been updated to include new procedure codes made payable and to delete procedure codes and modifiers no longer payable.

Section 292.110 has been updated to include new procedure codes made payable and to delete procedure codes no longer payable.

Section 292.410 has been updated to delete obsolete information from the section.

Section 292.440 has been updated to add the payable code **Z9950** and its description to the section.

Section 292.447 had been updated to add the revised example for Proper Completion of Claim to the section.

Section 292.551 has been updated to include procedure code **J7307** and its modifier and description. Obsolete language has been deleted from the section. Information has also been added to clarify Essure procedure specifications.

Section 292.552 has been updated to delete obsolete information.

Section 292.553 has been updated to delete obsolete information and asterisks.

Section 292.560 has been updated to delete obsolete information.

Section 292.580 has been updated to add the direction to “See section 251.280 for additional coverage requirement.”

Section 292.590 has been updated to advise providers that “Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See section 292.910 for further information.”

Section 292.591 has been updated to delete code **J0200** because it is not payable. Codes **J9041**, **J9263, J9264** and **J9305** are no longer included in this section, but are located in section 292.592. This section has also been updated to expand ICD-9-CM cancer diagnosis codes to include ranges from 230.0-238.9. In addition, obsolete language has been deleted.

Section 292.592 has been updated to include new procedure codes. Procedure codes that are no longer payable have been deleted. This list includes clarification of special coverage conditions for certain procedure codes. This section has also been updated to expand ICD-9-CM cancer diagnosis codes to include ranges from 230.0-238.9 for CPT codes **J0348** and **J1270**.

Section 292.593 has been updated to add new procedure codes, delete obsolete information and delete obsolete asterisks.

Section 292.594 has been updated to delete obsolete information.

Section 292.596 has been deleted from the manual. It is also deleted from the contents section.

Section 292.597 has been deleted from the manual because it is a duplicate of section 292.593. It is also deleted from the contents section.

Section 292.598 has been deleted from the manual because it is a duplicate of section 292.594. It is also deleted from the contents section.

Section 292.790 has been updated to add procedure codes, descriptions and diagnosis ranges.

Section 292.870 has been updated to inform that “the wound size description” must also be included and attached with the manufacturer’s invoice and the operative report.

Section 292.890 has been updated to include new clarifying language and expanded code ranges to bill for the Gastrointestinal Tract Imaging with Endoscopy Capsule.

Section 292.910 is a new section created to inform providers about the National Drug Codes (NDCs).

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

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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

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

Thank you for your participation in the Arkansas Medicaid Program.

____

Roy Jeffus, Director

TOC required

203.170 Physician's Role in Hospital Services 11-1-08

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

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

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

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

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

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

220.000 Benefit Limits 11-1-08

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 form DMS-671. All personal care services for beneficiaries under age 21 are reviewed by QSource of Arkansas.

225.100 Laboratory and X-Ray Services 11-1-08

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

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

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

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

1. The claims processing system automatically overrides benefit limitations for services supported by the following diagnoses:
   a. ICD-9-CM code ranges 140.0 through 208.91; and 230.0 through 238.9, or
   b. ICD-9-CM code 042; or
   c. ICD-9-CM code range 584 through 586.
2. Benefits may be extended for other conditions for documented reasons of medical necessity. Providers may request extensions of benefits according to instructions in Section 228.100 of this manual.

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

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

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

226.000 Physician Services Benefit Limit 11-1-08

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

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

1. Physician services in the office, patient's home or nursing facility.

2. Rural health clinic (RHC) encounters.
3. Medical services provided by a dentist.
4. Medical services furnished by an optometrist.
5. Certified nurse-midwife services.

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

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

1. Malignant Neoplasm ICD-9-CM code ranges 140.0 through 208.91 or 230.0-238.9
2. HIV/AIDS ICD-9-CM code 042
3. Renal Failure ICD-9-CM code range 584.5 through 586
4. Additionally, physician visits in the outpatient hospital are exempt from the extension of benefit requirements for pregnancy (ICD-9 code range 630 through 677, diagnosis codes V22.0 through V24.2 and V28.0 through V28.9

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

227.100 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services 11-1-08

Arkansas Medicaid employed retrospective review of occupational, physical and speech therapy services for beneficiaries under age 21. The purpose of retrospective review is promotion of effective, efficient and economical delivery of health care services.

The Quality Improvement Organization (QIO), QSource of Arkansas, under contract to the Arkansas Medicaid Program, performs retrospective reviews by reviewing medical records to determine if services delivered and reimbursed by Medicaid meet medical necessity requirements.

Specific guidelines have been developed for occupational, physical and speech therapy retrospective reviews. These guidelines are included for information to physicians prescribing and/or providing therapy services. The guidelines may be found in sections 227.200 through 227.320.

227.200 Occupational and Physical Therapy Guidelines for Retrospective Review 11-1-08

A. Occupational and physical therapy services are medically prescribed services for the diagnosis and treatment of movement dysfunction, which results in functional disabilities.

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.

2. The services must be of such a level of complexity, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition (See medical necessity definition in the Glossary of this manual.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical and/or occupational therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that therapy services are medically necessary, an annual evaluation must contain the following:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis applicable to specific therapy.
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger. The test results should be noted in the evaluation.
6. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child's functional mobility skills.
7. Assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
8. Signature and credentials of the therapist performing the evaluation.

C. Standardized Testing:

1. Tests used must be norm-referenced, standardized tests specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.
3. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age equivalent scores and percentage of delay cannot be used to qualify for services.
4. A score of -1.5 standard deviations or more from the mean in at least one subtest area or composite score is required to qualify for services.
5. If the child cannot be tested with a norm-referenced standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason why a standardized test could not be used must be included in the evaluation.
6. The Mental Measurement Yearbook (MMY) is the standard reference to determine reliability and validity. Refer to sections 227.210 and 227.220 for a list of standardized tests recognized by the Quality Improvement Organization (QIO) for retrospective reviews.

D. Other Objective Tests and Measures:

1. Range of Motion: A limitation of greater than ten degrees and/or documentation of how deficit limits function.

2. Muscle Tone: Modified Ashworth Scale.
3. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
4. Transfer Skills: Documented as amount of assistance required to perform transfer, e.g., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

E. Frequency, Intensity and Duration of Physical and/or Occupational Therapy Services:

Frequency, intensity and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program that can be implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.
3. Duration of Services: Therapy services should be provided as long as reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring or establishment of a home program should be implemented.

F. Progress Notes:

1. Child's name.
2. Date of service.
3. Time in and time out of each therapy session.
4. Objectives addressed (should coincide with the plan of care).
5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form measurement.
6. Progress notes must be legible.
7. Therapists must sign each date of entry with a full signature and credentials.
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

227.400 Recoupment Process 11-1-08

The Division of Medical Services (DMS), Utilization Review (UR) is required to initiate the recoupment process for all claims that the Quality Improvement Organization (QIO) has denied for not meeting the medical necessity requirement. Based on QIO findings during respective reviews, UR will initiate recoupment as appropriate.

Medicaid will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the claim has been denied.

251.000 Surgery 11-1-08

There are certain medical and surgical procedures that are not covered without prior authorization either because of federal requirements or because of the elective nature of the surgery.

Surgeons must include ten (10) days of inpatient postoperative care as part of their surgical charges. Surgeons will not be allowed to bill Medicaid separately for surgery and the follow-up care visits associated with the surgery except in the following instances:

A. The physician doing inpatient postoperative visits when he or she did not perform the surgery and is seeing the patient for a condition not related to the surgery. This "condition not related to surgery" must be reflected in the primary detail ICD-9-CM diagnosis code billed with the visit.

B. Diagnostic endoscopy procedures.

Postoperative care includes care given by a physician other than the surgeon when the care is for the same condition that necessitated the surgery. If an attending physician consults with a surgeon and following the surgery, resumes the patient's care, the attending physician may not bill Medicaid for post-op care rendered during the first ten (10) days after the surgery.

251.280 Hysterectomies 11-1-08

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.

   If the person is physically disabled and signs the consent form with an "X," two witnesses must also sign and include a statement regarding the reason the patient signed with an "X," such as stroke, paralysis, legally blind, etc

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

For hysterectomies for the mentally incompetent, the acknowledgement of sterility statement is required. A guardian must petition the court for permission to sign for the patient giving consent for the procedure to be performed. A copy of the court petition and the acknowledgement statement must be attached to the claim.

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.

251.290 Sterilization 11-1-08

A. Non-therapeutic sterilization means any procedure or operation for which the primary purpose is to render an individual permanently incapable of reproducing. Non-therapeutic sterilization is neither (1) a necessary part of the treatment of an existing illness or injury nor (2) medically indicated as an accompaniment of an operation of the female genitourinary tract. The reason the individual decides to take permanent and irreversible action is irrelevant. It may be for social, economic or psychological reasons or because a pregnancy would be inadvisable for medical reasons.

1. Prior authorization is not required for a sterilization procedure. However, all applicable criteria described in this manual must be met.

B. Federal regulations are very explicit concerning coverage of non-therapeutic sterilization. Therefore, Medicaid reimbursement will be made only when the following conditions are met:

1. The person on whom the sterilization procedure is to be performed voluntarily requests such services.
2. The person is mentally and legally competent to give informed consent.
3. The person is 21 years of age or older at the time informed consent is obtained.
4. The person to be sterilized shall not be an institutionalized individual. The regulations define “institutionalized individual” as a person who is:
    a. involuntarily confined or detained, under a civil or criminal statute in a correctional or rehabilitative facility including those for a mental illness, **or**
    b. confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

    If you have any questions regarding this requirement, contact the Arkansas Medicaid Program **before** the sterilization.
5. The person has been counseled, both orally and in writing, concerning the effect and impact of sterilization and alternative methods of birth control.

6. Informed consent and counseling must be properly documented. Only the official Form DMS-615 (4/96) - Sterilization Consent Form, properly completed, complies with documentation requirements. **View or print form DMS-615.** If the patient needs the Sterilization Consent Form (DMS-615) in an alternative format, such as large print, contact the Americans with Disabilities Act Coordinator. **View or print the Americans with Disabilities Act Coordinator contact information.**

   a. By signing the consent form, the patient certifies that she or he understands the entire process. By signing the consent form, the person obtaining consent and the physician certify that, to the best of their knowledge, the patient is mentally competent to give informed consent. If any questions concerning this requirement exist, you should contact the Arkansas Medicaid Program for clarification BEFORE the sterilization procedure is performed.

   b. The person obtaining the consent for sterilization must sign and date the form after the recipient and interpreter, if one is used. This may be done immediately after the recipient's and interpreter's signatures or it may be done at some later time, but always before the sterilization procedure. The signature will attest to the fact that all elements of informed consent were given and understood and that consent was voluntarily given.

   c. A copy of the consent form given to the recipient of a sterilization procedure must be an identical copy of the one he or she signed and dated and must reflect the signature of the person obtaining the consent.

   d. By signing the physician's statement on the consent form, the physician is certifying that shortly before the sterilization was performed, he again counseled the patient concerning the sterilization procedure. In keeping with federal interpretation of federal requirements, the State has defined "shortly before" as one week (seven days) prior to the performance of the sterilization procedure.

   The physician's signature on the consent form must be an original signature and not a rubber stamp.

7. Informed consent may not be obtained while the person to be sterilized is:

   a. In labor or during childbirth,

   b. Seeking to obtain or obtaining an abortion, or

   c. Under the influence of alcohol or other substances that affect the individual's state of awareness.

8. The sterilization must be performed at least 30 days, but not more than 180 days, after the date of informed consent. The following are exceptions to the 30-day waiting period:

   a. In the case of premature delivery, provided at least 72 hours have passed between giving the informed consent and performance of the sterilization procedure and counseling and informed consent was given at least 30 days before the expected date of delivery and

   b. In the case of emergency abdominal surgery, provided at least 72 hours have passed between giving of informed consent and the performance of the sterilization procedure.

   NOTE: Either of these exceptions to the 30-day waiting period must be properly documented on the DMS-615.

9. The person is informed, prior to any sterilization discussion or counseling, that no benefits or rights will be lost as a result of refusal to be sterilized and that sterilization is an entirely voluntary matter. This should be explained again just prior to the performance of the sterilization.

10. If the person is physically disabled and signs the consent form with an "X," two witnesses must also sign and include a statement regarding the reason the patient signed with an "X," such as stroke, paralysis, legally blind, etc. If a claim is received which does not have the statement attached, the claim will be denied.

C. A copy of the properly completed Sterilization Consent Form DMS-615, with all items legible, must be attached to each claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists and assistant surgeons. **It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist and assistant surgeon.**

Though prior authorization is not required, an improperly completed Sterilization Consent Form DMS-615 results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met.

View or print form DMS-615 and checklist.

256.000 Gastrointestinal Tract Imaging with Endoscopy Capsule 11-1-08

A. Arkansas Medicaid covers wireless endoscopy capsule for diagnosis of occult gastrointestinal bleeding in the anemic patient under the conditions listed below.

1. The site of the bleeding has not been identified by previous gastrointestinal endoscopy, colonoscopy, push endoscopy or other radiological procedures.
2. An abnormal x-ray of the small intestine is documented without an identified site of bleeding by endoscopic means.
3. Diagnosis of angiodysplasias of the GI tract is suspected, or
4. Individuals with confirmed Crohn's disease to determine whether there is involvement of the small bowel.

B. This procedure is covered for individuals of all ages based on medical necessity when performed with FDA-approved devices and by providers formally trained in upper and lower endoscopies.

C. Documentation of medical necessity requires a primary detail diagnosis of one of the following ICD-9CM diagnosis codes: 280.9, 555.0-555.9, 578.1, 578.9, or 792.1.

D. GI tract capsule endoscopy is not covered in the patient who has not undergone upper GI endoscopy and colonoscopy during the same period of illness in which a source of bleeding is not revealed.

E. This test is covered only for those beneficiaries with documented continuing blood loss and anemia secondary to bleeding.

F. See section 292.890 for procedure code and billing instructions.

262.000 Procedures That Require Prior Authorization 11-1-08

The following procedure codes require prior authorization:

Procedure Codes							
01966	11960	11970	11971	15400	15830	15847	19318
19324	19325	19328	19330	19340	19342	19350	19355

Procedure Codes							
19357	19361	19364	19366	19367	19368	19369	19370
19371	19380	20974	20975	21076	21077	21079	21080
21081	21082	21083	21084	21085	21086	21087	21088
21089	21120	21121	21122	21123	21125	21127	21137
21138	21139	21141	21142	21143	21145	21146	21147
21150	21151	21154	21155	21159	21160	21172	21175
21179	21180	21181	21182	21183	21184	21188	21193
21194	21195	21196	21198	21199	21208	21209	21244
21245	21246	21247	21248	21249	21255	21256	27412
27415	27416	28446	29866	29867	29868	30220	30400
30410	30420	30430	30435	30450	30460	30462	32851
32852	32853	32854	33140	33282	33284	33945	36470
36471	37785	37788	38240	38241	38242	42820	42821
42825	42826	42842	42844	42845	42860	42870	43257
43644	43645	43842	43845	43846	43847	43848	43850
43855	43860	43865	47135	48155	48160	48554	48556
50320	50340	50360	50365	50370	50380	51925	54360
54400	54415	54416	54417	55400	57335	58150	58152
58180	58260	58262	58263	58267	58270	58275	58280
58290	58291	58292	58293	58294	58345	58541*	58542*
58543*	58544*	58550	58552	58553	58554	58570***	58571***
58572***	58573***	58672	58673	58750	58752	59135	59840
59841	59850	59851	59852	59855	59856	59857	59866
61850	61860	61862	61870	61875	61880	61885	61886
61888	63650	63655	63660	63685	63688	64555	64573
64585	64809	64818	65710	65730	65750	65755	67900
69300	69310	69320	69714	69715	69717	69718	69930
87901	87903	87904	92326	93980	93981	D9220**	J7319
J7320	J7330	S0500	S2112	V2623	V2625		

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

Procedure Code	Modifier	Description
E0779	RR	Ambulatory infusion device
D0140	EP	EPSDT interperiodic dental screen
J7330		Autologous cultured chondrocytes, implant
L8614	EP	Cochlear device includes all internal and external components.
L8615	EP	Headset/headpiece for use with cochlear implant device, replacement.
L8616	EP	Microphone for use with cochlear implant device, replacement.
L8617	EP	Transmitter coil for use with cochlear implant device, replacement.
L8618	EP	Transmitter cable for use with cochlear implant device, replacement.
L8619	EP	External sound processor
L8621	EP	Zinc air battery for use with cochlear implant device, replacement, each.
L8622	EP	Alkaline battery for use with cochlear implant device, any size, replacement, each.
S0512*		Daily wear specialty contact lens, per lens
V2501*	UA	Supplying and fitting Keratoconus lens (hard or gas permeable) - 1 lens
V2501*	U1	Supplying and fitting of monocular lens (soft lens) - 1 lens
V5014**		Repair/modification of a hearing aid
Z1930		Non-emergency hysterectomy following c-section
92002*		Low vision services – evaluation

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

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

292.110 Non-covered CPT Procedure Codes 11-1-08

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.

Procedure Codes

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
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

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

292.410 Abortion Procedure Codes 11-1-08

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

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

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

All claims must be made on paper with attached documentation. A completed Certification Statement for Abortion (form DMS-2698 Rev. 8/04), patient history and physical are required for processing of claims.

Use the following procedure codes when billing for abortions.

01966	59840	59841	59850	59851	59852
59855	59856	59857			

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

292.440 Anesthesia Services 11-1-08

Anesthesia procedure codes (**00100** through **01999**) must be billed 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.**

Procedure Code	Documentation Required
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.
Z9950	Anesthesia for laparoscopic supracervical hysterectomy. **View or print form DMS-2606 and instructions for completion.**

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.

292.447 Example of Proper Completion of Claim 11-1-08

The following is a cutaway section of the CMS-1500 claim form demonstrating the proper method of entering the following information:

Line No. 1 - Anesthesia for Procedure
Line No. 2 - Qualifying Circumstance

The anesthesia time must be listed above the procedure code, but on the same detail.

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	07 15 07		21		180 min. = 12 units 00560	P3	441.3	xxx xx	12		NPI	105967001
2	07 15 07		21		99116	P3	441.3	xxx xx	1		NPI	105967001

292.551 Family Planning Services For Beneficiaries in Full Coverage Aid Categories 11-1-08

Family planning services are covered for beneficiaries in full coverage aid categories. Family planning procedures payable to physicians require a modifier “**FP**”. All procedure codes in these tables require a family planning diagnosis code in each claim detail.

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

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

*CPT codes **58661** and **58700** represent procedures to treat medical conditions as well as for elective sterilizations.

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

Procedure Code	Modifier(s)	Description
J1055	FP	Medroxyprogesterone acetate for contraceptive use
J7300	FP	Intrauterine copper contraceptive
J7302	FP	Levonorgestrel-releasing intrauterine contraceptive system
J7303	FP	Contraceptive supply, hormone containing vaginal ring
J7306	FP	Levonorgestrel (contraceptive) implant system, including implants and supplies
J7307	FP	J7307 is covered as a family planning benefit for regular full-coverage Medicaid beneficiaries. J7307 is not covered in family planning aide category 69. Benefit limited to two per seven years per beneficiary.
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, procedure code **S0612** is not covered as a family planning procedure. It is covered for regular Medicaid beneficiaries for annual gynecological examinations.

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

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

To file claims for these professional services, 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. All claims billed require that the primary detail diagnosis code for each procedure must be a family planning diagnosis.

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

2. 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. For post-Essure services limit, 6 months is 180 days, with the count beginning the day after the Essure procedure.
   a. Professional claims for procedure codes **58340** and **58345** must be filed with modifier **FP**. All claims billed require that the primary detail diagnosis for each procedure must be a family planning diagnosis code.
   b. Professional claims for procedure codes **72190**, **74740** and **74742** must be filed with modifier **FP** All claims billed require that the primary detail diagnosis for each procedure must be a family planning diagnosis code.
   c. Procedure codes **J1055**, **11976** and **58301** are covered family planning services. 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**. Medicaid allows post-Essure service for 6 months from the Essure procedure date of service, as specified in policy. For the post-Essure services limit, 6 months is 180 days, with the count beginning the day after the Essure procedure.

292.552 Family Planning Services for Beneficiaries in Limited Aid Category 69 — 11-1-08

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. All procedure codes in these tables require a family planning diagnosis code in each claim detail.

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. 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**.

292.553 Family Planning Laboratory Procedure Codes 11-1-08

This table contains laboratory procedure codes payable as family planning services for regular Medicaid beneficiaries and for beneficiaries in limited aid category 69. They are also payable when used for purposes other than family planning. Claims require modifier **FP** when the service diagnosis indicates family planning.

Independent Lab CPT Codes							
Q0111	81000	81001	81002	81003	81025	83020	83520
83896	84703	85014	85018	85660	86592	86593	86687
86701	87075	87081	87087	87210	87390	87470	87490
87491	87536	87590	87591	87621**	88142*	88143*	88150**
88152	88153	88154	88155**	88164	88165	88166	88167
88174	88175	89300	89310	89320			

***Procedure codes 88142 and 88143 are limited to one unit per beneficiary per state fiscal year.**
****Payable only to pathologists and independent labs.**

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

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

292.560 Genetic Services 11-1-08

The Arkansas Medicaid Program covers the following procedure codes regarding genetic services.

National Code	Local Code	Local Code Description
Bill on paper	Z1729	Prenatal Diagnosis Counseling
84702		Prenatal screening for fetal anomalies using maternal serum HCG and AFP

A. Documentation

In addition to the medical records physicians are required to keep as detailed in Section 202.200 of this manual, the beneficiary's medical record must verify the physician providing genetic services is a board-certified maternal fetal medicine physician as required by Arkansas Medicaid genetic policy.

B. Prenatal Diagnosis Counseling

Prenatal Diagnosis Counseling must be performed by a maternal fetal medicine physician or a staff member under his or her direct supervision. This service includes, but is not limited to:

1. Family, medical, pregnancy history
2. Psychosocial assessment and counseling of couple regarding genetic testing and disorder
3. Diagnosis, prognosis, available options, pregnancy management are explained to the couple.

C. Services Not Performed by a Physician

When procedure codes **Z1729 (must be billed on paper)** and **84702** are provided and the services are not performed by a physician, the provider must have written policies with a physician who assumes the responsibility for the provision of the services rendered and agrees:

1. To be immediately available for consultation to the staff performing the services,
2. To ensure that the clinic staff has appropriate training and adequate skills for performing the procedures for which they are responsible and
3. To periodically review the staff's level of performance in administering these procedures.

The physician must be physically present (under the same roof) at all times during the service delivery.

292.580 Hysterectomies 11-1-08

Physicians may use procedure code **Z0663** when billing for a total hysterectomy procedure when the diagnosis is malignant neoplasm or severe dysplasia. See section 251.280 for additional

coverage requirement. 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 11-1-08

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.

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See section 292.910 for further information.

292.591 Injections and Therapeutic Agents 11-1-08

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

   Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take home drugs." Refer to CPT code ranges **90765** through **90779** and **96401** through **96549** for therapeutic and chemotherapy administration procedure codes.

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

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

This list includes drugs covered for beneficiaries of all ages. However, when provided to individuals aged 21 or older, a diagnosis of ICD-9-CM 140.0 – 208.91, 230.0-238.9, or 042 is required.

Procedure Codes							
J0120	J0128	J0190	J0205	J0207	J0210	J0256	J0278
J0280	J0285	J0287	J0288	J0289	J0290	J0295	J0300
J0330	J0350	J0360	J0380	J0390	J0456	J0460	J0470
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
J1655	J1670	J1700	J1710	J1720	J1730	J1742	J1800
J1810	J1815	J1825	J1830	J1835	J1840	J1850	J1885
J1890	J1940	J1950	J1955	J1956	J1960	J1980	J1990
J2001	J2010	J2020	J2060	J2150	J2175	J2180	J2185
J2210	J2250	J2270	J2271	J2275	J2278	J2280	J2300
J2310	J2320	J2321	J2322	J2355	J2360	J2370	J2400
J2405	J2410	J2425	J2430	J2440	J2460	J2469	J2501
J2510	J2515	J2540	J2543	J2550	J2560	J2590	J2597
J2650	J2670	J2675	J2680	J2690	J2700	J2710	J2720
J2725	J2730	J2760	J2765	J2770	J2780	J2783*	J2800
J2820	J2920	J2930	J2941	J2950	J2995	J3000	J3010
J3030	J3070	J3105	J3120	J3130	J3140	J3150	J3230
J3240	J3250	J3260	J3265	J3280	J3301	J3302	J3303
J3305	J3310	J3315	J3320	J3350	J3360	J3364	J3365
J3370	J3400	J3410	J3430	J3470	J3475	J3480	J3485

Procedure Codes							
J3490*	J3520	J7197	J7308	J7310	J7501	J7504	J7505
J7506	J7507	J7509	J7510	J7511	J7513	J7518	J7599*
J8530	J9000	J9001	J9010	J9015	J9017	J9020	J9031
J9040	J9045	J9050	J9060	J9062	J9065	J9070	J9080
J9090	J9091	J9092	J9093	J9094	J9095	J9096	J9097
J9098*	J9100	J9110	J9120	J9130	J9140	J9150	J9151
J9165	J9170	J9181	J9182	J9185	J9190	J9200	J9201
J9202	J9206	J9208	J9209	J9211	J9212	J9213	J9214
J9215	J9216	J9217	J9218	J9230	J9245	J9260	J9265
J9266	J9268	J9270	J9280	J9290	J9291	J9300	J9310
J9320	J9340	J9355	J9357	J9360	J9370	J9375	J9380
J9390	J9600	J9999*	Q2009	Q2017	S0017	S0021	S0023
S0028	S0030	S0032	S0034	S0039	S0040	S0073	S0074
S0077	S0080	S0081	S0092	S0093	S0108	S0164	S0177
S0179	S0187						

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

292.592 Other Covered Injections and Immunizations with Special Instructions 11-1-08

Physicians may bill for immunization procedures on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 claim form. **View a DMS-694 sample form.** **View a CMS-1500 sample form.**

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

Procedure Code	Modifier(s)	Special Instructions
J0129*		Requires ICD-9-CM diagnosis code of 714.0-714.2 as primary diagnosis. Patient must have had inadequate response to one or more disease-modifying anti-rheumatic drugs such as Methotrexate or Tumor Necrosis Factor antagonists (Humira, Remicade, etc.). Records submitted with claim must include history and physical exam showing severity of rheumatoid arthritis, treatment with disease-modifying anti-rheumatic drugs, and treatment failure resulting in progression of joint destruction, swelling, tendonitis, etc. Prior approval letter from DMS Medical

Procedure Code	Modifier(s)	Special Instructions
		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 244.100 for additional coverage information and instructions for requesting prior approval.
J0220*		Requires an ICD-9-CM diagnosis code of 271.0. Evaluation by a physician with a specialty in clinical genetics documenting progress required annually. A prior approval letter from DMS Medical Director required and must be attached to each claim. See 244.100 for information regarding acquiring the prior approval letter.
J0348		Valid for any condition below, along with ICD-9-CM diagnosis code of 112.5 or 112.8 (and any valid 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, 230.0-238.9) or (3) Post transplant status (i.e., ICD-9-CM diagnosis code 986.80-996.89) or specify transplanted organ and transplant date
J0570		Payable for beneficiaries of all ages with no diagnosis restrictions.
J0585		Payable for beneficiaries of all ages when medically necessary. Botox A is reviewed for medical necessity based on diagnosis.
J0636		Payable for beneficiaries of all ages receiving dialysis due to renal failure (diagnosis codes 584-586).
J0637*		Covered when administered to patients with refractory aspergillosis who also have a diagnosis of malignant neoplasm or HIV disease. Complete history and physical exam, documentation of failure with other conventional therapy and dosage. After 30 days of use, an updated medical exam and history must be submitted.
J0702		Payable for beneficiaries of all ages. However, when provided to beneficiaries aged 21 and older, there must be a diagnosis of AIDS, cancer or complications during pregnancy (diagnosis code

Procedure Code	Modifier(s)	Special Instructions
		range 640 – 648.93).
J0881 J0885		Use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for red blood cell transfusion. In addition to the primary diagnosis, an ICD-9-CM diagnosis code from each column below must be billed on the claim.

Column 1	Column II	
	Code	**Description**
285.9 Secondary Anemia	V58.11	Encounter for antineoplastic chemotherapy
	V67.2	Following chemotherapy
	E933.1	Antineoplastic and immunosuppressive drugs

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.

In addition to the primary diagnosis, an ICD-9-CM diagnosis code from each column below must be billed on the claim.

Column I	Column II	
	Code	**Description**
285.29 Anemia of other chronic disease	070.54	Chronic Hepatitis C without mention of coma
	238.72-238.75	Myelodysplastic
	714.0-714.4	Rheumatoid Arthritis

Procedure Code	Modifier(s)	Special Instructions
J0882 J0886		Payable for dates of service on and after March 1, 2006. Covered when administered to patients diagnosed with ESRD (diagnosis range 584 – 586).
J0894*		Requires ICD-9-CM diagnosis codes of 205.00-205.91, 238.71-238.76, or 238.79. Prior approval letter from DMS Medical Director required to be attached to each claim. Refer to 244.100 for information regarding requesting prior approval.
J1100		Payable for beneficiaries of all ages. However, when provided to beneficiaries aged 21 and older, there must be a diagnosis of AIDS, cancer or complications during pregnancy (diagnosis code

Procedure Code	Modifier(s)	Special Instructions
		range 640 – 648.93).
J1270		Payable for beneficiaries with diagnosis codes 042,140.0 -208.91 + 230.0-238-9 + 787.2 + 588.81; Or ESRD 584 – 586 +787.2+ 588.81. Claims will be manually reviewed prior to reimbursement.
J1440 J1441		Payable for beneficiaries of all ages with no diagnosis restrictions.
J1458*		Payable for treatment of mucopolysaccharidosis (MPS VI), diagnosis code 277.5. Prior approval letter from DMS Medical Director required. Copy of prior approval letter must be attached to each claim. See section 244.100 for additional coverage information and instructions for requesting prior approval.
J1460 J1470 J1480 J1490 J1500 J1510 J1520 J1530 J1540 J1550 J1560		Covered for individuals of all ages with no diagnosis restrictions.
J1561		Claims are reviewed for medical necessity based on the diagnosis code.
J1562		Payable for all ages without diagnosis restriction.
J1566 J1568 J1569		Claims are reviewed for medical necessity, based on the diagnosis code.
J1600		Payable for patients with a detail diagnosis of rheumatoid arthritis (diagnosis code range 714.0 – 714.9).
J1640		Payable when administered to all beneficiaries with ICD-9-CM detail diagnosis 277.1).
J1650		Payable for all ages with no diagnosis restriction.
J1652		Payable for beneficiaries of all ages with no diagnosis restrictions.
J1740		Payable for beneficiaries of all ages with no diagnosis restrictions.
J1743*		Requires ICD-9-CM diagnosis code of 277.5 (MPS II). An evaluation by a physician with a specialty in clinical genetics, documenting progress and response to the medication is required

Procedure Code	Modifier(s)	Special Instructions
		annually. Requires prior approval letter from DMS Medical Director and a copy must be attached to each paper claim. Refer to section 244.100 for information on how to acquire a prior approval letter.
J1745*		For beneficiaries under 18 years of age: Effective for dates of service on and after 05/20/06, **J1745** is payable without an approval letter for beneficiaries under age 18 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 aged 18 years and above: Procedure code **J1745** is payable when one of the following conditions exist: 1) ICD-9-CM code 555.9 as the primary detail diagnosis **AND** a secondary diagnosis of 565.1 or 569.81 **OR** 2) ICD-9-CM code range 556.0 – 556.9 **OR** 3) ICD-9-CM code 696.0 **OR** 4) ICD-9-CM code 714.0 **NOTE:** ICD-9 diagnosis code 714.0 requires a prior approval letter from the Medical Director. The request for approval must include documentation showing failed trial of Enbrel or Humira. Claims must be submitted to EDS with any applicable attachments. Claims will be manually reviewed by Medicaid medical staff prior to payment. **OR** 5) ICD-9-CM 724.9. **NOTE:** ICD-9 diagnosis code 724.9 requires a prior approval letter from the Medical Director. The request for approval must include documentation showing failed trial of Enbrel or Humira. Claims must be submitted to EDS with any applicable attachments. Claims will be manually reviewed by Medicaid medical staff prior to payment.
J1751 J1752		Payable for all ages with no diagnosis restriction.
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 and 244.100 for additional coverage information and instructions for requesting prior approval. A copy of the prior approval letter must be attached to each claim.

Procedure Code	Modifier(s)	Special Instructions
J1931*		This procedure is covered for treatment of mucopolysaccharidosis (MPS I), ICD-9-CM diagnosis code 277.5. Prior approval from DMS Medical Director is required. See section 244.001 and 244.100 for additional coverage information and instructions for requesting prior approval. A copy of the prior approval letter must be attached to each claim.
J2260		Payable for Medicaid beneficiaries of all ages with congestive heart failure (ICD-9 diagnosis codes 428.0-428.9).
J2323*		Procedure requires a prior approval letter. See section 244.100. The history and physical showing a relapse of multiple sclerosis must be submitted with the request for the prior approval letter. This procedure must be billed on a paper claim. The approval letter must be attached to each claim. Requires review before payment.
J2353* J2354*		Payable for Medicaid beneficiaries of all ages. For ages 21 and older, J2353 and J2354 are covered for diagnosis of AIDs and cancer (ICD-9-CM diagnosis codes 140.0 – 208.91, 230.0 – 238.9 or 042). For other diagnoses, a prior approval letter is required and must be attached to each claim. See section 244.100 for information of requesting a prior approval letter.
J2503		Payable for beneficiaries diagnosed with macular degeneration (ICD-9-CM diagnosis code 362.50 – 362.52).
J2504		Payable for beneficiaries of all ages with a primary detail diagnosis of 279.2.
J2505		Payable for beneficiaries of all ages with a detail diagnosis from diagnosis code ranges 162.0 – 165.9, **or** 174.0 – 175.9 **or** 201.00 – 201.98 **or** 202.80 – 202.88. Diagnosis codes 288.00-288.04, 288.09 or 288.4 or 288.50-288.51 or 288.59, 289.53, V58.69, V67.51 and E933.1 are covered along with a diagnosis of AIDS or cancer. Diagnosis codes must be shown on the claim form.
J2513		Payable for beneficiaries of all ages with no diagnosis restrictions.
J2778*		Requires ICD-9-CM diagnosis code of 362.50 or 362.52 as primary diagnosis. Requires prior approval letter from DMS Medical Director attached to each claim. Refer to section 244.100 for information on how to acquire a prior approval letter.
J2788		Payable for beneficiaries of all ages with no diagnosis restrictions.
J2790 J2791		Payable for beneficiaries of all ages with no diagnosis restrictions.
J2792		Payable without restriction.
J2910		Payable for all beneficiaries with a primary detail diagnosis of

Procedure Code	Modifier(s)	Special Instructions
		rheumatoid arthritis (ICD-9 diagnosis codes 714.0 – 714.9).
J2916		Payable for beneficiaries of all ages with no restrictions.
J2993		Payable for beneficiaries of all ages with no diagnosis restrictions. Limited to 4 units per day in the office place of service. For the purpose of declotting catheters. Bill diagnosis 996.74 on the claim.
J2997		Payable for beneficiaries of all ages with no diagnosis restrictions. Limited to 4 units per day in the office place of service. For the purpose of declotting catheters. Bill diagnosis 996.74 on the claim.
J3396		Covered for all ages if one of the following diagnoses exist: ICD-9 diagnosis code 362.50 or 362.52; **or** ICD-9 diagnosis code 360.21; **or** ICD-9 diagnosis code 115.02 **or** 115.12 or 115.92. Claims may be filed electronically or on paper. See section 244.002 for additional coverage information.
J3420		Payable for patients with a primary detail diagnosis of pernicious anemia, 281.0. Coverage includes the B-12, administration and supplies. It must not be billed in multiple units.
J3465*		Covered for non-pregnant beneficiaries of all ages with no restrictions.
J3487 J3488		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. Payable for beneficiaries of all ages with no diagnosis restrictions.
J7187 J7190 J7191 J7192 J7193 J7194 J7195 J7197		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7198		Payable for all ages with no diagnosis restrictions.
J7199		For consideration, this code must be billed on a paper claim form with the name of the drug, dosage and the route of administration.
J7321 J7322 J7323 J7324		Requires prior authorization through Utilization Review Section of DMS. Providers must specify brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization. Written request must be submitted to DMS Utilization Review. Refer to 261.240 for PA information.
J7330		Requires prior authorization from AFMC for all providers. See sections 260.000, 261.000, 261.100 and 261.110.

Procedure Code	Modifier(s)	Special Instructions
J7340		Payable for beneficiaries of all ages with no diagnosis restrictions
J7341		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7346		Requires submission of operative report with each claim.
J7502		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7515		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7516		Payable for beneficiaries of all ages with no diagnosis restrictions
J7517		Payable for beneficiaries of all ages with no diagnosis restrictions
J7520 J7525 J7599*		For consideration, this code must be billed on a paper claim form with the name of the drug, dosage and the route of administration.
J9025		Coverage of this procedure code requires an ICD-9-CM diagnosis within the code range of 205.00 – 205.91, 238.71 - 238.76 or 238.79. A prior approval letter from the DMS Medical Director is required to be attached to each claim. Refer to 244.100 for information regarding requesting prior approval.
J9035*		Coverage of this procedure code requires an ICD-9-CM diagnosis within the code range of 153.0 – 154.8, 162.0 – 162.9, 174.0-175.9, or 189.0 – 189.9. A prior approval letter is required and must be attached to each claim. See section 244.100 for information on requesting prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9041		Coverage of this procedure code requires an ICD-9-CM diagnosis code of 203.0 – 203.8, and 200.40-200.48. A prior approval letter is required and must be attached to each claim. See section 244.100 for information on requesting prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9055		This procedure code requires an ICD-9-CM diagnosis code of 140.0 – 140.9, 153.0 – 154,, 160.0 – 161.9, 171.0, 172.0 – 172.4,173.0 – 173.4, or 195.0. A prior approval letter is required and must be attached to each claim. See section 244.100 for information on requesting prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9160		This procedure code is covered for all ages with ICD-9-CM diagnosis within the diagnosis range 202.10 - 202.18, 202.20 - 202.28, or 202.80 - 202.88. A prior approval letter is required and must be attached to each claim. See section 244.100 for information on requesting prior approval. Any one of the diagnosis codes from the above listed ranges is acceptable.
J9178		This procedure code requires an ICD-9-CM diagnosis code of 150.0-150.8, 151.0-151.9, 162.0-162.9, 171.0-171.9,174.0 – 175.9, 183.0, 200.0-200.8 or 202.0 - 202.90. A prior approval letter from

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

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

Procedure Code	Modifier(s)	Special Instructions
		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 identified for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.
90385		Limited to one injection per pregnancy.
90581*		Payable for ages 18 years and older. Indicate dose and attach manufacturer's invoice.
90585		Payable for all ages.
90586		Payable for ages 18 years and older.
90632		Payable when administered to beneficiaries ages 19 years and older.
90633 90634	EP, TJ	Payable when administered to beneficiaries ages 12 months – 18 years. See section 292.593.
90636	EP, TJ	Payable when administered to beneficiaries age 18 years and older. Modifiers are required only when administered to beneficiaries aged 18 years. See section 292.593.
90645 90646 90647	EP, TJ	Payable when administered to beneficiaries of all ages. Modifiers are required only when administered to beneficiaries aged 18 years and younger. See section 292.593 for billing instructions when administered to beneficiaries aged 18 years and younger.
90648	EP, TJ	Payable when administered to beneficiaries aged 18 years and younger. Refer to section 292.593 for more information.
90655 90657	EP, TJ	Influenza vaccines payable through the VFC program for beneficiaries 6 – 35 months of age. See section 292.593 for billing instructions.
90656 90658	EP, TJ	Influenza vaccines payable for beneficiaries aged 3 years and older. Modifiers required only when administered to children under age 19. Refer to sections 292.593 and 292.594 for influenza vaccine policy.
90660	EP, TJ	Covered for healthy individuals aged 2-49 and not pregnant. Modifiers required only when administered to beneficiaries under age 19. See sections 292.593 and 292.594 of this manual.
90665		Payable when administered to beneficiaries ages 19 years and older.
90669	EP, TJ	Administration of vaccine is covered for children under age 5 years. See section 292.593 for billing instructions.
90675* 90676*		Covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in field 24.D of claim form CMS-1500 for each date of service. If date spans are

Procedure Code	Modifier(s)	Special Instructions
		used, appropriate units of service must be indicated and must be identified for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.
90680	EP, TJ	VFC vaccine payable when administered to beneficiaries ages 6 weeks – 32 weeks. See section 292.593 for more information.
90690		Payable for beneficiaries ages 6 years and older.
90691		Payable for beneficiaries aged 3 years and older.
90700	EP, TJ	VFC vaccine payable when administered to beneficiaries under age 7 years. Modifiers are required. See section 292.593 for more information.
90702	EP, TJ	Payable for beneficiaries ages 0-6 years of age.
90703		Payable for all ages without restrictions and without modifiers.
90704		Payable for beneficiaries aged 1 year and older.
90705		Payable for ages 9 months and older.
90706		Payable for ages 1 year and older.
90707	U1	Payable when provided to women of childbearing age, ages 21 through 44, who may be at risk of exposure to these diseases. Coverage is limited to two (2) injections per lifetime. U1 modifier is required for this age group. Payable when administered to beneficiaries aged 19 and 20 years without modifiers.
90707	EP, TJ	Payable when administered to beneficiaries under age 19 years. Modifiers are required when administered to beneficiaries under age 19 years. See section 292.593.
90708		Payable for beneficiaries 9 months of age and older.
90710	EP, TJ	Payable for beneficiaries under age 21 years. Modifiers are required only when administered to children under age 19. See section 292.593 for additional information.
90713	EP, TJ	Payable for beneficiaries of all ages. However, modifiers are required only when administered to beneficiaries under age 19 years. See section 292.593.
90714	EP, TJ	Payable for beneficiaries ages 7 years and older. Modifiers are required when administered to beneficiaries under age 19 years. See section 292.593.
90715	EP, TJ	This vaccine is covered for individuals aged 7 years and older. Modifiers are required only when administered to beneficiaries under age 19 years. See section 292.593.

Procedure Code	Modifier(s)	Special Instructions
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.
90720	EP, TJ	This vaccine is covered under the VFC program for ages 0-18 years of age. Modifiers are required.
90721	EP, TJ	Covered for beneficiaries under age 21 years. Modifiers are required only when administered to beneficiaries under age 19 years. See section 292.593.
90723	EP, TJ	Covered for beneficiaries under age 19 years. See section 292.593.
90725*		Payable for all ages; submit manufacturer's invoice.
90727*		Payable for all ages; submit manufacturer's invoice.
90732		This code is payable for individuals aged 2 years and older. Patients age 21 years and older who receive the injection must be considered by the provider as high risk. All beneficiaries over age 65 may be considered high risk.
90733		Covered for beneficiaries of all ages.
90734	EP, TJ	Covered for beneficiaries of all ages. Modifiers are required only when administered to beneficiaries under age 19 years. See section 292.593.
90735		Payable for individuals under age 21 years.
90740		Three dose schedule. Payable for individuals of all ages.
90743	EP, TJ	Two dose schedule. Payable only when administered to children aged 0 – 18 years. See section 292.593.
90744	EP, TJ	Three dose schedule. Payable for ages 0 – 18 years. See section 292.593.
90746		Payable for ages 19 years and older.
90747	EP, TJ	Covered for beneficiaries of all ages. Modifiers are required **only** when administered to beneficiaries under age 19 years. See section 292.593.
90748	EP, TJ	Covered for beneficiaries of all ages. Modifiers are required **only** when administered to beneficiaries under age 19 years. See

Procedure Code	Modifier(s)	Special Instructions
		section 292.593.

* Procedure code requires paper billing with applicable attachments.

292.593 Vaccines for Children Program 11-1-08

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. Arkansas Medicaid established new procedure codes for billing the administration of VFC immunizations for children under the age of 19. To enroll in the VFC Program, contact the Arkansas Division of Health. Providers may also obtain the vaccines to administer from the Arkansas Division of Health. **View or print Arkansas Division of Health contact information.**

Medicaid policy regarding immunizations for adults remains unchanged by the VFC Program.

Vaccines available through the VFC program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ.** When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **TJ** must be used for billing.

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

90633	90634	90636	90645	90646	90647	90648	90655
90656	90657	90658	90660	90669	90680	90700	90702
90707	90710	90713	90714	90715	90716	90718	90720
90721	90723	90734	90743	90744	90747	90748	

292.594 Influenza Virus Vaccine 11-1-08

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

   For ARKids First-B beneficiaries, use modifier **TJ.**

B. Medicaid covers procedure code **90656**, influenza virus vaccine, split virus, preservative free, for ages 3 years and older.

   1. For individuals under 19 years of age, claims must be filed using modifiers **EP** and **TJ**.
   2. For ARKids First-B beneficiaries, use modifier **TJ.**
   3. For individuals ages 19 and older, no modifier is necessary.

C. Procedure code **90660**, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals ages 2 through 49 who are not pregnant.

   1. When filing claims for children 5 through18 years of age, use modifiers **EP** and **TJ**.
   2. For ARKids First-B beneficiaries, the procedure code must be billed using modifier **TJ**.

3. No modifier is required for filing claims for beneficiaries ages 19 through 49.

D. Procedure code **90657**, influenza virus vaccine, split virus, for children ages 6 through 35 months, is covered. Modifiers **EP** and **TJ** are required.

For ARKids First-B beneficiaries, use modifier **TJ.**

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

1. When filing claims for individuals under age 19, use modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **TJ.**
3. No modifier is required for filing claims for beneficiaries aged 19 and older.

292.790 Surgical Procedures with Certain Diagnosis Ranges 11-1-08

The following procedure codes are payable by the Arkansas Medicaid Program only if the diagnosis is in the range listed below:

Procedure Code	Procedure Description	Diagnosis Range
44950	Appendectomy	5400 – 5439
44955	Appendectomy w/other procedure	5400 – 5439
44960	Appendectomy with abscess	5400 – 5439
44970	Laparoscopic appendectomy	5400 – 5439
49520	Hernia	55000 – 55093

292.870 Bilaminate Graft or Skin Substitute Procedures 11-1-08

Arkansas Medicaid reimburses physicians who furnish the manufactured viable bilaminate graft or skin substitute. The product is manually priced and requires paper claims using procedure code **J7340**. The manufacturer's invoice, the wound size description and the operative report must be attached.

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

292.890 Gastrointestinal Tract Imaging with Endoscopy Capsule 11-1-08

Gastrointestinal Tract Imaging with Endoscopy Capsule, billed as **91110**, is payable for all ages and must be billed with the primary detail diagnosis of 280.9, 555.0-555.9, 578.1, 578.9, or 792.1.

This procedure code should be billed with no modifiers when performed in the physician's office place of service.

Modifier 26 must additionally be used to indicate billing for the professional component when performed in the inpatient, outpatient hospital, or ambulatory surgical center place of service.

CPT code **91110** is payable on electronic and paper claims. For coverage policy, see section 256.000.

292.910 National Drug Codes (NDCs) 11-1-08

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Health Care Financing Administration Common Procedure Code System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare & Medicaid Services (CMS). A "covered labeler" is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each State a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first 5 digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first 5 digits of the NDC) to the list of covered labelers which is maintained on the Arkansas Medicaid website.

A complete listing of **"Covered Labelers"** is located on the Arkansas Medicaid Web page at **www.medicaid.state.ar.us**, click on Provider Services, select Prescription Drug information, and then select Covered Labelers. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

LABELER CODE	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

In order for a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three segments or codes: a 5-digit labeler code, a 4-digit product code and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero in one of the three segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five digits with leading zeros; the product code as four digits with leading zeros; the package code as two digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123 **LABELER CODE (5 digits)**	**0456** **PRODUCT CODE (4 digits)**	**78** **PACKAGE CODE (2 digits)**

NDCs submitted in any configuration other than the 11 digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11 digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	**Required 11-digit NDC (5-4-2) Billing Format**
12345 6789 1	123456789**0**1
1111-2222-33	**0**1111222233
01111 456 71	01111**0**45671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPC/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one labeler to another, from one package size to another, and from one time period to another.

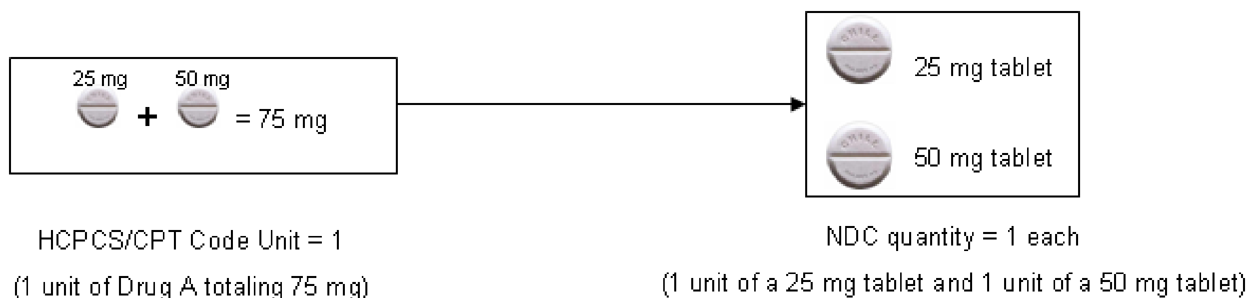
Exception: There is no requirement for an NDC when billing for vaccines radiopharmaceuticals, and allergen immunotherapy.

II. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

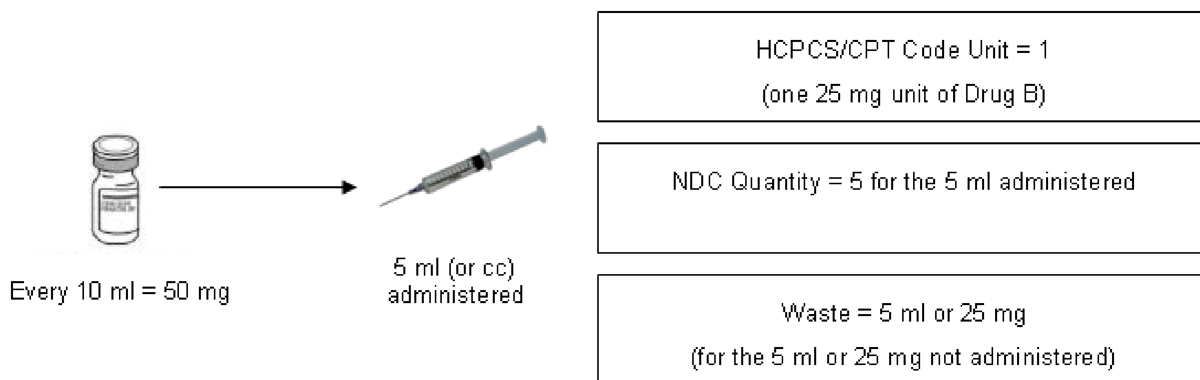
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Electronic claims can be filed with a maximum of 5 NDCs per detail.

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid requires providers using Provider Electronic Solutions (PES) to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

When billing multiple NDCs, the HCPCS/CPT should reflect the total charges and units of all administered NDCs. The NDC fields should reflect the price and units of each specific NDC, up to a maximum of five NDCs per detail.

For 837P professional claims, from the Service 2 tab, in the RX Indicator field, select “Y” to open the RX tab. On the RX tab, enter the NDC, Unit of Measure, Quantity and Price for each NDC.

If billing electronic claims using vendor software, check with your vendor to ensure your software will be able to capture the criteria necessary to submit these claims. Vendor companion guides are located on the Arkansas Medicaid Web page at **https://www.medicaid.state.ar.us/** . Click on Provider, select HIPAA, select Documents for vendors and then select Companion guides.

B. Paper Claims Filing – CMS-1500

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of “N4”, the 11-digit NDC, the unit of measure qualifier (F2 - International Unit; GR - Gram; ML - Milliliter; UN - Unit), and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced & arranged exactly as in Diagram 6.

Each NDC, when billed under the same procedure code on the same date of service is defined as a “sequence”. When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in the detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one NDC is associated with the HCPCS/CPT code.

Diagram 6

		24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
Detail 1 / Sequence 1	1	N4 12345678912 UN 1.00															123456789
		08	01	07	08	01	07	11		Z1234		1	25 00	1		NPI	
Sequence 2	2	N4 01111222233 UN 1.00															123456789
		08	01	07	08	01	07	11		Z1234		1	0 00	0		NPI	
Detail 2	3																123456789
		08	01	07	08	01	07	11		99213		1	55 00	1		NPI	
Sequence 1	4	N4 44444555506 ML 5.00															123456789
Detail 3		08	01	07	08	01	07	11		Z6789		1	35 00	1		NPI	
	5																
																NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Procedure Code/NDC Detail Attachment Form- DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the DMS-664 “Procedure Code/NDC Detail Attachment Form.” Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 8 for an example of the completed form. A copy of form DMS-664 is attached and may be copied for claim submission. Copies of the DMS-664 will not be provided. Section V of the provider manual will be updated to include this form.

Diagram 8

Detail #	Sequence #	NDC											Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0
1	2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0
3	1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML

III. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

IV. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

V. Drug Efficacy Study Implementation (DESI) Drugs

The Federal Drug Administration (FDA) reviews the effectiveness of drugs approved between 1938 and 1962 through a program named the Drug Efficacy Study Implementation (DESI) program. Drugs that were approved by the FDA before 1962 were permitted to remain on the market while evidence of their effectiveness was reviewed. If the DESI review indicates a lack of substantial evidence of a drug's effectiveness, the FDA will publish its proposal to withdraw approval of the drug for marketing. In accordance with Section 1903(i)(5) of the Social Security Act, federal funds participation (FFP) is not available for Less than Effective (LTE) drugs or the Identical, Related or Similar (IRS) drugs identified by the FDA and published quarterly by the Centers for Medicare & Medicaid Services

This means that any HCPCS/CPT code will not be payable when linked to any NDC with a DESI indicator. If it is determined that all NDCs linked to a specific HCPCS/CPT are DESI, this is an instance where the procedure code will no longer be payable.

A list of "DESI" drugs with the effective and end dates will be on the Arkansas Medicaid website. From the main page, click "Provider," then select "Prescription Drug Information" and then select "DESI NDCs (non-payable) associated with HCPCS/CPT Codes." See Diagram 9 for an example of the DESI list.

Diagram 9

ARKANSAS MEDICAID

DESI NDCs (non-payable) associated with HCPCS/CPT Codes

For further information -- please contact EDS Pharmacy Help Desk -- 1-800-707-3854

Last Updated 10/15/2007

NDC	DESI Drug Begin Date	Drug Label Name	Drug Manufacturer Name	HCPCS/CPT
00009025302	11/17/2003	DEPO-TESTADIOL VIAL	PHARMACIA/UPJHN	J1060

VI. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.