ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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

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

DATE: **November 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #165**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
217.040	10-13-03	217.040	11-1-09
244.000	5-1-08	244.000	11-1-09

Explanation of Updates

Section 217.040 is being updated to change language and requirements for bariatric surgery. The title of this section has been changed to read 'Bariatric Surgery for Treatment of Morbid Obesity.'

Section 244.000 has been updated to add procedure codes **43644, 43645, 43845, 43770, 43771, 43772, 43773,** and **43774** to the section which is titled 'Procedures that Require Prior Authorization'.

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

217.040 Bariatric Surgery for Treatment of Morbid Obesity 11-1-09

Bariatric surgery for morbid obesity is payable under the Medicaid Program with prior authorization. (See Section 241.000 of this manual for instructions on obtaining prior authorization.)

Morbid obesity is defined as a condition in which the presence of excess weight causes physical trauma; pulmonary and circulatory insufficiencies and complications related to treatment of other medical conditions.

Requirements for Bariatric Surgery

A. The beneficiary must be between 18 and 65 years of age.

B. The beneficiary has a documented body-mass index >35 and has at least one co-morbidity related to obesity.

C. The beneficiary must be free of endocrine disease as supported by an endocrine study consisting of a T3, T4, blood sugar and a 17-Keto Steroid or Plasma Cortisol.

D. Under the supervision of a physician, the beneficiary has made at least one documented attempt to lose weight in the past. The medically supervised weight loss attempt(s) as defined above must have been at least six months in duration.

E. Medical and psychiatric contraindications to the surgical procedure have been ruled out (and referrals made as necessary)

1. A complete history and physical, documenting the beneficiaries:
   a. Height, Weight, and BMI;
   b. The exclusion or diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome
2. A psychiatric evaluation no more than three months prior to requesting authorization. The evaluation should address the following:
   a. Ability to provide, without coercion, informed consent;
   b. Family and social support;
   c. Patient ability to comply with the postoperative care plan and identify potential psychiatric contraindications.

Note: Documentation that female beneficiaries have received counseling regarding potential birth defects from nutritional deficiencies if they should become pregnant during the weight stabilization period following bariatric surgery. Documentation all beneficiaries have been informed of possible adverse events related to the surgery.

Covered Procedures:

- Open and laparoscopic Roux-en-Y gastric bypass (RYGBP)
- Open and laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS)
- Laparoscopic Adjustable gastric banding(LAGB)
- Vertical banded gastroplasty
- Gastric Bypass

Non-Covered Procedures:

- Open adjustable gastric banding
- Open and laparoscopic sleeve gastrectomy

244.000 Procedures that Require Prior Authorization 11-1-09

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

J1565	Q0182	11960	11970	11971	15342	15343	15831
19318	19324	19325	19328	19330	19340	19342	19350
19355	19357	19361	19364	19366	19367	19368	19369
19370	19371	19380	20974	20975	21076	21077	21079
21080	21081	21082	21083	21084	21085	21086	21087
21088	21089	21120	21121	21122	21123	21125	21127
21137	21138	21139	21141	21142	21143	21145	21146
21147	21150	21151	21154	21155	21159	21160	21172
21175	21179	21180	21181	21182	21183	21184	21188
21193	21194	21195	21196	21198	21199	21208	21209
21244	21245	21246	21247	21248	21249	21255	21256
22520	22521	22522	30220	30400	30410	30420	30430
30435	30450	30460	30462	33140	33282	33284	36470
36471	37785	37788	38242	42820	42821	42825	42826
42842	42844	42845	42860	42870	43644	43645	43770
43771	43772	43773	43774	43842	43845	43846	43847
43848	43850	43855	43860	43865	50320	50340	50360
50365	50370	50380	51925	54360	54400	54415	54416
54417	55400	57335	58150	58152	58180	58260	58262
58263	58267	58270	58275	58280	58290	58291	58292
58293	58294	58345	58550	58552	58553	58554	58672
58673	58750	58752	59135	59840	59841	59850	59851
59852	59855	59856	59857	59866	61850	61860	61870
61875	61880	61885	61886	61888	63650	63655	63660
63685	63688	64573	64585	64809	64818	65710	65730

65750	65755	67900	69300	69310	69320	69714	69715
69717	69718	69930	87901	87903	87904	92393	92607
92608	93980	93981					

B. The following revenue codes require prior authorization.

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

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

DATE: **November 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #178**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
221.100	2-1-06	221.100	11-1-09
251.270	10-13-03	251.270	11-1-09
261.000	8-1-07	261.000	11-1-09
262.000	11-1-08	262.000	11-1-09
292.590	11-1-08	292.590	11-1-09
292.591	11-1-08	292.591	11-1-09
292.592	11-1-08	292.592	11-1-09
292.620	7-1-07	292.620	11-1-09
292.660	10-13-03	292.660	11-1-09

Explanation of Updates

Section 221.100 is revised to update information about Family Planning aid categories.

Section 251.270 is revised to provide coverage information regarding Bariatric Surgery.

Sections 261.000 and 262.000 are revised to add Bariatric surgical CPT procedure codes to the prior authorization section.

Section 292.590 is revised to provide information about HCPCS code **T1502** as payable for the administration of subcutaneous and/or intramuscular injections only.

Section 292.591 is revised to add HCPCS code **Q0166** as payable for -"Granistron HCl tab 1 mg.oral"(Kytril)**.**

Section 292.592 is revised to update the list of covered injections and immunizations.

Section 292.620 is revised to clarify billing for medical office supplies.

Section 292.660 is revised to incorporate Newborn care billing instructions from the CPT 2009 conversion.

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.

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Roy Jeffus, Director

TOC required

221.100 Additional Family Planning Benefit Information Regarding Aid Categories 69 and 61 11-1-09

A. Women in Aid Category 69, FP-W, are eligible for all family planning services, subject to the benefit limits listed in this manual.

Please refer to Section 243.100 for additional information regarding the Family Planning Services Demonstration Waiver.

B. Family planning services, including sterilization procedures, are also covered for women eligible in the Pregnant Woman-Poverty Level (PW-PL) category, Aid Category 61.Beneficiaries in aid category 61 are eligible for family planning services through the last day of the month in which the 60th day postpartum falls.

251.270 Bariatric Surgery for Treatment of Morbid Obesity 11-1-09

Bariatric Surgery for treatment of morbid obesity is payable under the Arkansas Medicaid Program with prior authorization. Refer to Section 261.100 of this manual for instructions on obtaining prior authorization.

Morbid obesity is defined as a condition in which the presence of excess weight causes physical trauma, pulmonary and circulatory insufficiencies and complications related to treatment of other medical conditions.

Requirements for Bariatric Surgery

A. The patient must be between 18 and 65 years of age.

B. The beneficiary has a documented body-mass index >35 and has at least one co-morbidity related to obesity.

C. The beneficiary must be free of endocrine disease as supported by an endocrine study consisting of a T3, T4, blood sugar and a 17-Keto Steroid or Plasma Cortisol.

D. Under the supervision of a physician the beneficiary has made at least one documented attempt to lose weight in the past. The medically supervised weight loss attempt(s) as defined above must have been at least six months in duration.

E. Medical and psychiatric contraindications to the surgical procedure have been ruled out (and referrals made as necessary)

1. A complete history and physical, documenting
   a. beneficiary's height, weight, and BMI
   b. the exclusion or diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome,
2. A psychiatric evaluation no more than three months prior to the requesting authorization. The evaluation should address these issues:
   a. Ability to provide, without coercion, informed consent,
   b. family and social support,
   c. patient ability to comply with the postoperative care plan and, identify potential psychiatric contraindications

Note: Documentation female candidates have received counseling regarding potential birth defects from nutritional deficiencies if they should become pregnant during the weight stabilization period

following bariatric surgery. Documentation all candidates have been informed of possible adverse events related to the surgery.

Covered Procedures

See Section 261.100 for prior authorization instructions and the Arkansas Medicaid Physicians fee schedule for covered procedure codes.

- Open and laparoscopic Roux-en-Y gastric bypass (RYGBP)
- Open and laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS)
- Laparoscopic adjustable gastric banding (LAGB) Vertical banded gastroplasty
- Gastric Bypass

Non-covered Procedures

The following bariatric surgery procedures are non-covered:

- Open adjustable gastric banding
- Open and laparoscopic sleeve gastrectomy

261.000 Obtaining Prior Authorization of Restricted Medical and Surgical Procedures 11-1-09

A. Certain medical and surgical procedures are covered only with prior authorization (PA). Most restricted procedures are prior authorized by the Arkansas Foundation for Medical Care, Inc. (AFMC). Refer to sections 261.100 through 261.220 for instructions on requesting PA from AFMC.

262.000 Procedures That Require Prior Authorization 11-1-09

The following procedure codes require prior authorization:

Procedure Codes							
D9220**	J7319	J7320	J7330	S0500	S2112	V2623	V2625
01966	11960	11970	11971	15400	15830	15847	19318
19324	19325	19328	19330	19340	19342	19350	19355
19357	19361	19364	19366	19367	19368	19369	19370
19371	19380	20974	20975	21076	21077	21079	21080
21081	21082	21083	21084	21085	21086	21087	21088
21089	21120	21121	21122	21123	21125	21127	21137
21138	21139	21141	21142	21143	21145	21146	21147
21150	21151	21154	21155	21159	21160	21172	21175
21179	21180	21181	21182	21183	21184	21188	21193
21194	21195	21196	21198	21199	21208	21209	21244
21245	21246	21247	21248	21249	21255	21256	27412
27415	27416	28446	29866	29867	29868	30220	30400
30410	30420	30430	30435	30450	30460	30462	32851
32852	32853	32854	33140	33282	33284	33945	36470

Procedure Codes							
36471	37785	37788	38240	38241	38242	42820	42821
42825	42826	42842	42844	42845	42860	42870	43257
43644	43645	43770	43771	43772	43773	43774	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					

* 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.

292.590 Injections 11-1-09

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.

T1502 is payable for beneficiaries of all ages. T1502 may be used for billing the administration of subcutaneous and/or Intramuscular injections only. This procedure code cannot be billed when the medication is administered “ORALLY.” No fee is billable for drugs administered orally.

T1502 cannot be billed to administer any medication given for family planning purposes.

No other fee is billable when the provider decides not to supply family planning injectable medications. T1502 cannot be billed when the drug administered is not FDA approved.

Procedure Code	Modifier	Eligibility Category
T1502	EP	ARKidsA (Ages 0-20)
T1502		ARKidsB
T1502		Ages 19 and above

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.

Arkansas Medicaid follows the 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 11-1-09

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

Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take home drugs." Refer to CPT code ranges **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

Procedure Codes							
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	J2650
J2670	J2675	J2680	J2690	J2700	J2710	J2720	J2725
J2730	J2760	J2765	J2770	J2780	J2783*	J2800	J2820
J2920	J2930	J2941	J2950	J2995	J3000	J3010	J3030
J3070	J3105	J3120	J3130	J3140	J3150	J3230	J3240
J3250	J3260	J3265	J3280	J3301	J3302	J3303	J3305
J3310	J3315	J3320	J3350	J3360	J3364	J3365	J3370
J3400	J3410	J3430	J3470	J3475	J3480	J3485	J3490*
J3520	J7197	J7308	J7310	J7501	J7504	J7505	J7506
J7507	J7509	J7510	J7511	J7513	J7518	J7599*	J8530
J9000	J9001	J9010	J9015	J9017	J9020	J9031	J9040
J9045	J9050	J9060	J9062	J9065	J9070	J9080	J9090

Procedure Codes							
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*	Q0166**	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.

** In addition use UB modifier for Q0166 –"Granistron HCl tab1mg.oral" (Kytril).

292.592 Other Covered Injections and Immunizations with Special Instructions 11-1-09

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

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

Procedure Code	Modifier(s)	Special Instructions
J0129*		Requires ICD-9-CM diagnosis code of 714.0-714.2 as primary diagnosis. Patient must have had inadequate response to one or more disease-modifying anti-rheumatic drugs such as Methotrexate or Tumor Necrosis Factor antagonists (Humira, Remicade, etc.). Records submitted with claim must include history and physical exam showing severity of rheumatoid arthritis, treatment with disease-modifying anti-rheumatic drugs, and treatment failure resulting in progression of joint destruction, swelling, tendonitis, etc. Prior approval letter from DMS Medical Director required to be attached to each claim. See 244.100 for information regarding requests for prior approval letters.
J0133		Payable for beneficiaries of all ages with diagnosis codes 053.0 –

Procedure Code	Modifier(s)	Special Instructions
		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 range 640 – 648.93).
J0881		Use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for red

<table>
<tr><th>Procedure Code</th><th>Modifier(s)</th><th>Special Instructions</th></tr>
<tr><td>J0885</td><td></td><td>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.
<table>
<tr><th>Column 1</th><th colspan="2">Column II</th></tr>
<tr><th></th><th>Code</th><th>Description</th></tr>
<tr><td rowspan="3">285.9 Secondary Anemia</td><td>V58.11</td><td>Encounter for antineoplastic chemotherapy</td></tr>
<tr><td>V67.2</td><td>Following chemotherapy</td></tr>
<tr><td>E933.1</td><td>Antineoplastic and immunosuppressive drugs</td></tr>
</table>
Use ICD-9-CM code 285.29 (primary) with 070.54, 238.72-238.75, or 714.0-714.4 (secondary) to represent patients with anemia due to 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.
<table>
<tr><th>Column I</th><th colspan="2">Column II</th></tr>
<tr><th></th><th>Code</th><th>Description</th></tr>
<tr><td rowspan="3">285.29 Anemia of other chronic disease</td><td>070.54</td><td>Chronic Hepatitis C without mention of coma</td></tr>
<tr><td>238.72-238.75</td><td>Myelodysplastic</td></tr>
<tr><td>714.0-714.4</td><td>Rheumatoid Arthritis</td></tr>
</table></td></tr>
<tr><td>J0882
J0886</td><td></td><td>Payable for dates of service on and after March 1, 2006. Covered when administered to patients diagnosed with ESRD (diagnosis range 584 – 586).</td></tr>
<tr><td>J0894*</td><td></td><td>Requires ICD-9-CM diagnosis codes of 205.00-205.91, 238.71-238.76, or 238.79. Prior approval letter from DMS Medical Director required to be attached to each claim. Refer to 244.100 for information regarding requesting prior approval.</td></tr>
<tr><td>J1100</td><td></td><td>Payable for beneficiaries of all ages. However, when provided to beneficiaries aged 21 and older, there must be a diagnosis of AIDS, cancer or complications during pregnancy (diagnosis code range 640 – 648.93).</td></tr>
<tr><td>J1270</td><td></td><td>Payable for beneficiaries with diagnosis codes 042,140.0 -208.91 + 230.0-238-9 + 787.2 + 588.81;</td></tr>
</table>

Procedure Code	Modifier(s)	Special Instructions
		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 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.

Procedure Code	Modifier(s)	Special Instructions
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.
J1750		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.
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

Procedure Code	Modifier(s)	Special Instructions
		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.
J2597		Payable for beneficiaries of all ages with no diagnosis restrictions.
J2778*		Requires ICD-9-CM diagnosis code of 362.50 or 362.52 as primary diagnosis. Requires prior approval letter from DMS Medical Director attached to each claim. Refer to section 244.100 for information on how to acquire a prior approval letter.
J2788		Payable for beneficiaries of all ages with no diagnosis restrictions.
J2790 J2791		Payable for beneficiaries of all ages with no diagnosis restrictions.
J2792		Payable without restriction.
J2910		Payable for all beneficiaries with a primary detail diagnosis of rheumatoid arthritis (ICD-9 diagnosis codes 714.0 – 714.9).
J2916		Payable for beneficiaries of all ages with no restrictions.

Procedure Code	Modifier(s)	Special Instructions
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		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.
J3488		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7187 J7190 J7191 J7192 J7193 J7194 J7195 J7197		Payable for beneficiaries of all ages with no diagnosis restrictions.
J7198		Payable for all ages with no diagnosis restrictions.
J7199		For consideration, this code must be billed on a paper claim form with the name of the drug, dosage and the route of administration.
J7321 J7322 J7323 J7324		Requires prior authorization through Utilization Review Section of DMS. Providers must specify brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization. Written request must be submitted to DMS Utilization Review. Refer to 261.240 for PA information.
J7330		Requires prior authorization from AFMC for all providers. See sections 260.000, 261.000, 261.100 and 261.110.
J7340		Payable for beneficiaries of all ages with no diagnosis restrictions

Procedure Code	Modifier(s)	Special Instructions
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 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.
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 each claim. See section 244.100 for additional coverage

Procedure Code	Modifier(s)	Special Instructions
		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 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

Procedure Code	Modifier(s)	Special Instructions
		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 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.

Procedure Code	Modifier(s)	Special Instructions
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.
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.

Procedure Code	Modifier(s)	Special Instructions
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 section 292.593.

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

292.620 Office Medical Supplies - Beneficiaries Under Age 21 11-01-09

For beneficiaries under age 21, procedure code **99070** is payable to physicians for supplies and materials (except eyeglasses), provided by the physician over and above those usually included with the office visit or other services rendered. Procedure code **99070** must not be billed for the provision of drug supply samples and may not be billed on the same date of service as a surgery code. Procedure code **99070** is limited to beneficiaries under age 21. Use the EP modifier for ARKids A.

292.660 Newborn Care 11-1-09

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn will be responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. The hospital/physician can refer interested individuals to Human Services through the Hospital/Physician Referral Program. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

Newborn Care Services (Initial Screening)

These procedure codes represent the initial newborn screening. This screening includes the physical exam of the baby and the conference(s) with newborn's parent(s) and is considered to be the initial newborn care/screen. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to codes 99460, 99461, and 99463.

Note the descriptions, modifiers, and required diagnosis range. The newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis of V30.00-V37.21 for all providers.

A. Physician Billing Instructions for Newborn Care

For ARKids A (EPSDT): Requires an EPSDT claim form or CMS 1500; may be billed electronically or on paper.

Procedure Code	Modifier 1	Modifier 2	Description
99460	EP	UA	Initial hospital/birthing center care, normal newborn (global)
99461	EP	UA	Initial care normal newborn other than hospital/birthing center (global)
99463	EP	UA	Initial hospital/birthing center care, normal newborn admitted/discharged same date of service (global)

For ARKids First B: Requires CMS-1500 claim form; may be billed electronically or on paper.

Procedure Code	Modifier	Description
99460	UA	Initial hospital/birthing center care, normal newborn (global)
99461	UA	Initial care normal newborn other than hospital/birthing center (global)
99463	UA	Initial hospital/birthing center care, normal newborn admitted/discharged same date of service (global)

View or print Child Health Services contact information.

For illness care, e.g., neonatal jaundice, use procedure codes **99221** through **99233**. Do **not** bill **99431, 99432** or **99435** in addition to these codes.

When billing for critical care services, refer to the CPT book for procedure codes and billing information.

For newborn resuscitation, use procedure code **99440.**