ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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NOTICE OF RULE MAKING

TO: **Health Care Providers – All Providers**

DATE: **August 26, 2016**

SUBJECT: **2016 Current Procedural Terminology (CPT®) Code Conversion**

I. General Information

A review of the 2016 Current Procedural Terminology (CPT®) procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting CPT® 2016 procedure codes for dates of service on and after August 26, 2016.

Procedure codes that are identified as deletions in CPT® 2016 (Appendix B) are **non-payable** for dates of service on and after August 26, 2016.

For the benefit of those programs impacted by the conversions, the Arkansas Medicaid website fee schedules will be updated soon after the implementation of the 2016 CPT® and Healthcare Common Procedure Coding System Level II (HCPCS) conversions.

II. Process for Obtaining Prior Authorization

When obtaining a Prior Authorization (PA) from the Arkansas Foundation for Medical Care (AFMC), please send your request to the following:

In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax	(479) 649-0799
Web portal	https://afmc.org/review/iexchange/
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	5111 Rogers Avenue, Suite 476 Fort Smith, AR 72903
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

III. Non-Covered 2016 CPT® Procedure Codes

A. Effective for dates of service on and after August 26, 2016, the following CPT® procedure codes are non-covered:

31652	31653	31654	33477	43210	50705	61645	61650
61651	65785	77767	77768	78265	78266	81219	81273
81311	81490	81493	81525	81528	81535	81536	81538
81540	81545	90625	90697	93050	96931	96932	96933
96934	96935	93636	99177				

B. All 2016 CPT® procedure codes listed in **Category II** (supplemental tracking for performance codes) and **Category III** (a set of temporary codes for emerging technology) are not recognized by Arkansas Medicaid; therefore, they are non-covered.

C. The following new 2016 CPT® procedure codes are not payable to Outpatient Hospitals because these services are covered by another CPT® procedure code, another HCPCS code or a revenue code:

10036	45742	47543	47544	50606	50706	64462

IV. CPT® Lab and Molecular Pathology Procedure Codes

Molecular Pathology procedure codes in this section listed in points A and B below, require Prior Authorization (PA). Providers are to acquire Prior Authorization before a claim for Molecular Pathology is filed for payment. Providers may request the PA from Arkansas Foundation for Medical Care (AFMC) before or after the procedure is performed as long as it is acquired within the 365-day filing deadline. Providers of these procedures may submit Molecular Pathology requests and medical record documentation to AFMC via mail, fax or electronically through a web portal. See additional contact information for AFMC in Section II of this notice.

Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory Services (Form DMS-841) and the attachment of all pertinent clinical documentation needed to justify the procedure. If the request is approved, a Prior Authorization number will be assigned and the provider will receive notification of the approval in writing by mail. If the request does not meet the medical necessity criteria and is denied, the requesting provider will receive notification of the denial in writing by mail. Reconsideration is allowed if new or additional information is received by AFMC within 30 days of the initial denial. A sample copy of Form DMS-841 is attached. This form may be found in Section V of the provider manual. Copies may be made of this form. The enclosed form is for informational purposes only. **Please do not complete the enclosed form unless you are submitting a Molecular Pathology PA request.**

Molecular Pathology procedure codes must be submitted on a redline paper claim form with the PA listed on the claim and the itemized invoice attached that supports the charges for the test billed.

A. The following 2016 CPT® Molecular Pathology codes require a Prior Authorization from the Arkansas Foundation for Medical Care (AFMC):

81162	81170	81218	81272	81276	81314	81412	81422*
81432*	81433*	81434*	81437*	81438*			

*Requires paper claim submission.

B. The following 2016 CPT® Laboratory codes with special coverage criteria include the following:

Procedure Code	Age Restriction in Years	Diagnosis	Special Instructions	Requires Prior Authorization
81412	No	No	Panel testing is only covered when the panel would replace and would be of similar or lower cost than individual gene testing including CF carrier testing.	Yes
81595	No	No	Generic testing for cardiac transplant rejection (CPT 81595) included only for patients at least (1) one year post transplant who are without clinical signs of rejections.	Yes

V. Hearing Providers

The following 2016 CPT® procedure codes are payable to Hearing Providers:

92537	92538

VI. Hospital Providers

The following 2016 CPT® procedure code is payable to Hospital Providers with special instructions:

Procedure Code	Required Modifiers	Age Restriction in Years
49185	No	No

NOTE: Requires paper billing and documentation attached that describes that sclerotherapy of fluid collections is indicated for the treatment of cysts, seromas or lymphoceles which are causing bleeding, infection, severe pain, organ torsion or organ dysfunction.

VII. Independent Radiology Providers

The following 2016 CPT® procedure codes are payable to Independent Radiology Providers:

72081	72082	72083	72084	73501	73502	73503	73521
73522	73523	73551	73552	74712	74713	77770	77771
77772							

Procedure Code	Required Modifiers	Age Restriction in Years
74712	No	No
74713	No	No

NOTE: Fetal MRI is covered when all of the following conditions are met: 1) Abnormalities are found on fetal ultrasound performed by an experienced sonologist which cannot be adequately further evaluated by 2D or 3D ultrasound. 2) The information obtained by fetal MRI is necessary for decisions about fetal or neonatal therapy, delivery planning or to advise a family about prognosis. 3) The fetus is 18 weeks gestational age or older. 4) The MRI is performed and interpreted at a center with technicians and radiologists who are either trained or highly experienced on fetal MRI and which has appropriate MRI equipment.

VIII. Nurse Practitioner

The payment for Laboratory codes listed on the **Nurse Practitioner Fee Schedule** is based on Clinical Laboratory Improvement Amendments (C.L.I.A.) certification. Note that only C.L.I.A.-certified providers may bill for lab procedures performed in the provider's office, place of service 11. Nurse Practitioner Providers that bill C.L.I.A.-required Laboratory procedure codes must have the current C.L.I.A. certification on file with the Arkansas Medicaid Provider Enrollment Unit.

*The **technical** component of Radiology procedure codes listed on the **Nurse Practitioner Fee Schedule** is payable when performed in the office place of service (11) if the Nurse Practitioner Provider owns the equipment. The technical component must be billed on the claim with modifier **TC** added to the procedure code on the claim detail.

Procedure Code	Required Modifiers	Age Restriction in Years
74712	No	No
74713	No	No

NOTE: Fetal MRI is covered when all of the following conditions are met: 1) Abnormalities are found on fetal ultrasound performed by an experienced sonologist which cannot be adequately further evaluated by 2D or 3D ultrasound. 2) The information obtained by fetal MRI is necessary for decisions about fetal or neonatal therapy, delivery planning or to advise a family about prognosis. 3) The fetus is 18 weeks gestational age or older. 4) The MRI is performed and interpreted at a center with technicians and radiologists who are either trained or highly experienced on fetal MRI and which has appropriate MRI equipment.

The following 2016 CPT® procedure codes are payable to Nurse Practitioner Providers:

69209	72081	72082	72083	72084	73501	73502	73503
73521	73522	73523	73551	73552	74712	74713	77770
77771	77772	80081	81162	81170	81218	81272	81276
81412	81432	81433	81434	81437	81438	81442	88350
99188							

IX. Oral Surgeons

The following 2016 CPT® procedure codes are payable to Oral Surgeon Providers:

99415	99416

X. Miscellaneous Information

A. Effective for dates of service on or after August 26, 2016 – sterilization procedure **58565** (hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) and the supply of the implant will no longer be covered by Arkansas Medicaid for any provider program.

B. Existing CPT® procedure codes **43775 and 43843** are now payable to Physicians:

Procedure Code	Required Modifiers	Age Restriction in Years	Special Instructions
43775	No	18y - 64y	Requires Prior Authorization
43843	No	18y - 64y	Requires Prior Authorization

C. Existing CPT® procedure code **99188** is now payable to Physicians and Nurse Practitioners:

Procedure Code	Required Modifier	Age Restriction in Years
99188	No	0 - 20y

NOTE: Dental prophylaxis and a fluoride treatment are preventive treatments covered by Medicaid. Prophylaxis, in addition to application of topical fluoride and/or fluoride varnish, is covered every six (6) months plus one (1) day for beneficiaries under age 21. As a result of Act 90 of 2011, Arkansas physicians, nurses and other licensed health care professionals, as well as dentists, dental hygienists and dental assistants, can apply fluoride varnish. Arkansas Medicaid covers fluoride varnish application performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health. Eligible physicians may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. Physicians and nurse practitioners must complete training on dental caries risk and have an approved fluoride varnish certification from the Arkansas Department of Health, Office of Oral Health. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate to HPE Provider Enrollment. The course that meets the requirements outlined by Act 90 of 2011 can be accessed at http://ar.train.org. If further treatment is needed due to severe periodontal problems, the provider must request Prior Authorization with a brief narrative.

Dental Providers must follow the Dental Program Manual for policy related to this service.

D. Existing CPT® procedure code **77387** is now payable to Nurse Practitioner, Physician, Hospital and Independent Radiology Providers with Prior Authorization from the Arkansas Foundation for Medical Care (AFMC):

Procedure Code	Required Modifier	Prior Authorization
77387	No	Yes

E. Diagnosis code **Z51.89** is a payable ICD-10 diagnosis and should be used according to ICD protocols.

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

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NOTICE OF RULE MAKING

TO: **Health Care Providers – All Providers**

DATE: **August 26, 2016**

SUBJECT: **2016 Healthcare Common Procedure Coding System Level II (HCPCS) Code Conversion and Code on Dental Procedures and Nomenclature (CDT) Conversion**

I. General Information

A review of the 2016 HCPCS procedure codes has been completed and the Arkansas Medicaid Program will begin accepting updated Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes on claims with dates of service on and after August 26, 2016. Drug procedure codes require National Drug Code (NDC) billing protocol. Drug procedure codes that represent radiopharmaceuticals, vaccines and allergen immunotherapy are exempt from the NDC billing protocol.

Procedure codes that are identified as deletions in 2016 HCPCS Level II and 2016 Current Dental Terminology (CDT) will become non-payable for dates of service on and after August 26, 2016.

Please NOTE: The Arkansas Medicaid website fee schedules will be updated soon after the implementation of the 2016 CPT and HCPCS conversions.

II. 2016 HCPCS Payable Procedure Codes Tables Information

Procedure codes are in separate tables. Tables are created for each affected provider type (i.e., Prosthetics, Home Health, etc.).

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

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

1. The **first** column of the list contains the HCPCS procedure codes. The procedure code may be on multiple lines on the table, depending on the applicable modifier(s) based on the service performed.
2. The **second** column indicates any modifiers that must be used in conjunction with the procedure code, when billed, either electronically or on paper.
3. The **third** column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years.
4. Certain procedure codes are covered only when the primary diagnosis is covered within a specific ICD diagnosis range. This information is used, for example, by physicians and hospitals. The **fourth** column, for all affected programs, indicates the

beginning and ending range of ICD CM diagnoses for which a procedure code may be used.

5. The **fifth** column contains information about the diagnosis list for which a procedure code may be used. (See Section IV of this notice for more information about diagnosis range and lists.)
6. The **sixth** column indicates whether a procedure is subject to medical review before payment. The column is titled "Review." The word "Yes" or "No" in the column indicates whether a review is necessary or not. Providers should consult their program manual to obtain the information that is needed for a review.
7. The **seventh** column shows procedure codes that require Prior Authorization (PA) before the service may be provided. The column is titled "PA." The word "Yes" or "No" in the column indicates if a procedure code requires Prior Authorization. Providers should consult their program manual to ascertain what information should be provided for the Prior Authorization process.

III. A. Process for Obtaining a Prior Authorization Number from Arkansas Foundation for Medical Care (AFMC)

In collaboration with AFMC, DMS is changing the process for acquiring prior approval for drug procedure codes from a prior approval letter to a Prior Authorization number (PA). Instead of attaching a prior approval letter to a paper claim, providers will now list the Prior Authorization number on the claim. This will mean that effective for claims submitted on and after August 26, 2016, drug procedure codes requiring Prior Authorization should be billed with the PA number listed on the claim form. These drugs may be billed electronically or on a paper claim. Additionally, these procedure codes requiring a PA will no longer require manual review during the processing of the claim.

As part of the transition, AFMC will send a letter to all providers who have approval letters spanning timeframes within the last 365 days at the time of the effective date of this policy. The letter will contain a Prior Authorization number and the total remaining number of the approved units that can be billed. Any providers who have questions regarding Prior Authorization numbers and/or the transition process outlined above can contact AFMC at the following:

Toll Free: 1-877-350-2362, ext. 8741 or (501) 212-8741

A Prior Authorization number (PA) must be requested before treatment is initiated for any drug, therapeutic agent or treatment that indicates a Prior Authorization is required in a provider manual or an official Division of Medical Services correspondence.

The Prior Authorization requests should be completed using the approved AFMC Prior Authorization request form and must be submitted by mail, fax or *iexchange* at (**https://afmc.org/review/iexchange/***)*. **(View or print PA form.)**

Field Code Changed

A decision letter will be returned to the provider by fax or *iexchange* within five (5) business days.

If approved, the Prior Authorization number must be appended to all applicable claims, within the scope of the approval and may be billed electronically or on a paper claim with additional documentation when necessary. Claims billed on paper will be subject to a 30 day hold of the adjudicated payment.

Denials will be subject to reconsideration if received by AFMC with additional documentation within fifteen (15) business days of date of denial letter.

A reconsideration decision will be returned within five (5) business days of receipt of the reconsideration request.

B. Contact Information for Obtaining Prior Authorization

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

In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax – General	(479) 649-0799
Fax – Physician Drug Reviews Only (PDR)	(501) 212-8663
Web portal	https://afmc.org/review/iexchange/
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	5111 Rogers Avenue, Suite 476 Fort Smith, AR 72903
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

IV. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), Diagnosis Range and Diagnosis Lists

Diagnosis is documented using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). Certain procedure codes are covered only for a specific primary diagnosis or a particular diagnosis range. **Diagnosis list 103** is specified here (**View ICD Codes.**). For any other diagnosis restrictions, reference the table for each individual program.

Field Code Changed

V. HCPCS Procedure Codes Payable to Certified Nurse Midwife Providers

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

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0695	No	18y & up	No	No	No	No
J2547	No	18y & up	View ICD Codes.	No	No	No
J7298*	FP	12y–65y	No	No	No	No

NOTE: J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.

*For females only

Field Code Changed

VI. Dental

A. The following 2016 American Dental Association (ADA) Dental procedure codes **are not covered** by Arkansas Medicaid:

D0251	D0422	D0423	D1354	D4283	D4285	D5221	D5222
D5223	D5224	D7881	D8681	D9243	D9932	D9933	D9934
D9935	D9943						

B. American Dental Association procedure code **D0190** is payable to dentists and oral surgeons. **D0190 is NOT payable with D0120, D0140, D1206, D1208** or **D1120** when billed on the same date of service or within 180 days.

C. American Dental Association procedure code **D9223** is payable to oral surgeons and dentists for ages 0y-20y with Prior Authorization. **D9223** replaces 2016 deleted codes **D9221** and **D9222.**

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

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

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1443	No	No	No	No	No	Yes

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

The following information is related to procedure codes payable to Federally Qualified Health Center providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7298*	FP	12y–65y	No	No	No	No
NOTE:	J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.					

*For females only

IX. HCPCS Procedure Codes Payable to Home Health Providers

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

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
A4337	NU EP	No	No	No	No	No
T4525*	NU EP	3y & up	No	No	No	No

*Existing code being made payable in 2016. The description for T4525 is as follows: Adult-sized disposable incontinent product, protective underwear/pull-on, small sized, each.

X. HCPCS Procedure Codes Payable to Hospitals

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

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
C9460	No	18y & up	No	No	No	No
NOTE:	Kengreal is a $P2Y_{12}$ platelet inhibitor indicated as an adjunct to percutaneous coronary intervention (PCI) for reducing the risk of periprocedure myocardial infarction (MI), repeat coronary revascularization, and stent thrombosis (ST) in patients who have not been treated with a $P2Y_{12}$ platelet inhibitor and are not being given a glycoprotein IIB/IIIA inhibitor.					
J0202	No	No	No	No	No	Yes
J0596	No	13y & up	View ICD Codes.	No	Yes	No
J0695	No	18y & up	No	No	No	No
J0714	No	18y & up	No	No	No	No
J0875	No	18y & up	No	No	No	No
J1443	No	No	No	No	No	Yes

Field Code Changed

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1447	No	No	No	No	No	Yes
J1575	No	18y & up	No	No	Yes	No
J1833	No	18y & up	No	No	No	No
J2407	No	18y & up	No	No	No	No
J2502	No	No	No	No	No	Yes
J2547	No	18y & up	View ICD Codes.	No	No	No
J2860	No	No	No	No	No	Yes
J3090	No	18y & up	No	No	No	No
J3380	No	No	No	No	No	Yes
J7121	No	No	No	No	No	No
J7188	No	No	No	No	No	Yes
J7205	No	No	No	No	No	Yes
J7298*	No	12y–65y	No	View ICD Codes.	No	No
J7298*	FP	12y–65y	No	No	No	No
NOTE:	J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.					
J7313	No	No	No	No	No	Yes
J7328	No	No	No	No	No	Yes
J9032	No	No	No	No	No	Yes
J9039	No	No	No	No	No	Yes
J9271	No	No	No	No	No	Yes
J9299	No	No	No	No	No	Yes
J9308	No	No	No	No	No	Yes
Q5101	No	No	No	No	No	Yes
Q9980	No	No	No	No	No	Yes

*For females only

Field Code Changed

Field Code Changed

XI. HCPCS Procedure Codes Payable to Nurse Practitioners

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

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
C9460	No	18y & up	No	No	No	No
NOTE:	Kengreal is a $P2Y_{12}$ platelet inhibitor indicated as an adjunct to percutaneous coronary intervention (PCI) for reducing the risk of periprocedure myocardial infarction (MI), repeat coronary revascularization, and stent thrombosis (ST) in patients who have not been treated with a $P2Y_{12}$ platelet inhibitor and are not being given a glycoprotein IIB/IIIA inhibitor.					
J0202	No	No	No	No	No	Yes
J0596	No	13y & up	View ICD Codes.	No	Yes	No
J0695	No	18y & up	No	No	No	No
J0714	No	18y & up	No	No	No	No
J0875	No	18y & up	No	No	No	No
J1443	No	No	No	No	No	Yes
J1447	No	No	No	No	No	Yes
J1575	No	18y & up	No	No	Yes	No
J1833	No	18y & up	No	No	No	No
J2407	No	18y & up	No	No	No	No
J2502	No	No	No	No	No	Yes
J2547	No	18y & up	View ICD Codes.	No	No	No
J2860	No	No	No	No	No	Yes
J3090	No	18y & up	No	No	No	No
J3380	No	No	No	No	No	Yes
J7121	No	No	No	No	No	No
J7188	No	No	No	No	No	Yes
J7205	No	No	No	No	No	Yes
J7298*	No	12y–65y	No	View ICD Codes.	No	No

Field Code Changed

Field Code Changed

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7298*	FP	12y–65y	No	No	No	No
NOTE:	J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.					
J7328	No	No	No	No	No	Yes
J9032	No	No	No	No	No	Yes
J9039	No	No	No	No	No	Yes
J9271	No	No	No	No	No	Yes
J9299	No	No	No	No	No	Yes
J9308	No	No	No	No	No	Yes
Q5101	No	No	No	No	No	Yes
Q9980	No	No	No	No	No	Yes

*For females only

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

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

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
C9460	No	18y & up	No	No	No	No
NOTE:	Kengreal is a $P2Y_{12}$ platelet inhibitor indicated as an adjunct to percutaneous coronary intervention (PCI) for reducing the risk of periprocedure myocardial infarction (MI), repeat coronary revascularization, and stent thrombosis (ST) in patients who have not been treated with a $P2Y_{12}$ platelet inhibitor and are not being given a glycoprotein IIB/IIIA inhibitor.					
J0202	No	No	No	No	No	Yes
J0596	No	13y & up	View ICD Codes.	No	Yes	No
J0695	No	18y & up	No	No	No	No
J0714	No	18y & up	No	No	No	No
J0875	No	18y & up	No	No	No	No
J1443	No	No	No	No	No	Yes

Field Code Changed

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1447	No	No	No	No	No	Yes
J1575	No	18y & up	No	No	Yes	No
J1833	No	18y & up	No	No	No	No
J2407	No	18y & up	No	No	No	No
J2502	No	No	No	No	No	Yes
J2547	No	18y & up	View ICD Codes.	No	No	No
J2860	No	No	No	No	No	Yes
J3090	No	18y & up	No	No	No	No
J3380	No	No	No	No	No	Yes
J7121	No	No	No	No	No	No
J7188	No	No	No	No	No	Yes
J7205	No	No	No	No	No	Yes
J7298*	No	12y–65y	No	View ICD Codes.	No	No
J7298*	FP	12y–65y	No	No	No	No
NOTE: J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.						
J7313	No	No	No	No	No	Yes
J7328	No	No	No	No	No	Yes
J9032	No	No	No	No	No	Yes
J9039	No	No	No	No	No	Yes
J9271	No	No	No	No	No	Yes
J9299	No	No	No	No	No	Yes
Q5101	No	No	No	No	No	Yes
Q9980	No	No	No	No	No	Yes

*For females only

Field Code Changed

XIII. HCPCS Procedure Codes Payable to Private Duty Nursing Providers

The following information is related to procedure codes payable to Private Duty Nursing providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
A4337	NU EP	No	No	No	No	No

XIV. HCPCS Procedure Codes Payable to Prosthetics Providers

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

Procedure codes in the table must be billed with appropriate modifiers. For procedure codes that require a Prior Authorization, the written PA request must be submitted to the Arkansas Foundation for Medical Care (AFMC) for wheelchairs and wheelchair-related equipment and services.

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

Procedure Code	Modifier	Diagnosis	Diagnosis List	Review	PA
A4337	NU EP	No	No	No	No
E1012	NU EP	No	No	No	Yes
T4525*	NU EP	No	No	No	No

*Existing code being made payable in 2016. The description for T4525 is as follows:
Adult-sized disposable incontinent product, protective underwear/pull-on, small sized, each.

XV. HCPCS Procedure Codes Payable to Ventilator Providers

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

⁂(…)This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

2016 Replacement Code	2016 Deleted Code	Required Modifier	Description	PA	Units	Payment Method
E0465	E0450	None	⁂(New equipment) Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Rental Only
E0465	E0450	UB	⁂(Volume control ventilator supplies – Includes suction catheter kits, trach kits, trach tubes, sterile water and all respiratory care supplies.) Volume control ventilator may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Purchase
E0465	E0450	U1	⁂(Used equipment) Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Rental Only
E0466	E0460	UI	Negative pressure ventilator; portable or stationary	Yes	1 per day (1 day = 1 unit)	Rental Only

2016 Replacement Code	2016 Deleted Code	Required Modifier	Description	PA	Units	Payment Method
E0466	E0463	No	⁂Pressure support ventilator, with volume control mode, may include pressure control mode, used with non-invasive interface (e.g., tracheostomy tube).	Yes	1 per day (1 day = 1 unit)	Rental Only
E0466	E0463	UB	⁂(Pressure support ventilator supplies – Includes suction catheter kits, trach kits, trach tubes, sterile water and all respiratory care supplies)	Yes	1 per day (1 day = 1 unit)	Purchase

XVI. Miscellaneous Information

A. Existing HCPCS procedure code **T4525** is being made payable in 2016 for Prosthetic and Home Health providers. The description for **T4525** is as follows:

Adult-sized disposable incontinent product, protective underwear/pull-on, small sized, each.

B. **L1902, L1904** and **L8621** have national new descriptions in HCPCS 2016.

C. HCPCS procedure code **C9349** is an existing code, whose description was changed in 2016. Effective on or before dates of service August 26, 2016, **C9349** will not be covered by Arkansas Medicaid.

D. The description for existing HCPCS procedure code **K0017** has been changed to the national description. Procedure codes **K0017** and **K0018** are existing codes, but the description and utilization of the codes have changed.

E. The following table represents updates in Specialized Wheelchair and Wheelchair Seating Systems for Individuals ages two (2) through adult:

Procedure Code	Modifier	Description	PA	Maximum Units	Payment Method
K0017	NU EP	Detachable , adjustable height armrest, base, replacement only	No	2	Purchase
K0018	NU EP	Detachable , adjustable height armrest, upper portion, replacement only	No	2	Purchase
L1902	NU EP	Ankle orthosis, ankle gauntlet or similar, with or without joints, prefabricated ,off the shelf	No	2	Purchase
L1904	NU EP	Ankle orthosis, ankle gauntlet or similar, with or without joints, custom fabricated	No	2	Purchase
L8621	EP	Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement each	Yes	180 units per 6 months (360)	

E. The following table of existing HCPCS codes are covered and require a Prior Authorization from AFMC.

Procedure Code	Procedure Code	Procedure Code	Procedure Code	Procedure Code	Procedure Code	Procedure Code
C9257	J0129	J0178	J0180	J0220	J0221	J0490
J0641	J0717	J0894	J0897	J1458	J1556	J1602
J1743	J1745	J1756	J1786	J1931	J2323	J2353
J2354	J2507	J2778	J3060	J3262	J3357	J3385
J7310	J7312	J7316	J7321	J7323	J7324	J7325
J7327	J9019	J9025	J9033	J9035	J9041	J9042
J9043	J9047	J9055	J9160	J9178	J9179	J9207
J9226	J9228	J9261	J9262	J9263	J9264	J9301
J9302	J9303	J9305	J9306	J9307	J9328	J9354
J9371	J9395	J9400	Q2043			

F. Diagnosis code **Z51.89** is a payable ICD-10 diagnosis and should be used according to ICD protocols.

XVII. Non-Covered HCPCS Procedure Codes

The following 2016 HCPCS procedure codes **are not covered** by Arkansas Medicaid:

C1822	C2613	C2623	C2645	C9349	C9458	C4959
C9743	G0296	G0297	G0300	G0475	G0476	G0477
G0478	G0479	G0480	G0481	G0482	G0483	G9473
G9474	G9475	G9476	G9477	G9478	G9479	G9480
G9496	G9497	G9498	G9499	G9500	G9501	G9502
G9503	G9504	G9505	G9506	G9507	G9508	G9509
G9510	G9511	G9512	G9513	G9514	G9515	G9516
G9517	G9518	G9519	G9520	G9521	G9522	G9523
G9524	G9525	G9526	G9529	G9530	G9531	G9532
G9533	G9534	G9535	G9536	G9537	G9538	G9539
G9540	G9541	G9542	G9543	G9544	G9547	G9548
G9549	G9550	G9551	G9552	G9553	G9554	G9555
G9556	G9557	G9558	G9559	G9560	G9561	G9562
G9563	G9572	G9573	G9574	G9577	G9578	G9579
G9580	G9581	G9582	G9583	G9584	G9585	G9593
G9594	G9595	G9596	G9597	G9598	G9599	G9600
G9601	G9602	G9603	G9604	G9605	G9606	G9607
G9608	G9609	G9610	G9611	G9612	G6913	G9614
G9615	G9616	G6917	G9618	G9619	G9620	G9621
G9622	G9623	G9624	G9625	G9626	G9627	G9628
G9629	G9630	G9631	G9632	G9633	G9634	G9635
G9636	G9637	G9638	G9639	G9640	G9641	G9642
G9643	G9644	G9645	G9646	G9647	G9648	G9649
G9650	G9651	G9652	G9653	G9654	G9655	G9656
G9657	G9658	G9659	G9660	G9661	G9662	G9663
G9664	G9665	G9666	G9667	G9669	G9670	G9671
G9672	G9673	G9674	G9675	G9676	G9677	J7297
J7340	J7503	J7512	J7999	J8655	L8607	P9070
P7091	P9072	Q4161	Q4162	Q4163	Q4164	Q4165
Q9950						

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

_____

Dawn Stehle
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – All Providers**

EFFECTIVE DATE: **August 26, 2016**

SUBJECT: **Provider Manual Update Transmittal SecV-6-16**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
500.000	—	500.000	—
—	—	DMS-6	8-26-16

Explanation of Updates

Section 500.000 is updated to add form DMS-6, Request for Prior Approval for the Special Pharmacy Therapeutic Agents and Treatments.

This transmittal and the enclosed forms are for informational purposes only. **Please do not complete the enclosed forms.**

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

REQUEST FOR PRIOR APPROVAL FOR THE SPECIAL PHARMACY THERAPEUTIC AGENTS AND TREATMENTS

AFMC
Attention: Physician Drug Review
1020 W. 4th St.
Suite 300
Little Rock, AR 72201
Phone: 501-212-8741
Fax: 501-212-8663

Date_____/_____/_____

Important: If all required information is not completed, the form will be returned to the provider.

(1) Performing Provider	(2) Provider ID
(3) Mailing Address	(4) Group Provider ID
City State Zip	
(5) Performing Provider Signature & Credentials	

(6) Beneficiary Name (Last) (First) (M.I.)	
(7) Address City State Zip	
(8) Medicaid Beneficiary ID (10 digits)	(9) DOB MM/DD/YY Sex

To file a Request for Prior Approval, the following information is required:

(10) Start Date	(11) End Date	(12) Diagnosis Code	(13) Procedure Code	(14) Procedure Description	(15) Dosage per Infusion	(16) Frequency (how often)	(17) Units

(18) Treatment Protocol

Note: Attach copies of medical records and physician orders signed by physician supporting medical necessity of requested services/procedures.

Instructions for Prior Approval Requests for Special Pharmacy Therapeutic Agents and Treatments

Please be sure to follow Arkansas Medicaid policy for each code, found online at:

Online Physician manual:

https://www.medicaid.state.ar.us/Download/provider/provdocs/Manuals/PHYSICN/PHYSICN_II.doc

Instructions in Section 292.950

Online Hospital manual:

https://www.medicaid.state.ar.us/Download/provider/provdocs/Manuals/hospital/HOSPITAL_II.doc

Instructions in Section 272.510

A PRIOR APPROVAL REQUEST CANNOT BE APPROVED WITHOUT THE FOLLOWING INFORMATION:

1. Performing Provider
2. Provider ID
3. Mailing Address
4. Group Provider ID or Hospital ID
5. Performing Provider Signature
6. Beneficiary Name
7. Beneficiary Address
8. Beneficiary Medicaid Number
9. Date of Birth
10. Start Date (when the infusion begins) i.e. 02/15/16
11. End Date (when the infusion ends) i.e. 02/15/17
12. Diagnosis Code ICD-10 i.e. M35.9
13. Procedure Code i.e. J1745
14. Procedure Code Description i.e. Infliximab 10 mg
15. Dosage per Infusion i.e. 40 mg
16. Frequency i.e. every 21 days
17. Units
18. Treatment Protocol

Instructions for Required Documentation for Prior Approval for Ophthalmologic Injections

Required Medical Record Documentation

1) A fluorescein angiogram or OCT performed to evaluate the lesion type, location and size, and presence of subretinal fluid.
2) In accordance with prescribing information for drug, patient screen for medical conditions that would contraindicate the use of drug.
3) Patient consent.
    a. Patient should be aware of the real potential for complications associated with this drug if treatment is “off-label.”
    b. Entry in the medical record documenting that these items have been discussed and the patient to understand the risks and benefits of the use of this drug in an off-label setting.
4) The medical record must contain the actual dosage, site, date and time of administration.
5) All clinical documentation must be signed by an enrolled Arkansas Medicaid physician.

Fax to:	501-212-8663
Call with questions:	501-212-8741

SECTION V – FORMS
500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

Field Code Changed

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form – AAS-9559	Client Employer
Dental – ADA-J430	Business Form Supplier

Field Code Changed

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adjustment Request Form – Medicaid XIX – Pharmacy Program	DMS-802

Field Code Changed

Form Name	Form Link	
Adverse Effects Form	DMS-2704	Field Code Changed
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A	Field Code Changed
Amplification/Assistive Technology Recommendation Form	DMS-686	Field Code Changed
Application for WebRA Hardship Waiver	DMS-7736	Field Code Changed
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687	Field Code Changed
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a	Field Code Changed
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	DMS-844	Field Code Changed
Arkansas Medicaid Patient-Centered Medical Home Program Practice Update/Change Request Form	DMS-801	Field Code Changed
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	DMS-845	Field Code Changed
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	DMS-846	Field Code Changed
ARKids First Behavioral Health Services Provider Qualification Form	DMS-612	Field Code Changed
Authorization for Automatic Deposit	autodeposit	Field Code Changed
Authorization for Payment for Services Provided	MAP-8	Field Code Changed
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633	Field Code Changed
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT	Field Code Changed
Certification Statement for Abortion	DMS-2698	Field Code Changed
Change of Ownership Information	DMS-0688	Field Code Changed
Child Health Management Services Enrollment Orders	DMS-201	Field Code Changed
Child Health Management Services Discharge Notification Form	DMS-202	Field Code Changed
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A	Field Code Changed
CHMS Request for Prior Authorization	DMS-102	Field Code Changed
Claim Correction Request	DMS-2647	Field Code Changed
Consent for Release of Information	DMS-619	Field Code Changed
Contact Lens Prior Authorization Request Form	DMS-0101	Field Code Changed
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653	Field Code Changed
DDTCS Transportation Log	DMS-638	Field Code Changed
DDTCS Transportation Survey	DMS-632	Field Code Changed
Dental Treatment Additional Information	DMS-32-A	Field Code Changed
Disclosure of Significant Business Transactions	DMS-689	Field Code Changed
Disproportionate Share Questionnaire	DMS-628	Field Code Changed

Form Name	Form Link	
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693	Field Code Changed
Early Childhood Special Education Referral Form	ECSE-R	Field Code Changed
EPSDT Provider Agreement	DMS-831	Field Code Changed
Explanation of Check Refund	HP-CR-002	Field Code Changed
Gait Analysis Full Body	DMS-647	Field Code Changed
Home Health Certification and Plan of Care	CMS-485	Field Code Changed
Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645	Field Code Changed
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685	Field Code Changed
Individual Renewal Form for School-Based Audiologists	DMS-7782	Field Code Changed
Lower-Limb Prosthetic Evaluation	DMS-650	Field Code Changed
Lower-Limb Prosthetic Prescription	DMS-651	Field Code Changed
Media Selection/E-Mail Address Change Form	HP-MS-005	Field Code Changed
Medicaid Claim Inquiry Form	HP-CI-003	Field Code Changed
Medicaid Form Request	HP-MFR-001	Field Code Changed
Medical Equipment Request for Prior Authorization & Prescription	DMS-679	Field Code Changed
Medical Transportation and Personal Assistant Verification	DMS-616	Field Code Changed
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633	Field Code Changed
Notice Of Noncompliance	DMS-635	Field Code Changed
NPI Reporting Form	DMS-683	Field Code Changed
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640	Field Code Changed
Ownership and Conviction Disclosure	DMS-675	Field Code Changed
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish	Field Code Changed Field Code Changed
Practitioner Identification Number Request Form	DMS-7708	Field Code Changed
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615	Field Code Changed
Primary Care Physician Managed Care Program Referral Form	DMS-2610	Field Code Changed
Primary Care Physician Participation Agreement	DMS-2608	Field Code Changed
Primary Care Physician Selection and Change Form	DMS-2609	Field Code Changed
Procedure Code/NDC Detail Attachment Form	DMS-664	Field Code Changed
Provider Application	DMS-652	Field Code Changed
Provider Communication Form	AAS-9502	Field Code Changed

Form Name	Form Link	
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A	Field Code Changed
Provider Enrollment Application and Contract Package	Application Packet	Field Code Changed
Quarterly Monitoring Form	AAS-9506	Field Code Changed
Referral for Audiology Services – School-Based Setting	DMS-7783	Field Code Changed
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634	Field Code Changed
Referral for Medical Assistance	DMS-630	Field Code Changed
Request for Appeal	DMS-840	Field Code Changed
Request for Extension of Benefits	DMS-699	Field Code Changed
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671	Field Code Changed
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602	Field Code Changed
Request for Molecular Pathology Laboratory Services	DMS-841	Field Code Changed
Request for Orthodontic Treatment	DMS-32-0	Field Code Changed
Request for Prior Approval for the Special Pharmacy Therapeutic Agents and Treatments	DMS-6	Field Code Changed
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692	Field Code Changed
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601	Field Code Changed
Research Request Form	HP-0288	Field Code Changed
Service Log – Personal Care Delivery and Aides Notes	DMS-873	Field Code Changed
Sterilization Consent Form	DMS-615 English DMS-615 Spanish	Field Code Changed Field Code Changed
Sterilization Consent Form – Information for Men	PUB-020	Field Code Changed
Sterilization Consent Form – Information for Women	PUB-019	Field Code Changed
Targeted Case Management Contact Monitoring Form	DMS-690	Field Code Changed
Upper-Limb Prosthetic Evaluation	DMS-648	Field Code Changed
Upper-Limb Prosthetic Prescription	DMS-649	Field Code Changed
Vendor Performance Report	Vendorperformreport	Field Code Changed
Verification of Medical Services	DMS-2618	Field Code Changed

In order by form number:

AAS-9502
AAS-9506
AAS-9559
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-2704
DMS-32-A
DMS-32-0
DMS-6
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-690
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-801
DMS-802
DMS-831
DMS-840
DMS-841
DMS-844
DMS-845
DMS-846
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association
Americans with Disabilities Act Coordinator
Arkansas Department of Education, Health and Nursing Services Specialist
Arkansas Department of Education, Special Education
Arkansas Department of Finance Administration, Sales and Tax Use Unit
Arkansas Department of Human Services, Division of Aging and Adult Services
Arkansas Department of Human Services, Appeals and Hearings Section
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit

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Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit — Field Code Changed
Arkansas Department of Human Services, Children's Services — Field Code Changed
Arkansas Department of Human Services, Division of County Operations, Customer Assistance Section — Field Code Changed
Arkansas Department of Human Services, Division of Medical Services — Field Code Changed
Arkansas DHS, Division of Medical Services Director — Field Code Changed
Arkansas DHS, Division of Medical Services, Benefit Extension Requests, UR Section — Field Code Changed
Arkansas DHS, Division of Medical Services, Dental Care Unit — Field Code Changed
Arkansas DHS, Division of Medical Services, Hewlett Packard Enterprise Provider Enrollment Unit — Field Code Changed
Arkansas DHS, Division of Medical Services, Financial Activities Unit — Field Code Changed
Arkansas DHS, Division of Medical Services, Hearing Aid Consultant — Field Code Changed
Arkansas DHS, Division of Medical Services, Medical Assistance Unit — Field Code Changed
Arkansas DHS, Division of Medical Services, Medical Director for Clinical Affairs — Field Code Changed
Arkansas DHS, Division of Medical Services, Pharmacy Unit — Field Code Changed
Arkansas DHS, Division of Medical Services, Program Communications Unit — Field Code Changed
Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit — Field Code Changed
Arkansas DHS, Division of Medical Services, Third-Party Liability Unit — Field Code Changed
Arkansas DHS, Division of Medical Services, UR/Home Health Extensions — Field Code Changed
Arkansas DHS, Division of Medical Services, Utilization Review Section — Field Code Changed
Arkansas DHS, Division of Medical Services, Visual Care Coordinator — Field Code Changed
Arkansas Department of Health — Field Code Changed
Arkansas Department of Health, Health Facility Services — Field Code Changed
Arkansas Department of Human Services, Accounts Receivable — Field Code Changed
Arkansas Foundation for Medical Care — Field Code Changed
Arkansas Foundation for Medical Care, Retrospective Review for Therapy and Prior Authorization for Personal Care for Under Age 21 — Field Code Changed
Arkansas Foundation for Medical Care, Provider Relations Representative — Field Code Changed
Arkansas Hospital Association — Field Code Changed
Arkansas Office of Medicaid Inspector General (OMIG) — Field Code Changed
ARKids First-B — Field Code Changed
ARKids First-B ID Card Example — Field Code Changed
Central Child Health Services Office (EPSDT) — Field Code Changed
ConnectCare Helpline — Field Code Changed
County Codes — Field Code Changed
Dental Contractor — Field Code Changed
Hewlett Packard Enterprise Claims Department — Field Code Changed

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Summary for
2016 CPT and HCPCS Procedure Code Conversion

To comply with federal regulation 45 CFR Subpart J, Section 162.1002, these Notices of Rulemaking informs providers of the implementation of the annual Current Procedure Codes, (CPT), and the annual Healthcare Common Procedure Codes Systems, (HCPCS). These data sets are created and published by the American Medical Association and the Centers for Medicare and Medicaid on an annual basis. This Rule is necessary for consistency with the utilization of procedure codes used by Medicare and other third party payers of medical claims. These data sets are standardized and are used nationally for claims processing. This emergency notice will help expedite claims processing. Payable procedure codes will be added to the provider fee schedules and policy manuals will be updated as necessary. This will ensure that additional claims system testing will not be needed before implementation, resulting in subsequent delays and further lost efficiency of time. It will also help to put 2016 CPT/HCPCS planning, programming, testing, and promulgation processes back on its regular timelines. Emergency filing is necessary to allow providers to bill on the 2016 codes.