

## Arkansas Medicaid Autism Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Fee Schedule

This fee schedule does not address the various coverage limitations routinely applied by Arkansas Medicaid before final payment is determined (e.g., beneficiary and provider eligibility, benefit limits, billing instructions, frequency of services, third party liability, age restrictions, prior authorization, co-payments/coinsurance where applicable). Procedure codes and/or fee schedule amounts listed do not guarantee payment, coverage or amount allowed.

Although every effort is made to ensure the accuracy of this information, discrepancies may occur. This fee schedule may be changed or updated at any time to correct such discrepancies. The reimbursement rates reflected in this fee schedule are in effect as of the date of this report. The reimbursement rate applied to a claim depends on the claim's date of service because Arkansas Medicaid's reimbursement rates are date-of-service effective. This fee schedule reflects only procedure codes that are currently payable. Any procedure code reflecting a Medicaid maximum of \$0.00 is manually priced.

Please note that Arkansas Medicaid will reimburse the lesser of the amount billed or the Medicaid maximum. For a full explanation of the procedure codes and modifiers listed here, refer to your Arkansas Medicaid provider manual and provider notices.

Run Date 10/5/20

### Provider Type: 90

Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Medicaid Maximum Allowed Amount
97151	EP				\$20.00
97152	EP				\$15.00
97153	EP				\$15.00
97154	EP				\$8.00
97155	EP				\$22.50
97156	EP				\$20.00
97158	EP				\$10.00